Appendix N

Prior Authorization Request Denial Reasons

PAR Denial Reasons are listed alphabetically by type

AIDS Services

Denial Code	Long Description
0201	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
0233	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0235	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0237	CLIENT IDENTIFICATION NUMBER DOES NOT MATCH CLIENTS FIRST NAME.
0238	THE CLIENT IDENTIFICATION NUMBER DOES NOT MATCH THE CLIENTS LAST NAME.
0242	SECONDARY DIAGNOSIS CODE IS INVALID.
0248	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0249	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0258	THE PRIMARY DIAGNOSIS CODE IS REQUIRED.
0272	THE PRIMARY DIAGNSOSIS CODE IS INVALID.
0339	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0340	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0400	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0853	HCPCS - ANNUAL UPDATE
0885	NEVER EVENTS MODIFIERS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
0886	NEVER EVENTS DIAGNOSIS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
1000	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
1002	RENDERING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1003	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1007	RENDERING PROVIDER ID IS NOT ON FILE.
1024	THE LEVEL OF CARE DOES NOT AGREE WITH THE CLIENT FILE.
1048	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1801	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
1806	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
1900	THE BILLING PROVIDERS TAXONOMY CODE IS INVALID.
1901	THE RENDERING PROVIDERS TAXONOMY CODE IS INVALID.
1927	A NATIONAL PROVIDER IDENTIFIER IS REQUIRED FOR THE BILLING PROVIDER.
1934	A NATIONAL PROVIDER INDENTIFIER IS REQUIRED FOR THE RENDERING PROVIDER.
1936	THE BILLING PROVIDER NUMBER IS INVALID.
1960	INTERNAL PROCESSING IS REQUIRED.
1964	THE BILLING PROVIDER INDICATED IS NOT ALLOWABLE AS A BILLING PROVIDER.
1965	RENDERING PROVIDER NUMBER IS MISSING/INVALID FOR THIS PROCEDURE PROVIDER.
1974	PRESCRIBING/REFERRING/ORDERING PROVIDER INDICATED IS NOT CERTIFIED AS A PRESCRIBING/REFERRING/ORDERING PROVIDER.
1975	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
1976	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
2001	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2003	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2017	THE CLIENT IS ENROLLED IN A MEDICAID OR OTHER MANAGED CARE PROGRAM.
2037	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2043	THIS SERVICE IS NOT COVERED. THE CLIENT IS IN A DIVESTMENT PENALTY PERIOD.
2603	CLIENT LOCKED-IN TO A PROVIDER OR ENROLLED IN A HOSPICE. CONTACT CLIENTS HOSPICE FOR PAYMENT OF SERVICES OR RESUBMIT WITH DOCUMENTATION OF UNRELATED NATURE OF CARE.
4027	THE DIAGNOSIS CODE IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
4031	THE PROCEDURE SUBMITTED IS NOT APPROPRIATE FOR CLIENTS GENDER.

Denial Code	Long Description
4040	THE PRIMARY DIAGNOSIS CODE IS NOT ON FILE.
4041	THE SECONDARY DIAGNOSIS IS NOT ON FILE.
4046	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4059	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4077	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4127	INTERNAL PROCESSING IS REQUIRED.
4131	INTERNAL PROCESSING IS REQUIRED.
4151	THE PROVIDER IS NOT AUTHORIZED TO PERFORM THE PROCEDURE.
4227	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4244	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4321	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4322	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4374	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4711	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR CLIENTS AGE.
4733	DIAGNOSIS AND/OR PROCEDURE AND/OR PLACE OF SERVICE (POS) CODE IS NOT COVERED FOR EXPRESS ENROLLMENT CLIENTS.
4802	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
4804	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4874	PLEASE REFER TO PA MESSAGES FOR RETURN INFORMATION.
4975	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
7500	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
P001	THE BILLING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THE SERVICES.
P002	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P003	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P005	THE PRIOR AUTHORIZATION CAN NOT BE END DATED. THE PRIOR AUTHORIZATION STATUS IS NOT APPROVED OR APPROVED WITH REVISIONS.
P006	PLEASE FURNISH THE PROCEDURE CODE AND CORRESPONDING DESCRIPTION.
P008	THE BILLING PROVIDER NUMBER IS INVALID.
P009	THE BILLING PROVIDER NUMBER IS INVALID.
P010	THE REQUESTED END DATE IS INVALID.
P011	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P012	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P013	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P014	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P015	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P016	THE REQUESTED START DATE IS MISSING OR INVALID.
P019	THE REQUESTED START DATE IS MISSING OR INVALID.
P020	THE RENDERING PROVIDER NUMBER IS INVALID.
P021	THE RENDERING PROVIDER NUMBER IS INVALID.
P022	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P023	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P024	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P026	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P027	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P030	FIRST MODIFIER IS INVALID.
P031	FIRST MODIFIER IS INVALID.

Denial Code	Long Description
P032	SECOND MODIFIER IS INVALID.
P033	SECOND MODIFIER IS INVALID.
P034	THIRD MODIFIER IS INVALID.
P035	THIRD MODIFIER IS INVALID.
P036	FOURTH MODIFIER IS INVALID.
P037	FOURTH MODIFIER IS INVALID.
P038	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P039	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P040	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P041	CLIENTS FIRST NAME IS MISSING.
P042	CLIENTS LAST NAME IS MISSING.
P043	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P044	BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES REQUESTED.
P045	FIRST MODIFIER IS INVALID.
P046	SECOND MODIFIER IS INVALID.
P047	THIRD MODIFIER IS INVALID.
P048	FOURTH MODIFIER IS INVALID.
P052	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P053	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P054	RENDERING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES FOR THE BENEFIT PLAN.
P055	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P057	PLEASE FURNISH THE REVENUE CODE AND CORRESPONDING DESCRIPTION.
P061	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P062	THE CLIENT ID AND/OR NAME INDICATED ON THE PA REQUEST IS INCORRECT. THE CLIENT ID AND/OR NAME HAS BEEN UPDATED. PLEASE VERIFY THE ID AND/OR NAME IS CORRECT.
P064	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
P067	THE FREQUENCY OF HOURS REQUESTED ARE NOT APPROPRIATE FOR THIS CLIENT AND HAVE BEEN MODIFIED ACCORDINGLY.
P079	BILLING PROVIDER IS ON PAYMENT SUSPENSION DUE TO CREDIBLE ALLEGATION OF FRAUD.
P120	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAS BEEN REDUCED.
P121	THE SERVICE/ PROCEDURE REQUESTED IS NOT SUPPORTED BY SUBMITTED DOCUMENTATION.
P126	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
P128	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.
P138	SERVICE(S) DO NOT MEET COLORADO MEDICAID GUIDELINES.
P167	REQUESTED DOCUMENTATION HAS NOT BEEN SUBMITTED.
P178	THE SERVICE REQUESTED IS NOT MEDICALLY NECESSARY.
P179	THE MEDICAL NECESSITY FOR THIS SERVICE IS NOT SUPPORTED BY THE SUBMITTED DOCUMENTATION.
P233	THE DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE ADDITIONAL CARE.
P257	THIS CLIENTS FUNCTIONAL ASSESSMENT SCORES PLACE THIS CLIENT OUTSIDE ELIGIBILITY FOR DAY TREATMENT.
P274	OUR RECORDS INDICATE THIS CLIENT IS INVOLVED IN EFFECTIVE AND APPROPRIATE SERVICE ELSEWHERE.
P292	INTENSIVE REHABILITATION HOURS ARE NO LONGER APPROPRIATE AS INDICATED BY HISTORY, DIAGNOSIS, AND/ OR FUNCTIONAL ASSESSMENT SCORES.
P328	THE SERVICES REQUESTED INCLUDE NON-COVERED SERVICES, AND HOURS ARE REDUCED ACCORDINGLY.
P339	THE CLIENTS PAST HISTORY INDICATES REDUCED TREATMENT HOURS ARE WARRANTED.

Denial Code	Long Description
P342	THE REQUEST DOES NOT MEET GENERALLY ACCEPTED CONDITIONS REQUIRING FLUORIDE TREATMENTS.
P346	SERVICES EXCEED COLORADO MEDICAID LIMITATION AND DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE MEDICAL NECESSITY OF THE SERVICE.
P349	THE SERVICE REQUESTED WAS PERFORMED LESS THAN FIVE YEARS AGO.
P353	THE EXISTING APPLIANCE HAS NOT BEEN WORN FOR THREE YEARS.
P367	THE CLIENT HAS BEEN TOTALLY WITHOUT TEETH AND AN APPLIANCE FOR FIVE YEARS.
P392	THE CLIENT IS MISSING AN ANTERIOR TOOTH AND/OR HAS TWO OR MORE POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P405	THE SERVICE(S) REQUESTED COULD ADEQUATELY BE PERFORMED IN THE DENTAL OFFICE.
P406	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE OF GOOD PERIODONTAL HEALTH (AMERICAN ACADEMY OF PERIODONTOLOGY PERIODONTAL CLASSIFICATION OF TYPE I OR II).
P407	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE VISIBLE ON RADIOGRAPHS THAT AT LEAST 50 PERCENT OF THE CLINICAL CROWN IS INTACT.
P409	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING SIX OR MORE TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED, INCLUDING THIRD MOLARS.
P410	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING ONE OR MORE ANTERIOR TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED.
P411	DOCUMENTATION DOES NOT SUPPORT THE NEED FOR PERIODONTIC SERVICES. POCKETS ARE LESS THAN 4MM AND/OR GREATER THAN 6MM FOR CLIENT AND/OR THE CLIENT IS UNDER THE AGE OF 13.
P412	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA.
P413	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA. THIS PA HAS BEEN GRANTED AS APPROVED NOT APPROVED WITH REVISIONS. THE DURATION REQUESTED MAY HAVE BEEN REDUCED TO REFLECT COVERAGE LIMITATIONS, PRESCRIBER ORDERS, CONFLICTI
P417	THE SERVICE(S) REQUESTED COULD BE ADEQUATELY PERFORMED WITH LOCAL ANESTHESIA.
P437	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO POOR ORAL HYGIENE.
P444	THIS LINE ITEM IS A DUPLICATE OF ANOTHER LINE ITEM ON THIS PRIOR AUTHORIZATION (PA) REQUEST. PLEASE CORRECT.
P446	THIS IS A DUPLICATE OF AN EXISTING PRIOR AUTHORIZATION (PA) REQUEST. YOU MAY CONTACT PROVIDER SERVICES IF YOU REQUIRE ASSISTANCE. DUPLICATE PA REQUEST
P448	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO DECAY HISTORY.
P449	QUESTIONABLE LONG TERM PROGNOSIS DUE TO GUM AND BONE DISEASE.
P456	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO APPARENT ROOT INFECTION.
P457	OUR RECORDS INDICATE THIS CLIENT HAS EXCEEDED ESTABLISHED PROGRAM LIMITATIONS. COLORADO MEDICAID WILL NOT AUTHORIZE NEW DENTURES.
P458	DOCUMENTATION PROVIDED INDICATES A LESS ELABORATE PROCEDURE SHOULD BE CONSIDERED.
P502	RENTAL ONLY ALLOWED; MEDICAL NEED FOR PURCHASE HAS NOT BEEN DOCUMENTED.
P503	PURCHASE ONLY ALLOWED; MEDICAL NEED FOR RENTAL HAS NOT BEEN DOCUMENTED.
P504	OCCUPATIONAL THERAPY GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P505	THE SERVICE REQUESTED IS INCLUDED IN THE NURSING HOME RATE STRUCTURE.
P511	THIS NATIONAL DRUG CODE IS ONLY BILLABLE AS PART OF A COMPOUND DRUG.
P515	THE PRESENCE OF A HANDICAPPING MALOCCLUSION OR HANDICAPPING DENTOFACIAL DEFORMITY IS NOT SUPPORTED BY THE DOCUMENTATION SUBMITTED.
P521	THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVERED BY COLORADO MEDICAID.
P522	GASTRO-INTESTINAL SURGERY FOR THE PURPOSE OF WEIGHT CONTROL IS COVERED ONLY AS A LIFE THREATENING PROCEDURE.
P523	THE TREATMENT REQUEST IS NOT CONSISTENT WITH THE CLIENT'S DIAGNOSIS.
P524	PSYCHOTHERAPY PROVIDED IN THE CLIENTS HOME IS NOT A COVERED BENEFIT OF COLORADO MEDICAID .
P525	THE INFORMATION PROVIDED IS NOT CONSISTENT WITH THE INTENSITY OF SERVICES REQUESTED.
P526	INTENSIVE MULTIPLE MODALITY TREATMENT IS NOT CONSISTENT WITH THE INFORMATION PROVIDED.

Denial Code	Long Description
P527	MULTIPLE PROVIDERS OF TREATMENT ARE NOT INDICATED FOR THIS CLIENT.
P528	THE DURATION OF TREATMENT SESSIONS EXCEED CURRENT COLORADO MEDICAID GUIDELINES.
P534	DOCUMENTATION OF POOR PHYSICAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P535	OTHER PHYSICAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P536	THE PHYSICAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P537	USE OF PHYSICAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P538	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF A PHYSICAL THERAPIST.
P539	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS AND LIVING ARRANGEMENT.
P540	GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P541	THE PROCEDURE(S) REQUESTED ARE NOT MEDICAL IN NATURE.
P542	DOCUMENTATION OF POOR OCCUPATIONAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P543	DOCUMENTATION OF POOR SPEECH THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P544	OTHER OCCUPATIONAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P546	THE OCCUPATIONAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P547	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF PHYSICAL THERAPY.
P548	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P549	ACTIVITIES TO PROMOTE DIVERSION OR GENERAL MOTIVATION ARE NONCOVERED COLORADO MEDICAID SERVICES.
P550	REVISIONS OF THE REQUEST IS NECESSITATED BY THE CLIENTS MINIMAL PROGRESS.
P551	RESTORATIVE NURSING INVOLVEMENT COULD BE INCREASED.
P552	CLIENTS DEMONSTRATED RESPONSE TO CURRENT THERAPY DOES NOT WARRANT THE INTENSE FREQUENCY REQUESTED.
P553	MAINTENANCE IS TWO TIMES PER WEEK OR LESS.
P554	THE SPEECH THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P555	USE OF OCCUPATIONAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P556	USE OF SPEECH THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P557	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF AN OCCUPATIONAL THERAPIST.
P558	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
P559	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P560	THE MATERIALS/ SERVICES REQUESTED ARE PRINCIPALLY COSMETIC IN NATURE.
P561	THE LENS FORMULA DOES NOT JUSTIFY REPLACEMENT.
P562	THE CHANGE IN THE LENS FORMULA DOES NOT WARRANT MULTIPLE REPLACEMENTS.
P563	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P564	LENSES ONLY ARE APPROVED; PLEASE DISPENSE A CONTRACTED FRAME. THE NON-CONTRACTED FRAME IS NOT MEDICALLY JUSTIFIED.
P565	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P566	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P567	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF OCCUPATIONAL THERAPY.
P568	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF SPEECH THERAPY.

Denial Code	Long Description
P569	LEVEL, INTENSITY, OR EXTENT OF SERVICE(S) REQUESTED HAS BEEN MODIFIED CONSISTENT WITH MEDICAL NEED AS DEFINED IN THE PLAN OF CARE.
P570	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P571	THE SERVICE ASKED FOR IS NOT COVERED BY COLORADO MEDICAID AS THESE TASKS CAN BE DONE BY NURSES OR ACTIVITY STAFF.
P572	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P573	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.
P574	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P575	MEDICAL NEED FOR EQUIPMENT/ SUPPLY REQUESTED IS NOT SUPPORTED BY DOCUMENTATION SUBMITTED.
P576	OTHER SPEECH THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P577	DOCUMENTATION SUBMITTED IDENTIFIES THAT THE CLIENT HAS FEWER THAN TWO POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P582	LESS EXPENSIVE ALTERNATIVE SERVICES ARE AVAILABLE FOR THIS CLIENT.
P634	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P711	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING PERIODONTAL SCALING AND ROOT PLANNING.
P712	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING GINGIVECTOMY.
P754	AN APPROVED SUBSTANCE ABUSE DAY TREATMENT PROGRAM CANNOT EXCEED A SIX WEEK PERIOD.
P761	THE CLIENT DOES NOT APPEAR TO BE ABLE OR WILLING TO ABSTAIN FROM ALCOHOL/DRUG USAGE WHILE IN TREATMENT. THEREFORE, SUBSTANCE ABUSE DAY TREATMENT SERVICES ARE NOT APPROVED.
P764	THIS CLIENT HAS COMPLETED INTENSIVE SUBSTANCE ABUSE TREATMENT WITHIN THE PAST 12 MONTHS. THE DOCUMENTATION PROVIDED IS NOT ADEQUATE TO JUSTIFY ADDITIONAL INTENSIVE TREATMENT AT THIS TIME.
P785	A LESS THAN SIX-WEEK HEALING PERIOD HAS BEEN SPECIFIED FOR THIS PRIOR AUTHORIZATION. THEREFORE IT IS NOT NECESSARY TO WAIT THE FULL SIX WEEKS AFTER EXTRACTIONS BEFORE TAKING DENTURE IMPRESSIONS.
P818	SIX-WEEK HEALING TIME IS REQUIRED BETWEEN EDENTULATION AND FINAL IMPRESSIONS. PAYMENT FOR DENTURES WILL BE DENIED OR RECOUPED IF HEALING PERIOD IS NOT OBSERVED.
P849	COLORADO MEDICAID HAS DETERMINED THERE WERE (ARE) SEVERAL HOME HEALTH AGENCIES WILLING TO PROVIDE MEDICALLY NECESSARY SKILLED NURSING SERVICES TO THIS CLIENT.
P864	THE DOCUMENTATION YOU HAVE SUBMITTED DOES NOT MEET THE REQUIREMENTS OF COLORADO MEDICAID.
P873	THE MEDICAL NECESSITY FOR THE HOURS REQUESTED IS NOT SUPPORTED BY THE INFORMATION SUBMITTED.
P874	THE DOCUMENTATION SUBMITTED INDICATES THE TASKS SPECIFIED CAN BE COMPLETED DURING THE VISITS APPROVED.
P878	THE DOCUMENTATION SUBMITTED DOES NOT INDICATE THAT MEDICALLY ORIENTED TASKS ARE MEDICALLY NECESSARY; THEREFORE PERSONAL CARE SERVICES HAVE BEEN APPROVED.
P880	THE QUANTITY OF SERVICES AUTHORIZED FOR THIS CLIENTS PERSONAL CARE HAS BEEN AMENDED BASED ON INFORMATION RECEIVED FROM ONE OR MORE OF THESE SOURCES: THE CLIENT, THEIR PHYSICIAN, AND/OR THE IN-HOME VISIT BY STAFF OF THE OIG (OFFICE OF INSPECTOR GENERAL).
P885	THE USE OF THIS DRUG FOR THE INTENDED PURPOSE IS NOT COVERED BY COLORADO MEDICAID, CONSISTENT WITH COLORADO ADMINISTRATIVE CODE AND FEDERAL LAW.
P924	THE MEDICAL RECORDS SUBMITTED WITH THE CURRENT REQUEST CONFLICT OR DISAGREE WITH OUR MEDICAL RECORDS ON THIS CLIENT.
P950	INDEPENDENT NURSES, PLEASE NOTE PAYABLE SERVICES MAY NOT EXCEED 12 HOURS/DAY OR 60 HOURS/WEEK.
P951	SERVICES CAN ONLY BE AUTHORIZED THROUGH ONE YEAR FROM THE PRESCRIPTION DATE.

Denial Code	Long Description
P952	LEAD INSPECTION IS A COVERED COLORADO MEDICAID SERVICE WHEN THE CHILD HAS BEEN SHOWN TO HAVE LEAD POISONING (E.G., CHILD HAS A BLOOD LEAD LEVEL > 19 UG/DL OR TWO CONSECUTIVE BLOOD LEAD LEVELS OF 15-19 UG/DL DONE AT LEAST 90 DAYS APART). THE INSPECTION MUS
P953	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P954	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P956	THE REQUEST CAN ONLY BE BACKDATED A MAXIMUM OF 14 DAYS FROM FIRST DATE RECEIVED BY COLORADO MEDICAID.
P957	COMPLETE PERIODONTAL CHARTING AT TIME OF SERVICE, AND SUBMIT CHARTING, COPY OF OPERATIVE REPORT, TOGETHER WITH A COPY OF THE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF), F-11035, TO PA UNIT ATTENTION DENTAL CONTSULTANT.
P958	NOTE THAT CODE D4341 HAS BEEN CHANGED. REFER TO THE DECISION NOTICE FOR AUTHORIZED QUANTITY.
P960	YOUR PA HAS BEEN APPROVED FOR 90 DAYS. THE 90 DAY APPROVAL DOES NOT IMPLY THE PA REQUEST MEETS PRIOR AUTHORIZATION CRITERIA. AFTER ADDITIONAL INFORMATION IS AVAILABLE IN INTERCHANGE, COLORADO MEDICAID WILL CREATE AN AMENDMENT REQUEST TO EXTEND THE PA FOR
P961	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P962	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
PA10	THE REQUESTED END DATE IS INVALID.
PA12	PLEASE FURNISH A WRITTEN DESCRIPTION OF THE CLIENTS DIAGNOSIS.
PA13	PROVIDE DIAGNOSES WITH DATES OF ONSET.
PA14	IDENTIFY PROBLEMS TO BE TREATED.
PA15	THE AUDIOLOGISTS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1), F-11020, AND PRIOR AUTHORIZATION REQUEST/HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2), F-11021.
PA16	THE PHYSICIANS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION/PHYSICIAN OTOLOGICAL REPORT (PA/POR), F-11019.
PA17	SUBMIT BRIEF HISTORY WITH REFERRAL INFORMATION, LIVING SITUATION, FUNCTIONAL STATUS, AND OTHER PERTINENT INFORMATION. WHAT CHANGE OF STATUS RESULTED IN REFERRAL AT THIS TIME?
PA18	PLEASE FURNISH THE CLIENTS HEIGHT AND WEIGHT.
PA19	PLEASE SUBMIT CLINICAL INFORMATION SUFFICIENT TO VERIFY THE NEED FOR THE REQUESTED SERVICE(S).
PA20	PLEASE RESUBMIT WITH COMPLETE PERIODONTAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PA21	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL EDUCATIONAL PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA22	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL PROGRAM PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA23	REFER TO THE DURABLE MEDICAL EQUIPMENT INDEX FOR APPROPRIATE CODE AND DESCRIPTION. DO NOT USE AN "UNLISTED" CODE.
PA24	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUALIZED FAMILY SERVICE PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA25	INFORMATION ON THE REQUEST FORM IS ILLEGIBLE, AND THE REQUEST CANNOT BE PROCESSED.
PA26	RE-EVALUATE YOUR GOALS. EMPHASIS SHOULD BE ON FUNCTIONAL SELF-CARE. GOALS MUST BE RELATED TO FUNCTIONAL OUTCOME.
PA27	PLEASE CLARIFY THE NUMBER OF HOURS PER WEEK REQUESTED.
PA28	PLEASE CLARIFY THE NUMBER OF HOURS PER DAY REQUESTED.
PA29	PLEASE CLARIFY THE NUMBER OF VISITS PER DAY REQUESTED.
PA30	ATTACH SUPPORTIVE DOCUMENTATION; HOME EXERCISE PROGRAM AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.

Denial Code	Long Description
PA31	THE DIAGNOSIS CODE INDICATED ON THE REQUEST DOES NOT CORRESPOND TO THE DIAGNOSIS CODE DESCRIPTION.
PA32	PLEASE SUBMIT ADDITIONAL INFORMATION SUFFICIENT TO VERIFY APPROPRIATENESS AND NEED FOR TRANSPLANT.
PA33	PLEASE SUBMIT THE INITIAL AND PROGRESSIVE OBJECTIVE FINDINGS.
PA34	ATTACH SUPPORTIVE DOCUMENTATION, FACILITY PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA35	PLEASE SUBMIT THE CLIENTS ORIGINAL COMPLAINTS AND EXAMINATION FINDINGS.
PA36	ATTACH SUPPORTIVE DOCUMENTATION, IN-HOME AUTISM PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA37	PLEASE SUBMIT YOUR TREATMENT PLAN FOR THIS CLIENT.
PA38	ATTACH SUPPORTIVE DOCUMENTATION AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA39	INITIAL EVALUATIONS MUST BE PERFORMED BY AN OCCUPATIONAL THERAPIST REGISTERED (OTR), PER AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA) STANDARDS.
PA41	IDENTIFY THE PLACE OF SERVICE AND ITS EFFECT ON SUPPORTING THE DESIRED TREATMENT OUTCOME.
PA42	PLEASE INDICATE THE HOURS OF USE OF OXYGEN PER 24-HOUR PERIOD.
PA43	PROVIDE BASELINE DOCUMENTATION FOR THIS CLIENTS LIMITATIONS USING UNITS OF MEASUREMENT THAT ARE APPLIED CONSISTENTLY WHEN REPORTING STATUS.
PA44	IDENTIFY FUNCTIONAL LIMITATIONS AS THEY ARE RELATED TO IDENTIFIED CONDITIONS.
PA46	CORRELATE PLAN OF CARE TO REQUESTED PROCEDURE CODES.
PA47	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE FREQUENCY/DURATION REQUESTED.
PA48	PLEASE PROVIDE THE NAME AND CREDENTIALS OF THE RENDERING PROVIDER.
PA50	COLORADO MEDICAID RECORDS INDICATE THE CLIENT OWNS A WHEELCHAIR. DOCUMENT THE REASON AND NEED FOR REPLACEMENT AND COST TO REPAIR CURRENT WHEELCHAIR.
PA51	PLEASE DISTINGUISH PRIMARY AND SUPPORTIVE MODALITIES.
PA52	PLEASE SUBMIT A PROGRESS REPORT.
PA53	MULTIPLE FAMILY CLIENTS TREATMENT BY THE SAME PROVIDER REQUIRES FURTHER INFORMATION DOCUMENTING COORDINATION OF TREATMENT PLAN.
PA54	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE MINUTES REQUESTED.
PA55	MEDICAL NECESSITY OF TREATMENT REQUIRES ADDITIONAL DOCUMENTATION.
PA56	GIVEN AGE, DIAGNOSES, CURRENT LEVEL OF FUNCTION, PAST RESPONSE TO TREATMENT, AND LIVING SITUATION, EXPAND ON POTENTIAL FOR SIGNIFICANT FUNCTIONAL PROGRESS WITHIN THE NEXT SIX MONTHS. EMPHASIZE WHY PROGRESS IS EXPECTED WITH SERVICES AT THIS TIME.
PA57	SUBMIT THE INITIAL FINDINGS. INCLUDE A COMPREHENSIVE EVALUATION.
PA58	SUBMIT PROGRESSIVE, OBJECTIVE FINDINGS. INCLUDE A PERTINENT RE-EVALUATION.
PA59	PLEASE SUPPLY INFORMATION REGARDING THE CLIENTS MEDICATION REQUIREMENTS, IF ANY.
PA60	PLEASE SPECIFY IF THE CLIENT IS IN AN EDUCATIONAL SETTING.
PA61	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA62	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
PA63	THE SKILLS OF A THERAPIST ARE PURPOSEFUL AND SKILLED INTERVENTIONS REQUIRED TO CONTINUALLY DESIGN, IMPLEMENT, REASSESS, MODIFY/GRADE, AND/OR DISCONTINUE A PLAN OF CARE IN A TIMELY MANNER, BASED ON THE COMPLEXITY OF THE CLIENTS MEDICAL CONDITION AND/OR CO
PA64	PLEASE SUBMIT A THERAPY PLAN OF CARE, INCLUDING A CURRENT, DATED EVALUATION.
PA65	A PLAN OF CARE SIGNED AND DATED BY THE PHYSICIAN IS REQUIRED.
PA66	THE SKILLS OF A THERAPIST ARE REQUIRED WHEN ONLY THE THERAPIST CAN SAFELY AND EFFECTIVELY DELIVER THE THERAPEUTIC PROCEDURES BECAUSE OF THEIR UNIQUE KNOWLEDGE, TRAINING, AND EXPERTISE. DESCRIBE THE REASON THAT SOMEONE OTHER THAN A THERAPIST CANNOT SAFELY
PA67	PLEASE SPECIFY IF THE CLIENTS WORK SITE DEMANDS GOOD BINAURAL HEARING.

Denial Code	Long Description
PA68	DESCRIBE THE REASON, BASED ON THE CLIENTS COGNITIVE, PHYSICAL, COMMUNICATION, OR RESOURCE STATUS, THAT A HOME PROGRAM, EQUIPMENT, OR ENVIRONMENTAL ADAPTATIONS ALONE CANNOT MEET CLIENTS NEEDS.
PA69	PLEASE SPECIFY IF THE CLIENT HAS AN ACCOMPANYING DISABILITY THAT ADDS TO THE HEARING PROBLEM.
PA70	DISTINGUISH REQUESTED PROCEDURES AND GOALS FROM OTHER SERVICES THIS CLIENT RECEIVES. THEY MAY NOT BE DUPLICATIVE.
PA71	PLEASE INDICATE THE NUMBER OF DAYS REQUESTED.
PA73	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA74	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA75	PLEASE DOCUMENT CARRYOVER OF THE THERAPY PROGRAM TO NURSING.
PA76	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA79	PROVIDE EVIDENCE OF SIGNIFICANT FUNCTIONAL PROGRESS IN LAST SIX MONTHS.
PA84	THE GRANT DATE OF THIS REQUEST CANNOT BE PRIOR TO THE SIGNATURE DATE OF THE PRESCRIBING PHYSICIAN.
PA86	PROVIDE EVIDENCE OF SKILLS GAINED IN THERAPY CARRYING OVER TO OTHER SETTINGS WITHIN SIX MONTHS.
PA87	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE NUMBER OF SESSIONS REQUESTED.
PA88	THE REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL SCOPE OF PRACTICE.
PA89	PRIOR AUTHORIZATION IS NOT REQUIRED UNTIL LIMITATION OF SERVICE HAS BEEN REACHED.
PA91	PLEASE SUBMIT REQUIRED X-RAYS.
PA92	PLEASE PROVIDE AN EXPLANATION FOR THE MATERIAL SUBMITTED WITH THE REQUEST.
PA95	PLEASE DESCRIBE HOW THE PROVISION OF THIS SERVICE WOULD PREVENT INSTITUTIONALIZATION OF THE CLIENT.
PA96	COULD THE EXISTING DENTURE(S) BE RELINED OR REBASED? IF NOT, PLEASE EXPLAIN WHY NOT.
PA97	REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL STANDARDS OF PRACTICE.
PA98	PLEASE INDICATE IF THE CLIENT IS CURRENTLY BEING TUBE FED.
PB02	PLEASE PROVIDE THE REQUIRED DATED SIGNATURES ON THE ATTACHMENTS.
PB03	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING THE LOSS/DESTRUCTION/THEFT OF THE HEARING AID.
PB04	DESCRIBE THE CLIENTS ABILITY TO STAND OR AMBULATE SUFFICIENTLY TO ACCOMPLISH SELF-CARE ACTIVITIES.
PB07	PLEASE SUBMIT AN ORTHODONTIC STUDY MODEL OR DIAGNOSTIC CASTS.
PB09	PLEASE PROVIDE A PHOTOGRAPH OF THE INVOLVED AREA(S).
PB10	PLEASE PROVIDE AN ESTIMATION (IN GRAMS) OF THE TOTAL AMOUNT OF TISSUE TO BE RESECTED.
PB11	PLEASE SUBMIT THE PLAN OF CARE FOR CO-TREATMENT.
PB12	FURNISH A DETAILED DESCRIPTION FOR THE PROCEDURE CODE REQUESTED.
PB13	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB15	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB18	PLEASE COMPLETE THE ATTACHED OUT-OF-STATE PROVIDER DATA SHEET, F-11001, AND RESUBMIT.
PB20	A SIGNED AND DATED PRESCRIPTION IS REQUIRED WITHIN THREE MONTHS OF RECEIPT BY COLORADO MEDICAID FOR INITIAL REQUESTS AND WITHIN 12 MONTHS OF RECEIPT BY COLORADO MEDICAID FOR SUBSEQUENT REQUESTS.
PB21	PLEASE COMPLETE THE APPROPRIATE PRIOR AUTHORIZATION ATTACHMENT. CONTACT PROVIDER SERVICES OR THE PRIOR AUTHORIZATION UNIT FOR ASSISTANCE.
PB23	PHYSICAL THERAPY ASSISTANT NOTES AND ALL FORMS SUBMITTED MUST BE COSIGNED BY A REGISTERED PHYSICAL THERAPIST.

Denial Code	Long Description
PB31	ARE YOU REQUESTING A COMPLETE APPLIANCE, OR REPLACEMENT PARTS?
PB32	THE PROCEDURE CODE INDICATED ON THE REQUEST DOES NOT MATCH THE DESCRIPTION OF SERVICE; PLEASE CORRECT AND RESUBMIT.
PB35	THE SERVICE REQUESTED DOES NOT REQUIRE PRIOR AUTHORIZATION.
PB41	PLEASE FURNISH A CURRENT MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT, F-11090 (DATED WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID).
PB45	THE CERTIFICATION PERIOD ON THE PLAN OF CARE (POC) DOES NOT COVER THE REQUESTED GRANT/START DATE. PLEASE RESUBMIT YOUR REQUEST WITH A NEW POC.
PB49	A CERTIFIED OCCUPATIONAL THERAPY ASSISTANTS NOTES MUST BE COSIGNED BY AN OCCUPATIONAL THERAPIST REGISTERED.
PB51	ADDITIONAL INFORMATION IS REQUIRED ON PRIOR AUTHORIZATION TO ENABLE PRICING.
PB54	REQUESTED SERVICES DO NOT MATCH SERVICES ON THE PHYSICIANS ORDERS.
PB59	PLEASE PROVIDE AN INDIVIDUAL EDUCATIONAL PLAN (IEP), WHICH HAS BEEN SIGNED BY THE PROVIDER NO EARLIER THAN NINE MONTHS PRIOR TO RECEIPT AT COLORADO MEDICAID; OTHERWISE, DOCUMENT WHY NO IEP EXISTS.
PB65	PLEASE FURNISH THE ANTICIPATED TOTAL CHARGES FOR THIS REQUEST.
PB66	A PHOTOCOPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED; THE DATE MUST BE WITHIN SIX MONTHS OF RECEIPT BY COLORADO MEDICAID.
PB67	THE PRESCRIPTION DATE MUST INCLUDE MONTH, DAY, AND YEAR.
PB68	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID.
PB73	THE SERVICES IDENTIFIED ON THE PLAN OF CARE DO NOT APPEAR APPROPRIATE FOR THE PROCEDURE CODE(S) REQUESTED ON THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018.
PB74	THE CLIENT/PROVIDER DOES NOT HAVE RETROACTIVE ENROLLMENT.
PB75	THE REQUESTED START DATE IS MORE THAN 14 DAYS BEFORE OR 62 DAYS AFTER RECEIPT.
PB82	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
PB83	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A HOME HEALTH AIDE. PLEASE RESUBMIT AS A PERSONAL CARE WORKER OR PROVIDE ADDITIONAL DOCUMENTATION.
PB86	THE SERVICES REQUESTED ARE NOT BEING PROVIDED IN THE CLIENTS RESIDENCE. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL.
PB87	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A NURSE. PLEASE RESUBMIT AS A HOME HEALTH AIDE OR PROVIDE ADDITIONAL DOCUMENTATION.
PB92	PLEASE FURNISH THE CLIENTS COMPLETE ADDRESS.
PB94	IF THE CLIENT IS A RESIDENT OF A NURSING HOME, SUPPLY THE COMPLETE NAME AND ADDRESS OF THE NURSING HOME.
PB99	THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018, MUST BE SIGNED AND DATED.
PC01	PLEASE SUPPLY THE RENDERING PROVIDERS PROVIDER NUMBER.
PC03	THE DRUG ENFORCEMENT ADMINISTRATION NUMBER IS MISSING OR INVALID.
PC06	PLEASE DESCRIBE YOUR PROGRAM; INCLUDE ENTRY DATE, TERMINATION DATE, HOURS PER WEEK, AND NUMBER OF WEEKS OF PRIMARY INTENSIVE SERVICE REQUESTED.
PC07	PLEASE DESCRIBE YOUR "AFTERCARE/FOLLOW-UP" PLANS FOR THIS CLIENT.
PC08	PLEASE SUPPLY DOCUMENTATION OF PREVIOUS SUBSTANCE ABUSE SERVICES WITH DATE(S) AND OUTCOME.
PC09	PLEASE DESCRIBE IN DETAIL THE TREATMENT OBJECTIVES/GOALS FOR THIS CLIENT.
PC10	PLEASE DESCRIBE THE FAMILY SITUATION/DYNAMICS. EXPLAIN HOW THE FAMILY WILL BE INCORPORATED INTO THE CLIENTS PLAN OF CARE.
PC12	PLEASE EXPLAIN IF YOUR SERVICE ENCOURAGES THE CLIENT TO ATTEND SELF-HELP GROUPS.
PC13	PLEASE SUPPLY A SPECIFIC SCHEDULE OF ACTIVITIES, INCLUDING DAY, TIME OF DAY, LENGTH OF SESSION, AND SERVICE TO BE RENDERED DURING THAT TIME.
PC15	PLEASE FURNISH DIAGNOSTIC RATIONALE.
PC17	PLEASE DOCUMENT IF THE CLIENT EVER RECEIVED SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT.

Denial Code	Long Description
PC19	PLEASE FURNISH MORE EXTENSIVE AND IN-DEPTH HISTORICAL AND PSYCHOSOCIAL DATA.
PC20	PLEASE SUPPLY THE DATE THE CLIENT BECAME TOTALLY ENDENTULOUS.
PC23	PLEASE SUBMIT A PHYSICIANS STATEMENT REGARDING THE MEDICAL NECESSITY OF DENTURES FOR THIS CLIENT. THE PHYSICIANS STATEMENT MUST DOCUMENT THE MEDICAL NEED FOR DENTURES.
PC24	THE SERVICE REQUESTED WAS PREVIOUSLY AUTHORIZED. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT INDICATING THIS FACT IS REQUIRED.
PC25	PLEASE SUPPLY SUFFICIENT MITIGATING CIRCUMSTANCES TO WARRANT THE CONSTRUCTION OF NEW DENTURES(S).
PC26	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
PC28	PLEASE SUBMIT A PHYSICIANS STATEMENT INDICATING DENTURES ARE NECESSARY FOR THIS NURSING HOME CLIENT.
PC29	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING LOSS OR DESTRUCTION OF DENTURE(S). INCLUDE SIGNED STATEMENT FROM CLIENT OR FACILITY DIRECTOR REGARDING HOW, WHEN AND WHERE LOST.
PC30	PLEASE PROVIDE COMPLETE INTRAORAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PC31	PLEASE DESCRIBE ANY RELATED DEFORMITIES OF THE FEET.
PC34	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD WITH REQUESTED DME ITEM(S) AND DOCUMENT IF THE CLIENT CAN USE SAFELY AND INDEPENDENTLY.
PC35	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD AND DESCRIBE THE RESULTS AND EFFECTIVENESS OF THE SERVICE REQUESTED.
PC39	PLEASE INDICATE LITER FLOW PER MINUTE, HOURS OF USE PER 24 HOUR PERIOD, AND THE EXPECTED DURATION OF NEED.
PC40	THE ITEM DOES NOT REQUIRE PRIOR AUTHORIZATION UNTIL THE LIFE EXPECTANCY HAS BEEN REACHED.
PC41	PLEASE SUPPLY INFORMATION INDICATING THE NECESSITY OF POSITIONING THE CLIENT'S BODY IN MULTIPLE POSITIONS.
PC42	PLEASE INDICATE IF THE BED HEIGHT MUST BE CHANGED TO ALLOW FOR SAFE TRANSFER OR ADEQUATE BED CARE.
PC43	SUPPLY A PHYSICIANS STATEMENT INDICATING TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR UNIT HAS REDUCED PAIN, IMPROVED/INCREASED THE CLIENTS ACTIVITY LEVEL, AND/OR REDUCED CLIENTS USE OF PAIN MEDICATION.
PC44	A CURRENT AUTHORIZATION FOR THIS SERVICE IS ON FILE FOR ANOTHER PROVIDER. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT OF THAT FACT IS REQUIRED BY THE CLIENT OF FIRST PROVIDER.
PC59	DOCUMENT DECLINE OR PROGRESS IN SPECIFIC, MEASURABLE, OBJECTIVE TERMS.
PC60	DOCUMENT IF CLIENT HAS DEMONSTRATED A GOOD APPOINTMENT COMPLIANCE RECORD.
PC61	THE PHYSICIANS SIGNATURE DATE MUST NOT EXCEED 90 DAYS FROM THE DATE OF RECEIPT BY COLORADO MEDICAID.
PC62	REQUESTS FOR A CONTINUATION OF THERAPY SHOULD NOT BE SUBMITTED MORE THAN FOUR WEEKS PRIOR TO THE EXPIRATION DATE OF THE CURRENT AUTHORIZATION.
PC63	PLEASE FURNISH THE STYLE AND MANUFACTURER OF THE FRAME.
PC64	PLEASE FURNISH THE CLIENTS LENS FORMULA.
PC66	ALL REQUESTS FOR TINTS REQUIRE DOCUMENTATION OF THE VISUAL OR MEDICAL CONDITION RELATED TO PHOTOPHOBIA.
PC67	PLEASE DOCUMENT THE REASON AND JUSTIFICATION FOR REPLACEMENT BEYOND THE FIRST LENS/FRAME.
PC68	DOCUMENT IF ALL REMAINING MAXILLARY AND/OR MANDIBULAR TEETH ARE DECAY-FREE, PROPERLY RESTORED, AND PERIODONTICALLY SOUND.
PC72	SUPPLY MORE DETAIL REGARDING PROGRESS (ATTACHMENT OF GOALS, ETC.). CORRELATE PROGRESS TO PREVIOUS GOALS AND IDENTIFIED LIMITATIONS.
PC77	PLEASE SUBMIT A PLAN OF CARE DESCRIBING THE SERVICES THAT WOULD BE PROVIDED.
PC78	PLEASE DOCUMENT SPECIFIC, MEASURABLE GOALS.

Denial Code	Long Description
PC82	THE PRIOR AUTHORIZATION (PA) SYSTEM CAN PROCESS ONLY 26 DETAILS PER PA REQUEST. PLEASE RESUBMIT YOUR REQUEST WITH NO MORE THAN 26 DETAILS.
PC83	PLEASE SUPPLY A PHYSICIANS PRESCRIPTION DATED WITHIN ONE MONTH OF REQUESTED SUBSTANCE ABUSE DAY TREATMENT.
PC84	PLEASE PROVIDE INFORMATION INDICATING THIS CLIENT IS APPROPRIATELY DETOXIFIED FROM ALCOHOL AND/OR OTHER DRUGS.
PC85	PLEASE PROVIDE INFORMATION TO INDICATE THE CLIENTS ABILITY TO ABSTAIN FROM ALCOHOL OR DRUGS WHILE IN THE SUBSTANCE ABUSE DAY TREATMENT PROGRAM.
PC86	PLEASE INDICATE IF THIS CLIENT IS WILLING TO PARTICIPATE IN AFTERCARE OR CONTINUING CARE SERVICES.
PC87	PROVIDE MORE INFORMATION ON TREATMENT HISTORY; INCLUDE SERVICE PROVIDED, DATES, AND OUTCOME. PROVIDE DETAIL OF PREVIOUS TREATMENT.
PC88	PLEASE PROVIDE MORE RATIONALE FOR THE APPROPRIATENESS AND MEDICAL NECESSITY OF SUBSTANCE ABUSE DAY TREATMENT.
PC89	PROVIDE A TREATMENT PLAN THAT CONTAINS MEASURABLE GOALS AND OBJECTIVES CORRESPONDING TO THE IDENTIFIED DEFICIT.
PC91	PLEASE PROVIDE MORE INFORMATION ON FAMILY INVOLVEMENT TREATMENT.
PC92	PLEASE PROVIDE MORE HISTORY AND EXPLANATION ABOUT THE ISSUE OF ABSTINENCE FOR THIS CLIENT.
PC94	PLEASE PROVIDE THE ANTICIPATED BEGINNING DATE AND/OR THE ESTIMATED SUBSTANCE ABUSE DAY TREATMENT DISCHARGE DATE.
PC95	PLEASE SUPPLY JUSTIFICATION FOR BEGINNING CLIENT IN SERVICE PRIOR TO AUTHORIZATION BEING OBTAINED.
PC96	THE INITIAL THREE HOURS OF SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IN A CALENDAR YEAR DO NOT REQUIRE PRIOR AUTHORIZATION.
PC97	REIMBURSEMENT FOR INITIAL SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IS LIMITED TO THREE HOURS IN A CALENDAR YEAR AND DOES NOT REQUIRE PRIOR AUTHORIZATION.
PC98	THIS DRUG IS CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE BILL USING THE APPROPRIATE NATIONAL DRUG CODE (NDC) OR SUBMIT A COMPLETED DRUG ADDITION REQUEST FORM IF THE NDC IS NOT LISTED IN THE DRUG INDEX.
PC99	THIS DRUG IS NOT CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL, CURRENT ADMINISTRATIVE RULE, OR COLORADO DRUG INDEX FOR COVERAGE LIMITATIONS.
PD01	DOCUMENT THAT CLIENT HAS ACHIEVED GOOD ORAL HYGIENE, PERIODONTAL CASE TYPE 1 OR 2, AND IS MOTIVATED TO MAINTAIN SAME.
PD03	PLEASE PROVIDE AN ARTERIAL BLOOD GAS READING OR PULSE OXIMETRY RESULTS DONE ON ROOM AIR SIGNED AND DATED BY A MEDICAL DOCTOR. THIS SHOULD BE DONE WITHIN 60 DAYS OF REQUESTED SERVICE.
PD04	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 30 DAYS OF RECEIPT BY COLORADO MEDICAID.
PD07	SUBMIT A PHOTOCOPY OF A VALID PRESCRIPTION, ISSUED WITHIN THE PAST YEAR, OR COMPLETE SECTION B OF THE PRIOR AUTHORIZATION/DRUG ATTACHMENT (PA/DGA), F-11049.
PD10	BRAND MEDICALLY NECESSARY MUST BE IN THE PRESCRIBERS OWN HANDWRITING AND WRITTEN DIRECTLY ON THE PRESCRIPTION OR A SEPARATE ORDER ATTACHED TO THE ORIGINAL PRESCRIPTION.
PD12	COMPLETE DENTURES, PARTIAL DENTURES, DENTURE RELINES, AND FIXED PROSTHODONTIC SERVICES ARE NOT COVERED SERVICES FOR ADULTS FOR DATES OF SERVICE ON AND AFTER OCTOBER 1, 1995.
PD22	PLEASE COMPLETE ALL REQUIRED ELEMENTS ON THE PERSONAL CARE SCREENING TOOL (PCST), F-11133.
PD24	THIS PRIOR AUTHORIZATION REQUEST IS UNABLE TO BE PROCESSED. PLEASE RESUBMIT WITH ADDITIONAL REQUIRED FORMS, INCLUDING THE ENTIRE PERSONAL CARE SCREENING TOOL (PCST), F-11133; PERSONAL CARE ADDENDUM, F-11136; AND SUPPORTING DOCUMENTATION, AS DIRECTED.
PD25	THERE IS A PERSONAL CARE SCREENING TOOL (PCST), F-11133, COMPLETED BY ANOTHER AGENCY. CONTACT THE AGENCY TO TRANSFER SCREEN.

Denial Code	Long Description
PD26	THERE IS A LIMITED TERM CARE FUNCTIONAL SCREEN (LTC-FS) COMPLETED BY ANOTHER AGENCY. THE PERSONAL CARE SCREENING TOOL (PCST), F-11133, INFORMATION IS IN CONFLICT WITH LTC-FS.
PD27	ONLY ONE LEVEL OF FUNCTION MAY BE SELECTED FOR ALL ELEMENTS EXCEPT TOILETING. COLORADO MEDICAID IS UNABLE TO PROCESS THE PRIOR AUTHORIZATION REQUEST.
PD28	NO UNITS MAY BE REQUESTED USING THIS PRIOR AUTHORIZATION PROCESS. PLEASE SUBMIT WITH THE APPROPRIATE ATTACHMENTS FOR REQUESTING SPECIFIC PERSONAL CARE WORKER UNITS.
PD29	CLIENT IS NOT ELIGIBLE FOR THE REQUESTED SERVICE(S) AS OF THE REQUESTED START DATE.
PD30	NO TRAVEL TIME MAY BE AUTHORIZED WHEN NO PERSONAL CARE WORKER SERVICE IS AUTHORIZED.
PD32	PROVIDER NOT CERTIFIED TO RENDER THE SERVICE(S) REQUESTED.
PD34	BASED ON THE DOCUMENTATION SUBMITTED, THIS REQUEST CAN NOT BE PRIOR AUTHORIZED. REFER TO THE PA MESSAGES FROM THE CONSULTANT FOR COMPLETE EXPLANATION.
PD98	PLEASE DOCUMENT HOW AND WHEN EACH PREVIOUSLY AUTHORIZED PRO RE NATA VISIT WAS USED.

Adult Division for Intellectual and Developmental Disabilities (DIDD)

Denial Code	Long Description
0201	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
0233	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0235	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0237	CLIENT IDENTIFICATION NUMBER DOES NOT MATCH CLIENTS FIRST NAME.
0238	THE CLIENT IDENTIFICATION NUMBER DOES NOT MATCH THE CLIENTS LAST NAME.
0242	SECONDARY DIAGNOSIS CODE IS INVALID.
0248	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0249	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0251	PROCEDURE CODE MODIFIER IN FIRST POSITION IS INVALID.
0252	THE PROCEDURE CODE MODIFIER IN SECOND POSITION IS INVALID FOR REQUESTED START DATE OR DATE OF RECEIPT.
0253	THE PROCEDURE CODE MODIFIER IN THIRD POSITION IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
0258	THE PRIMARY DIAGNOSIS CODE IS REQUIRED.
0272	THE PRIMARY DIAGNSOSIS CODE IS INVALID.
0400	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0853	HCPCS - ANNUAL UPDATE
0885	NEVER EVENTS MODIFIERS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
0886	NEVER EVENTS DIAGNOSIS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
1000	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
1002	RENDERING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1003	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1007	RENDERING PROVIDER ID IS NOT ON FILE.
1047	THE RENDERING PROVIDERS CERTIFICATION HAS BEEN CANCELLED.
1048	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1801	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
1804	A CERTIFIED SUBSTANCE ABUSE DAY TREATMENT PROVIDER MUST SUBMIT A SUBSTANCE ABUSE DAY TREATMENT PROCEDURE CODE.
1806	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
1808	THE BILLING PROVIDER DOES NOT HAVE THE REQUIRED CERTIFICATION ADDENDUM ON FILE.
1900	THE BILLING PROVIDERS TAXONOMY CODE IS INVALID.
1901	THE RENDERING PROVIDERS TAXONOMY CODE IS INVALID.

Denial Code	Long Description
1927	A NATIONAL PROVIDER IDENTIFIER IS REQUIRED FOR THE BILLING PROVIDER.
1934	A NATIONAL PROVIDER INDENTIFIER IS REQUIRED FOR THE RENDERING PROVIDER.
1936	THE BILLING PROVIDER NUMBER IS INVALID.
1937	THE RENDERING PROVIDER NUMBER IS INVALID.
1960	INTERNAL PROCESSING IS REQUIRED.
1963	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.
1964	THE BILLING PROVIDER INDICATED IS NOT ALLOWABLE AS A BILLING PROVIDER.
1965	RENDERING PROVIDER NUMBER IS MISSING/INVALID FOR THIS PROCEDURE PROVIDER.
1974	PRESCRIBING/REFERRING/ORDERING PROVIDER INDICATED IS NOT CERTIFIED AS A PRESCRIBING/REFERRING/ORDERING PROVIDER.
1975	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
1976	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
2001	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2003	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2017	THE CLIENT IS ENROLLED IN A MEDICAID OR OTHER MANAGED CARE PROGRAM.
2037	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2603	CLIENT LOCKED-IN TO A PROVIDER OR ENROLLED IN A HOSPICE. CONTACT CLIENTS HOSPICE FOR PAYMENT OF SERVICES OR RESUBMIT WITH DOCUMENTATION OF UNRELATED NATURE OF CARE.
3324	THE MODIFIER HAS BEEN DISCONTINUED BY THE CENTERS OF MEDICARE AND MEDICAID SERVICES OR THE AMERICAN MEDICAL ASSOCIATION FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
3337	THE PROCEDURE CODE HAS BEEN TERMINATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AMERICAN MEDICAL ASSOCIATION, OR AMERICAN DENTAL ASSOCIATION FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT. RESUBMIT WITH VALID A PROCEDURE CODE.
3339	THE PROCEDURE BILLED IS NOT PAYABLE ACCORDING TO DEFICIT REDUCTION ACT (DEFRA) GUIDELINES.
3351	THE PROCEDURE IS NOT COVERED FOR CLIENTS WITH A NURSING HOME AUTHORIZATION ON THE REQUESTED START DATE OR DATE OF RECEIPT.
3353	THE PROCEDURE IS NOT A COVERED SERVICE FOR HOME AND COMMUNITY-BASED WAIVER CLIENTS.
4021	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4027	THE DIAGNOSIS CODE IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
4031	THE PROCEDURE SUBMITTED IS NOT APPROPRIATE FOR CLIENTS GENDER.
4032	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4034	THE PROCEDURE CODE HAS AN AGE RESTRICTION.
4036	THE PLACE OF SERVICE CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4040	THE PRIMARY DIAGNOSIS CODE IS NOT ON FILE.
4041	THE SECONDARY DIAGNOSIS IS NOT ON FILE.
4046	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4127	INTERNAL PROCESSING IS REQUIRED.
4131	INTERNAL PROCESSING IS REQUIRED.
4141	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4149	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4150	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4236	ETIOLOGY DIAGNOSIS CODE(S) (E-CODES) ARE INVALID AS THE PRIMARY DIAGNOSIS.
4244	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4245	THE FOURTH POSITION MODIFIER IS INVALID FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT.
4256	THE PROCEDURE CODE AND MODIFIER COMBINATION IS NOT PAYABLE FOR THE CLIENTS BENEFIT PLAN.
4257	THE MODIFIERS SUBMITTED ARE EITHER INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT OR THE MODIFIERS ARE MISSING.
4311	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4315	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4316	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4371	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4372	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.

Denial Code	Long Description
4711	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR CLIENTS AGE.
4714	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS AGE.
4731	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS DIAGNOSIS.
4742	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4743	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4744	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4745	DIAGNOSIS AND/OR PROCEDURE AND/OR PLACE OF SERVICE (POS) CODE IS NOT COVERED FOR EXPRESS ENROLLMENT CLIENTS.
4746	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4801	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4802	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
4821	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
4871	PLEASE REFER TO PA MESSAGES FOR RETURN INFORMATION.
4963	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS GENDER.
4990	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
7500	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
7509	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
P001	THE BILLING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THE SERVICES.
P002	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P003	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P005	THE PRIOR AUTHORIZATION CAN NOT BE END DATED. THE PRIOR AUTHORIZATION STATUS IS NOT APPROVED OR APPROVED WITH REVISIONS.
P006	PLEASE FURNISH THE PROCEDURE CODE AND CORRESPONDING DESCRIPTION.
P008	THE BILLING PROVIDER NUMBER IS INVALID.
P009	THE BILLING PROVIDER NUMBER IS INVALID.
P010	THE REQUESTED END DATE IS INVALID.
P011	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P012	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P013	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P014	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P015	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P016	THE REQUESTED START DATE IS MISSING OR INVALID.
P019	THE REQUESTED START DATE IS MISSING OR INVALID.
P020	THE RENDERING PROVIDER NUMBER IS INVALID.
P021	THE RENDERING PROVIDER NUMBER IS INVALID.
P022	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P023	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P024	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P026	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P027	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P030	FIRST MODIFIER IS INVALID.
P031	FIRST MODIFIER IS INVALID.
P032	SECOND MODIFIER IS INVALID.
P033	SECOND MODIFIER IS INVALID.
P034	THIRD MODIFIER IS INVALID.
P035	THIRD MODIFIER IS INVALID.

Denial Code	Long Description
P036	FOURTH MODIFIER IS INVALID.
P037	FOURTH MODIFIER IS INVALID.
P038	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P039	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P040	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P041	CLIENTS FIRST NAME IS MISSING.
P042	CLIENTS LAST NAME IS MISSING.
P043	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P044	BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES REQUESTED.
P045	FIRST MODIFIER IS INVALID.
P046	SECOND MODIFIER IS INVALID.
P047	THIRD MODIFIER IS INVALID.
P048	FOURTH MODIFIER IS INVALID.
P052	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P053	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P054	RENDERING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES FOR THE BENEFIT PLAN.
P055	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P061	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P062	THE CLIENT ID AND/OR NAME INDICATED ON THE PA REQUEST IS INCORRECT. THE CLIENT ID AND/OR NAME HAS BEEN UPDATED. PLEASE VERIFY THE ID AND/OR NAME IS CORRECT.
P064	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
P067	THE FREQUENCY OF HOURS REQUESTED ARE NOT APPROPRIATE FOR THIS CLIENT AND HAVE BEEN MODIFIED ACCORDINGLY.
P079	BILLING PROVIDER IS ON PAYMENT SUSPENSION DUE TO CREDIBLE ALLEGATION OF FRAUD.
P120	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAS BEEN REDUCED.
P121	THE SERVICE/ PROCEDURE REQUESTED IS NOT SUPPORTED BY SUBMITTED DOCUMENTATION.
P126	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
P128	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.
P138	SERVICE(S) DO NOT MEET COLORADO MEDICAID GUIDELINES.
P167	REQUESTED DOCUMENTATION HAS NOT BEEN SUBMITTED.
P178	THE SERVICE REQUESTED IS NOT MEDICALLY NECESSARY.
P179	THE MEDICAL NECESSITY FOR THIS SERVICE IS NOT SUPPORTED BY THE SUBMITTED DOCUMENTATION.
P233	THE DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE ADDITIONAL CARE.
P257	THIS CLIENTS FUNCTIONAL ASSESSMENT SCORES PLACE THIS CLIENT OUTSIDE ELIGIBILITY FOR DAY TREATMENT.
P274	OUR RECORDS INDICATE THIS CLIENT IS INVOLVED IN EFFECTIVE AND APPROPRIATE SERVICE ELSEWHERE.
P292	INTENSIVE REHABILITATION HOURS ARE NO LONGER APPROPRIATE AS INDICATED BY HISTORY, DIAGNOSIS, AND/ OR FUNCTIONAL ASSESSMENT SCORES.
P328	THE SERVICES REQUESTED INCLUDE NON-COVERED SERVICES, AND HOURS ARE REDUCED ACCORDINGLY.
P339	THE CLIENTS PAST HISTORY INDICATES REDUCED TREATMENT HOURS ARE WARRANTED.
P342	THE REQUEST DOES NOT MEET GENERALLY ACCEPTED CONDITIONS REQUIRING FLUORIDE TREATMENTS.
P346	SERVICES EXCEED COLORADO MEDICAID LIMITATION AND DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE MEDICAL NECESSITY OF THE SERVICE.
P349	THE SERVICE REQUESTED WAS PERFORMED LESS THAN FIVE YEARS AGO.
P353	THE EXISTING APPLIANCE HAS NOT BEEN WORN FOR THREE YEARS.
P367	THE CLIENT HAS BEEN TOTALLY WITHOUT TEETH AND AN APPLIANCE FOR FIVE YEARS.

Denial Code	Long Description
P392	THE CLIENT IS MISSING AN ANTERIOR TOOTH AND/OR HAS TWO OR MORE POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P405	THE SERVICE(S) REQUESTED COULD ADEQUATELY BE PERFORMED IN THE DENTAL OFFICE.
P406	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE OF GOOD PERIODONTAL HEALTH (AMERICAN ACADEMY OF PERIODONTOLOGY PERIODONTAL CLASSIFICATION OF TYPE I OR II).
P407	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE VISIBLE ON RADIOGRAPHS THAT AT LEAST 50 PERCENT OF THE CLINICAL CROWN IS INTACT.
P409	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING SIX OR MORE TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED, INCLUDING THIRD MOLARS.
P410	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING ONE OR MORE ANTERIOR TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED.
P411	DOCUMENTATION DOES NOT SUPPORT THE NEED FOR PERIODONTIC SERVICES. POCKETS ARE LESS THAN 4MM AND/OR GREATER THAN 6MM FOR CLIENT AND/OR THE CLIENT IS UNDER THE AGE OF 13.
P412	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA.
P413	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA. THIS PA HAS BEEN GRANTED AS APPROVED NOT APPROVED WITH REVISIONS. THE DURATION REQUESTED MAY HAVE BEEN REDUCED TO REFLECT COVERAGE LIMITATIONS, PRESCRIBER ORDERS, CONFLICTI
P417	THE SERVICE(S) REQUESTED COULD BE ADEQUATELY PERFORMED WITH LOCAL ANESTHESIA.
P437	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO POOR ORAL HYGIENE.
P444	THIS LINE ITEM IS A DUPLICATE OF ANOTHER LINE ITEM ON THIS PRIOR AUTHORIZATION (PA) REQUEST. PLEASE CORRECT.
P446	THIS IS A DUPLICATE OF AN EXISTING PRIOR AUTHORIZATION (PA) REQUEST. YOU MAY CONTACT PROVIDER SERVICES IF YOU REQUIRE ASSISTANCE. DUPLICATE PA REQUEST
P448	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO DECAY HISTORY.
P449	QUESTIONABLE LONG TERM PROGNOSIS DUE TO GUM AND BONE DISEASE.
P456	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO APPARENT ROOT INFECTION.
P457	OUR RECORDS INDICATE THIS CLIENT HAS EXCEEDED ESTABLISHED PROGRAM LIMITATIONS. COLORADO MEDICAID WILL NOT AUTHORIZE NEW DENTURES.
P458	DOCUMENTATION PROVIDED INDICATES A LESS ELABORATE PROCEDURE SHOULD BE CONSIDERED.
P502	RENTAL ONLY ALLOWED; MEDICAL NEED FOR PURCHASE HAS NOT BEEN DOCUMENTED.
P503	PURCHASE ONLY ALLOWED; MEDICAL NEED FOR RENTAL HAS NOT BEEN DOCUMENTED.
P504	OCCUPATIONAL THERAPY GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P505	THE SERVICE REQUESTED IS INCLUDED IN THE NURSING HOME RATE STRUCTURE.
P511	THIS NATIONAL DRUG CODE IS ONLY BILLABLE AS PART OF A COMPOUND DRUG.
P515	THE PRESENCE OF A HANDICAPPING MALOCCLUSION OR HANDICAPPING DENTOFACIAL DEFORMITY IS NOT SUPPORTED BY THE DOCUMENTATION SUBMITTED.
P521	THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVERED BY COLORADO MEDICAID.
P522	GASTRO-INTESTINAL SURGERY FOR THE PURPOSE OF WEIGHT CONTROL IS COVERED ONLY AS A LIFE THREATENING PROCEDURE.
P523	THE TREATMENT REQUEST IS NOT CONSISTENT WITH THE CLIENT'S DIAGNOSIS.
P524	PSYCHOTHERAPY PROVIDED IN THE CLIENTS HOME IS NOT A COVERED BENEFIT OF COLORADO MEDICAID .
P525	THE INFORMATION PROVIDED IS NOT CONSISTENT WITH THE INTENSITY OF SERVICES REQUESTED.
P526	INTENSIVE MULTIPLE MODALITY TREATMENT IS NOT CONSISTENT WITH THE INFORMATION PROVIDED.
P527	MULTIPLE PROVIDERS OF TREATMENT ARE NOT INDICATED FOR THIS CLIENT.
P528	THE DURATION OF TREATMENT SESSIONS EXCEED CURRENT COLORADO MEDICAID GUIDELINES.
P534	DOCUMENTATION OF POOR PHYSICAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P535	OTHER PHYSICAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P536	THE PHYSICAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P537	USE OF PHYSICAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.

Denial Code	Long Description
P538	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF A PHYSICAL THERAPIST.
P539	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS AND LIVING ARRANGEMENT.
P540	GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P541	THE PROCEDURE(S) REQUESTED ARE NOT MEDICAL IN NATURE.
P542	DOCUMENTATION OF POOR OCCUPATIONAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P543	DOCUMENTATION OF POOR SPEECH THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P544	OTHER OCCUPATIONAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P546	THE OCCUPATIONAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P547	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF PHYSICAL THERAPY.
P548	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P549	ACTIVITIES TO PROMOTE DIVERSION OR GENERAL MOTIVATION ARE NONCOVERED COLORADO MEDICAID SERVICES.
P550	REVISIONS OF THE REQUEST IS NECESSITATED BY THE CLIENTS MINIMAL PROGRESS.
P551	RESTORATIVE NURSING INVOLVEMENT COULD BE INCREASED.
P552	CLIENTS DEMONSTRATED RESPONSE TO CURRENT THERAPY DOES NOT WARRANT THE INTENSE FREQUENCY REQUESTED.
P553	MAINTENANCE IS TWO TIMES PER WEEK OR LESS.
P554	THE SPEECH THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P555	USE OF OCCUPATIONAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P556	USE OF SPEECH THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P557	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF AN OCCUPATIONAL THERAPIST.
P558	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
P559	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P560	THE MATERIALS/ SERVICES REQUESTED ARE PRINCIPALLY COSMETIC IN NATURE.
P561	THE LENS FORMULA DOES NOT JUSTIFY REPLACEMENT.
P562	THE CHANGE IN THE LENS FORMULA DOES NOT WARRANT MULTIPLE REPLACEMENTS.
P563	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P564	LENSES ONLY ARE APPROVED; PLEASE DISPENSE A CONTRACTED FRAME. THE NON-CONTRACTED FRAME IS NOT MEDICALLY JUSTIFIED.
P565	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P566	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P567	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF OCCUPATIONAL THERAPY.
P568	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF SPEECH THERAPY.
P569	LEVEL, INTENSITY, OR EXTENT OF SERVICE(S) REQUESTED HAS BEEN MODIFIED CONSISTENT WITH MEDICAL NEED AS DEFINED IN THE PLAN OF CARE.
P570	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P571	THE SERVICE ASKED FOR IS NOT COVERED BY COLORADO MEDICAID AS THESE TASKS CAN BE DONE BY NURSES OR ACTIVITY STAFF.
P572	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P573	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.

Denial Code	Long Description
P574	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P575	MEDICAL NEED FOR EQUIPMENT/ SUPPLY REQUESTED IS NOT SUPPORTED BY DOCUMENTATION SUBMITTED.
P576	OTHER SPEECH THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P577	DOCUMENTATION SUBMITTED IDENTIFIES THAT THE CLIENT HAS FEWER THAN TWO POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P582	LESS EXPENSIVE ALTERNATIVE SERVICES ARE AVAILABLE FOR THIS CLIENT.
P634	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P711	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING PERIODONTAL SCALING AND ROOT PLANNING.
P712	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING GINGIVECTOMY.
P754	AN APPROVED SUBSTANCE ABUSE DAY TREATMENT PROGRAM CANNOT EXCEED A SIX WEEK PERIOD.
P761	THE CLIENT DOES NOT APPEAR TO BE ABLE OR WILLING TO ABSTAIN FROM ALCOHOL/DRUG USAGE WHILE IN TREATMENT. THEREFORE, SUBSTANCE ABUSE DAY TREATMENT SERVICES ARE NOT APPROVED.
P764	THIS CLIENT HAS COMPLETED INTENSIVE SUBSTANCE ABUSE TREATMENT WITHIN THE PAST 12 MONTHS. THE DOCUMENTATION PROVIDED IS NOT ADEQUATE TO JUSTIFY ADDITIONAL INTENSIVE TREATMENT AT THIS TIME.
P785	A LESS THAN SIX-WEEK HEALING PERIOD HAS BEEN SPECIFIED FOR THIS PRIOR AUTHORIZATION. THEREFORE IT IS NOT NECESSARY TO WAIT THE FULL SIX WEEKS AFTER EXTRACTIONS BEFORE TAKING DENTURE IMPRESSIONS.
P818	SIX-WEEK HEALING TIME IS REQUIRED BETWEEN EDENTULATION AND FINAL IMPRESSIONS. PAYMENT FOR DENTURES WILL BE DENIED OR RECOUPED IF HEALING PERIOD IS NOT OBSERVED.
P849	COLORADO MEDICAID HAS DETERMINED THERE WERE (ARE) SEVERAL HOME HEALTH AGENCIES WILLING TO PROVIDE MEDICALLY NECESSARY SKILLED NURSING SERVICES TO THIS CLIENT.
P864	THE DOCUMENTATION YOU HAVE SUBMITTED DOES NOT MEET THE REQUIREMENTS OF COLORADO MEDICAID.
P873	THE MEDICAL NECESSITY FOR THE HOURS REQUESTED IS NOT SUPPORTED BY THE INFORMATION SUBMITTED.
P874	THE DOCUMENTATION SUBMITTED INDICATES THE TASKS SPECIFIED CAN BE COMPLETED DURING THE VISITS APPROVED.
P878	THE DOCUMENTATION SUBMITTED DOES NOT INDICATE THAT MEDICALLY ORIENTED TASKS ARE MEDICALLY NECESSARY; THEREFORE PERSONAL CARE SERVICES HAVE BEEN APPROVED.
P880	THE QUANTITY OF SERVICES AUTHORIZED FOR THIS CLIENTS PERSONAL CARE HAS BEEN AMENDED BASED ON INFORMATION RECEIVED FROM ONE OR MORE OF THESE SOURCES: THE CLIENT, THEIR PHYSICIAN, AND/OR THE IN-HOME VISIT BY STAFF OF THE OIG (OFFICE OF INSPECTOR GENERAL).
P885	THE USE OF THIS DRUG FOR THE INTENDED PURPOSE IS NOT COVERED BY COLORADO MEDICAID, CONSISTENT WITH COLORADO ADMINISTRATIVE CODE AND FEDERAL LAW.
P924	THE MEDICAL RECORDS SUBMITTED WITH THE CURRENT REQUEST CONFLICT OR DISAGREE WITH OUR MEDICAL RECORDS ON THIS CLIENT.
P950	INDEPENDENT NURSES, PLEASE NOTE PAYABLE SERVICES MAY NOT EXCEED 12 HOURS/DAY OR 60 HOURS/WEEK.
P951	SERVICES CAN ONLY BE AUTHORIZED THROUGH ONE YEAR FROM THE PRESCRIPTION DATE.
P952	LEAD INSPECTION IS A COVERED COLORADO MEDICAID SERVICE WHEN THE CHILD HAS BEEN SHOWN TO HAVE LEAD POISONING (E.G., CHILD HAS A BLOOD LEAD LEVEL > 19 UG/DL OR TWO CONSECUTIVE BLOOD LEAD LEVELS OF 15-19 UG/DL DONE AT LEAST 90 DAYS APART). THE INSPECTION MUS
P953	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P954	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P956	THE REQUEST CAN ONLY BE BACKDATED A MAXIMUM OF 14 DAYS FROM FIRST DATE RECEIVED BY COLORADO MEDICAID.

Denial Code	Long Description
P957	COMPLETE PERIODONTAL CHARTING AT TIME OF SERVICE, AND SUBMIT CHARTING, COPY OF OPERATIVE REPORT, TOGETHER WITH A COPY OF THE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF), F-11035, TO PA UNIT ATTENTION DENTAL CONTSULTANT.
P958	NOTE THAT CODE D4341 HAS BEEN CHANGED. REFER TO THE DECISION NOTICE FOR AUTHORIZED QUANTITY.
P960	YOUR PA HAS BEEN APPROVED FOR 90 DAYS. THE 90 DAY APPROVAL DOES NOT IMPLY THE PA REQUEST MEETS PRIOR AUTHORIZATION CRITERIA. AFTER ADDITIONAL INFORMATION IS AVAILABLE IN INTERCHANGE, COLORADO MEDICAID WILL CREATE AN AMENDMENT REQUEST TO EXTEND THE PA FOR
P961	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P962	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
PA10	THE REQUESTED END DATE IS INVALID.
PA12	PLEASE FURNISH A WRITTEN DESCRIPTION OF THE CLIENTS DIAGNOSIS.
PA13	PROVIDE DIAGNOSES WITH DATES OF ONSET.
PA14	IDENTIFY PROBLEMS TO BE TREATED.
PA15	THE AUDIOLOGISTS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1), F-11020, AND PRIOR AUTHORIZATION REQUEST/HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2), F-11021.
PA16	THE PHYSICIANS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION/PHYSICIAN OTOLOGICAL REPORT (PA/POR), F-11019.
PA17	SUBMIT BRIEF HISTORY WITH REFERRAL INFORMATION, LIVING SITUATION, FUNCTIONAL STATUS, AND OTHER PERTINENT INFORMATION. WHAT CHANGE OF STATUS RESULTED IN REFERRAL AT THIS TIME?
PA18	PLEASE FURNISH THE CLIENTS HEIGHT AND WEIGHT.
PA19	PLEASE SUBMIT CLINICAL INFORMATION SUFFICIENT TO VERIFY THE NEED FOR THE REQUESTED SERVICE(S).
PA20	PLEASE RESUBMIT WITH COMPLETE PERIODONTAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PA21	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL EDUCATIONAL PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA22	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL PROGRAM PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA23	REFER TO THE DURABLE MEDICAL EQUIPMENT INDEX FOR APPROPRIATE CODE AND DESCRIPTION. DO NOT USE AN "UNLISTED" CODE.
PA24	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUALIZED FAMILY SERVICE PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA25	INFORMATION ON THE REQUEST FORM IS ILLEGIBLE, AND THE REQUEST CANNOT BE PROCESSED.
PA26	RE-EVALUATE YOUR GOALS. EMPHASIS SHOULD BE ON FUNCTIONAL SELF-CARE. GOALS MUST BE RELATED TO FUNCTIONAL OUTCOME.
PA27	PLEASE CLARIFY THE NUMBER OF HOURS PER WEEK REQUESTED.
PA28	PLEASE CLARIFY THE NUMBER OF HOURS PER DAY REQUESTED.
PA29	PLEASE CLARIFY THE NUMBER OF VISITS PER DAY REQUESTED.
PA30	ATTACH SUPPORTIVE DOCUMENTATION; HOME EXERCISE PROGRAM AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA31	THE DIAGNOSIS CODE INDICATED ON THE REQUEST DOES NOT CORRESPOND TO THE DIAGNOSIS CODE DESCRIPTION.
PA32	PLEASE SUBMIT ADDITIONAL INFORMATION SUFFICIENT TO VERIFY APPROPRIATENESS AND NEED FOR TRANSPLANT.
PA33	PLEASE SUBMIT THE INITIAL AND PROGRESSIVE OBJECTIVE FINDINGS.
PA34	ATTACH SUPPORTIVE DOCUMENTATION, FACILITY PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA35	PLEASE SUBMIT THE CLIENTS ORIGINAL COMPLAINTS AND EXAMINATION FINDINGS.

Denial Code	Long Description
PA36	ATTACH SUPPORTIVE DOCUMENTATION, IN-HOME AUTISM PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA37	PLEASE SUBMIT YOUR TREATMENT PLAN FOR THIS CLIENT.
PA38	ATTACH SUPPORTIVE DOCUMENTATION AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA39	INITIAL EVALUATIONS MUST BE PERFORMED BY AN OCCUPATIONAL THERAPIST REGISTERED (OTR), PER AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA) STANDARDS.
PA41	IDENTIFY THE PLACE OF SERVICE AND ITS EFFECT ON SUPPORTING THE DESIRED TREATMENT OUTCOME.
PA42	PLEASE INDICATE THE HOURS OF USE OF OXYGEN PER 24-HOUR PERIOD.
PA43	PROVIDE BASELINE DOCUMENTATION FOR THIS CLIENTS LIMITATIONS USING UNITS OF MEASUREMENT THAT ARE APPLIED CONSISTENTLY WHEN REPORTING STATUS.
PA44	IDENTIFY FUNCTIONAL LIMITATIONS AS THEY ARE RELATED TO IDENTIFIED CONDITIONS.
PA46	CORRELATE PLAN OF CARE TO REQUESTED PROCEDURE CODES.
PA47	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE FREQUENCY/DURATION REQUESTED.
PA48	PLEASE PROVIDE THE NAME AND CREDENTIALS OF THE RENDERING PROVIDER.
PA50	COLORADO MEDICAID RECORDS INDICATE THE CLIENT OWNS A WHEELCHAIR. DOCUMENT THE REASON AND NEED FOR REPLACEMENT AND COST TO REPAIR CURRENT WHEELCHAIR.
PA51	PLEASE DISTINGUISH PRIMARY AND SUPPORTIVE MODALITIES.
PA52	PLEASE SUBMIT A PROGRESS REPORT.
PA53	MULTIPLE FAMILY CLIENTS TREATMENT BY THE SAME PROVIDER REQUIRES FURTHER INFORMATION DOCUMENTING COORDINATION OF TREATMENT PLAN.
PA54	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE MINUTES REQUESTED.
PA55	MEDICAL NECESSITY OF TREATMENT REQUIRES ADDITIONAL DOCUMENTATION.
PA56	GIVEN AGE, DIAGNOSES, CURRENT LEVEL OF FUNCTION, PAST RESPONSE TO TREATMENT, AND LIVING SITUATION, EXPAND ON POTENTIAL FOR SIGNIFICANT FUNCTIONAL PROGRESS WITHIN THE NEXT SIX MONTHS. EMPHASIZE WHY PROGRESS IS EXPECTED WITH SERVICES AT THIS TIME.
PA57	SUBMIT THE INITIAL FINDINGS. INCLUDE A COMPREHENSIVE EVALUATION.
PA58	SUBMIT PROGRESSIVE, OBJECTIVE FINDINGS. INCLUDE A PERTINENT RE-EVALUATION.
PA59	PLEASE SUPPLY INFORMATION REGARDING THE CLIENTS MEDICATION REQUIREMENTS, IF ANY.
PA60	PLEASE SPECIFY IF THE CLIENT IS IN AN EDUCATIONAL SETTING.
PA61	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA62	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
PA63	THE SKILLS OF A THERAPIST ARE PURPOSEFUL AND SKILLED INTERVENTIONS REQUIRED TO CONTINUALLY DESIGN, IMPLEMENT, REASSESS, MODIFY/GRADE, AND/OR DISCONTINUE A PLAN OF CARE IN A TIMELY MANNER, BASED ON THE COMPLEXITY OF THE CLIENTS MEDICAL CONDITION AND/OR CO
PA64	PLEASE SUBMIT A THERAPY PLAN OF CARE, INCLUDING A CURRENT, DATED EVALUATION.
PA65	A PLAN OF CARE SIGNED AND DATED BY THE PHYSICIAN IS REQUIRED.
PA66	THE SKILLS OF A THERAPIST ARE REQUIRED WHEN ONLY THE THERAPIST CAN SAFELY AND EFFECTIVELY DELIVER THE THERAPEUTIC PROCEDURES BECAUSE OF THEIR UNIQUE KNOWLEDGE, TRAINING, AND EXPERTISE. DESCRIBE THE REASON THAT SOMEONE OTHER THAN A THERAPIST CANNOT SAFELY
PA67	PLEASE SPECIFY IF THE CLIENTS WORK SITE DEMANDS GOOD BINAURAL HEARING.
PA68	DESCRIBE THE REASON, BASED ON THE CLIENTS COGNITIVE, PHYSICAL, COMMUNICATION, OR RESOURCE STATUS, THAT A HOME PROGRAM, EQUIPMENT, OR ENVIRONMENTAL ADAPTATIONS ALONE CANNOT MEET CLIENTS NEEDS.
PA69	PLEASE SPECIFY IF THE CLIENT HAS AN ACCOMPANYING DISABILITY THAT ADDS TO THE HEARING PROBLEM.
PA70	DISTINGUISH REQUESTED PROCEDURES AND GOALS FROM OTHER SERVICES THIS CLIENT RECEIVES. THEY MAY NOT BE DUPLICATIVE.
PA71	PLEASE INDICATE THE NUMBER OF DAYS REQUESTED.

Denial Code	Long Description
PA73	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA74	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA75	PLEASE DOCUMENT CARRYOVER OF THE THERAPY PROGRAM TO NURSING.
PA76	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA79	PROVIDE EVIDENCE OF SIGNIFICANT FUNCTIONAL PROGRESS IN LAST SIX MONTHS.
PA84	THE GRANT DATE OF THIS REQUEST CANNOT BE PRIOR TO THE SIGNATURE DATE OF THE PRESCRIBING PHYSICIAN.
PA86	PROVIDE EVIDENCE OF SKILLS GAINED IN THERAPY CARRYING OVER TO OTHER SETTINGS WITHIN SIX MONTHS.
PA87	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE NUMBER OF SESSIONS REQUESTED.
PA88	THE REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL SCOPE OF PRACTICE.
PA89	PRIOR AUTHORIZATION IS NOT REQUIRED UNTIL LIMITATION OF SERVICE HAS BEEN REACHED.
PA91	PLEASE SUBMIT REQUIRED X-RAYS.
PA92	PLEASE PROVIDE AN EXPLANATION FOR THE MATERIAL SUBMITTED WITH THE REQUEST.
PA95	PLEASE DESCRIBE HOW THE PROVISION OF THIS SERVICE WOULD PREVENT INSTITUTIONALIZATION OF THE CLIENT.
PA96	COULD THE EXISTING DENTURE(S) BE RELINED OR REBASED? IF NOT, PLEASE EXPLAIN WHY NOT.
PA97	REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL STANDARDS OF PRACTICE.
PA98	PLEASE INDICATE IF THE CLIENT IS CURRENTLY BEING TUBE FED.
PB02	PLEASE PROVIDE THE REQUIRED DATED SIGNATURES ON THE ATTACHMENTS.
PB03	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING THE LOSS/DESTRUCTION/THEFT OF THE HEARING AID.
PB04	DESCRIBE THE CLIENTS ABILITY TO STAND OR AMBULATE SUFFICIENTLY TO ACCOMPLISH SELF-CARE ACTIVITIES.
PB07	PLEASE SUBMIT AN ORTHODONTIC STUDY MODEL OR DIAGNOSTIC CASTS.
PB09	PLEASE PROVIDE A PHOTOGRAPH OF THE INVOLVED AREA(S).
PB10	PLEASE PROVIDE AN ESTIMATION (IN GRAMS) OF THE TOTAL AMOUNT OF TISSUE TO BE RESECTED.
PB11	PLEASE SUBMIT THE PLAN OF CARE FOR CO-TREATMENT.
PB12	FURNISH A DETAILED DESCRIPTION FOR THE PROCEDURE CODE REQUESTED.
PB13	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB15	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB18	PLEASE COMPLETE THE ATTACHED OUT-OF-STATE PROVIDER DATA SHEET, F-11001, AND RESUBMIT.
PB20	A SIGNED AND DATED PRESCRIPTION IS REQUIRED WITHIN THREE MONTHS OF RECEIPT BY COLORADO MEDICAID FOR INITIAL REQUESTS AND WITHIN 12 MONTHS OF RECEIPT BY COLORADO MEDICAID FOR SUBSEQUENT REQUESTS.
PB21	PLEASE COMPLETE THE APPROPRIATE PRIOR AUTHORIZATION ATTACHMENT. CONTACT PROVIDER SERVICES OR THE PRIOR AUTHORIZATION UNIT FOR ASSISTANCE.
PB23	PHYSICAL THERAPY ASSISTANT NOTES AND ALL FORMS SUBMITTED MUST BE COSIGNED BY A REGISTERED PHYSICAL THERAPIST.
PB31	ARE YOU REQUESTING A COMPLETE APPLIANCE, OR REPLACEMENT PARTS?
PB32	THE PROCEDURE CODE INDICATED ON THE REQUEST DOES NOT MATCH THE DESCRIPTION OF SERVICE; PLEASE CORRECT AND RESUBMIT.
PB35	THE SERVICE REQUESTED DOES NOT REQUIRE PRIOR AUTHORIZATION.
PB41	PLEASE FURNISH A CURRENT MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT, F-11090 (DATED WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID).
PB45	THE CERTIFICATION PERIOD ON THE PLAN OF CARE (POC) DOES NOT COVER THE REQUESTED GRANT/START DATE. PLEASE RESUBMIT YOUR REQUEST WITH A NEW POC.
PB49	A CERTIFIED OCCUPATIONAL THERAPY ASSISTANTS NOTES MUST BE COSIGNED BY AN OCCUPATIONAL THERAPIST REGISTERED.
PB51	ADDITIONAL INFORMATION IS REQUIRED ON PRIOR AUTHORIZATION TO ENABLE PRICING.

Denial Code	Long Description
PB54	REQUESTED SERVICES DO NOT MATCH SERVICES ON THE PHYSICIANS ORDERS.
PB59	PLEASE PROVIDE AN INDIVIDUAL EDUCATIONAL PLAN (IEP), WHICH HAS BEEN SIGNED BY THE PROVIDER NO EARLIER THAN NINE MONTHS PRIOR TO RECEIPT AT COLORADO MEDICAID; OTHERWISE, DOCUMENT WHY NO IEP EXISTS.
PB65	PLEASE FURNISH THE ANTICIPATED TOTAL CHARGES FOR THIS REQUEST.
PB66	A PHOTOCOPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED; THE DATE MUST BE WITHIN SIX MONTHS OF RECEIPT BY COLORADO MEDICAID.
PB67	THE PRESCRIPTION DATE MUST INCLUDE MONTH, DAY, AND YEAR.
PB68	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID.
PB73	THE SERVICES IDENTIFIED ON THE PLAN OF CARE DO NOT APPEAR APPROPRIATE FOR THE PROCEDURE CODE(S) REQUESTED ON THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018.
PB74	THE CLIENT/PROVIDER DOES NOT HAVE RETROACTIVE ENROLLMENT.
PB75	THE REQUESTED START DATE IS MORE THAN 14 DAYS BEFORE OR 62 DAYS AFTER RECEIPT.
PB82	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
PB83	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A HOME HEALTH AIDE. PLEASE RESUBMIT AS A PERSONAL CARE WORKER OR PROVIDE ADDITIONAL DOCUMENTATION.
PB86	THE SERVICES REQUESTED ARE NOT BEING PROVIDED IN THE CLIENTS RESIDENCE. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL.
PB87	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A NURSE. PLEASE RESUBMIT AS A HOME HEALTH AIDE OR PROVIDE ADDITIONAL DOCUMENTATION.
PB92	PLEASE FURNISH THE CLIENTS COMPLETE ADDRESS.
PB94	IF THE CLIENT IS A RESIDENT OF A NURSING HOME, SUPPLY THE COMPLETE NAME AND ADDRESS OF THE NURSING HOME.
PB99	THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018, MUST BE SIGNED AND DATED.
PC01	PLEASE SUPPLY THE RENDERING PROVIDERS PROVIDER NUMBER.
PC03	THE DRUG ENFORCEMENT ADMINISTRATION NUMBER IS MISSING OR INVALID.
PC06	PLEASE DESCRIBE YOUR PROGRAM; INCLUDE ENTRY DATE, TERMINATION DATE, HOURS PER WEEK, AND NUMBER OF WEEKS OF PRIMARY INTENSIVE SERVICE REQUESTED.
PC07	PLEASE DESCRIBE YOUR "AFTERCARE/FOLLOW-UP" PLANS FOR THIS CLIENT.
PC08	PLEASE SUPPLY DOCUMENTATION OF PREVIOUS SUBSTANCE ABUSE SERVICES WITH DATE(S) AND OUTCOME.
PC09	PLEASE DESCRIBE IN DETAIL THE TREATMENT OBJECTIVES/GOALS FOR THIS CLIENT.
PC10	PLEASE DESCRIBE THE FAMILY SITUATION/DYNAMICS. EXPLAIN HOW THE FAMILY WILL BE INCORPORATED INTO THE CLIENTS PLAN OF CARE.
PC12	PLEASE EXPLAIN IF YOUR SERVICE ENCOURAGES THE CLIENT TO ATTEND SELF-HELP GROUPS.
PC13	PLEASE SUPPLY A SPECIFIC SCHEDULE OF ACTIVITIES, INCLUDING DAY, TIME OF DAY, LENGTH OF SESSION, AND SERVICE TO BE RENDERED DURING THAT TIME.
PC15	PLEASE FURNISH DIAGNOSTIC RATIONALE.
PC17	PLEASE DOCUMENT IF THE CLIENT EVER RECEIVED SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT.
PC19	PLEASE FURNISH MORE EXTENSIVE AND IN-DEPTH HISTORICAL AND PSYCHOSOCIAL DATA.
PC20	PLEASE SUPPLY THE DATE THE CLIENT BECAME TOTALLY ENDENTULOUS.
PC23	PLEASE SUBMIT A PHYSICIANS STATEMENT REGARDING THE MEDICAL NECESSITY OF DENTURES FOR THIS CLIENT. THE PHYSICIANS STATEMENT MUST DOCUMENT THE MEDICAL NEED FOR DENTURES.
PC24	THE SERVICE REQUESTED WAS PREVIOUSLY AUTHORIZED. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT INDICATING THIS FACT IS REQUIRED.
PC25	PLEASE SUPPLY SUFFICIENT MITIGATING CIRCUMSTANCES TO WARRANT THE CONSTRUCTION OF NEW DENTURES(S).
PC26	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
PC28	PLEASE SUBMIT A PHYSICIANS STATEMENT INDICATING DENTURES ARE NECESSARY FOR THIS NURSING HOME CLIENT.

Denial Code	Long Description
PC29	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING LOSS OR DESTRUCTION OF DENTURE(S). INCLUDE SIGNED STATEMENT FROM CLIENT OR FACILITY DIRECTOR REGARDING HOW, WHEN AND WHERE LOST.
PC30	PLEASE PROVIDE COMPLETE INTRAORAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PC31	PLEASE DESCRIBE ANY RELATED DEFORMITIES OF THE FEET.
PC34	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD WITH REQUESTED DME ITEM(S) AND DOCUMENT IF THE CLIENT CAN USE SAFELY AND INDEPENDENTLY.
PC35	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD AND DESCRIBE THE RESULTS AND EFFECTIVENESS OF THE SERVICE REQUESTED.
PC39	PLEASE INDICATE LITER FLOW PER MINUTE, HOURS OF USE PER 24 HOUR PERIOD, AND THE EXPECTED DURATION OF NEED.
PC40	THE ITEM DOES NOT REQUIRE PRIOR AUTHORIZATION UNTIL THE LIFE EXPECTANCY HAS BEEN REACHED.
PC41	PLEASE SUPPLY INFORMATION INDICATING THE NECESSITY OF POSITIONING THE CLIENT'S BODY IN MULTIPLE POSITIONS.
PC42	PLEASE INDICATE IF THE BED HEIGHT MUST BE CHANGED TO ALLOW FOR SAFE TRANSFER OR ADEQUATE BED CARE.
PC43	SUPPLY A PHYSICIANS STATEMENT INDICATING TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR UNIT HAS REDUCED PAIN, IMPROVED/INCREASED THE CLIENTS ACTIVITY LEVEL, AND/OR REDUCED CLIENTS USE OF PAIN MEDICATION.
PC44	A CURRENT AUTHORIZATION FOR THIS SERVICE IS ON FILE FOR ANOTHER PROVIDER. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT OF THAT FACT IS REQUIRED BY THE CLIENT OF FIRST PROVIDER.
PC59	DOCUMENT DECLINE OR PROGRESS IN SPECIFIC, MEASURABLE, OBJECTIVE TERMS.
PC60	DOCUMENT IF CLIENT HAS DEMONSTRATED A GOOD APPOINTMENT COMPLIANCE RECORD.
PC61	THE PHYSICIANS SIGNATURE DATE MUST NOT EXCEED 90 DAYS FROM THE DATE OF RECEIPT BY COLORADO MEDICAID.
PC62	REQUESTS FOR A CONTINUATION OF THERAPY SHOULD NOT BE SUBMITTED MORE THAN FOUR WEEKS PRIOR TO THE EXPIRATION DATE OF THE CURRENT AUTHORIZATION.
PC63	PLEASE FURNISH THE STYLE AND MANUFACTURER OF THE FRAME.
PC64	PLEASE FURNISH THE CLIENTS LENS FORMULA.
PC66	ALL REQUESTS FOR TINTS REQUIRE DOCUMENTATION OF THE VISUAL OR MEDICAL CONDITION RELATED TO PHOTOPHOBIA.
PC67	PLEASE DOCUMENT THE REASON AND JUSTIFICATION FOR REPLACEMENT BEYOND THE FIRST LENS/FRAME.
PC68	DOCUMENT IF ALL REMAINING MAXILLARY AND/OR MANDIBULAR TEETH ARE DECAY-FREE, PROPERLY RESTORED, AND PERIODONTICALLY SOUND.
PC72	SUPPLY MORE DETAIL REGARDING PROGRESS (ATTACHMENT OF GOALS, ETC.). CORRELATE PROGRESS TO PREVIOUS GOALS AND IDENTIFIED LIMITATIONS.
PC77	PLEASE SUBMIT A PLAN OF CARE DESCRIBING THE SERVICES THAT WOULD BE PROVIDED.
PC78	PLEASE DOCUMENT SPECIFIC, MEASURABLE GOALS.
PC82	THE PRIOR AUTHORIZATION (PA) SYSTEM CAN PROCESS ONLY 26 DETAILS PER PA REQUEST. PLEASE RESUBMIT YOUR REQUEST WITH NO MORE THAN 26 DETAILS.
PC83	PLEASE SUPPLY A PHYSICIANS PRESCRIPTION DATED WITHIN ONE MONTH OF REQUESTED SUBSTANCE ABUSE DAY TREATMENT.
PC84	PLEASE PROVIDE INFORMATION INDICATING THIS CLIENT IS APPROPRIATELY DETOXIFIED FROM ALCOHOL AND/OR OTHER DRUGS.
PC85	PLEASE PROVIDE INFORMATION TO INDICATE THE CLIENTS ABILITY TO ABSTAIN FROM ALCOHOL OR DRUGS WHILE IN THE SUBSTANCE ABUSE DAY TREATMENT PROGRAM.
PC86	PLEASE INDICATE IF THIS CLIENT IS WILLING TO PARTICIPATE IN AFTERCARE OR CONTINUING CARE SERVICES.
PC87	PROVIDE MORE INFORMATION ON TREATMENT HISTORY; INCLUDE SERVICE PROVIDED, DATES, AND OUTCOME. PROVIDE DETAIL OF PREVIOUS TREATMENT.
PC88	PLEASE PROVIDE MORE RATIONALE FOR THE APPROPRIATENESS AND MEDICAL NECESSITY OF SUBSTANCE ABUSE DAY TREATMENT.

Denial Code	Long Description
PC89	PROVIDE A TREATMENT PLAN THAT CONTAINS MEASURABLE GOALS AND OBJECTIVES CORRESPONDING TO THE IDENTIFIED DEFICIT.
PC91	PLEASE PROVIDE MORE INFORMATION ON FAMILY INVOLVEMENT TREATMENT.
PC92	PLEASE PROVIDE MORE HISTORY AND EXPLANATION ABOUT THE ISSUE OF ABSTINENCE FOR THIS CLIENT.
PC94	PLEASE PROVIDE THE ANTICIPATED BEGINNING DATE AND/OR THE ESTIMATED SUBSTANCE ABUSE DAY TREATMENT DISCHARGE DATE.
PC95	PLEASE SUPPLY JUSTIFICATION FOR BEGINNING CLIENT IN SERVICE PRIOR TO AUTHORIZATION BEING OBTAINED.
PC96	THE INITIAL THREE HOURS OF SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IN A CALENDAR YEAR DO NOT REQUIRE PRIOR AUTHORIZATION.
PC97	REIMBURSEMENT FOR INITIAL SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IS LIMITED TO THREE HOURS IN A CALENDAR YEAR AND DOES NOT REQUIRE PRIOR AUTHORIZATION.
PC98	THIS DRUG IS CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE BILL USING THE APPROPRIATE NATIONAL DRUG CODE (NDC) OR SUBMIT A COMPLETED DRUG ADDITION REQUEST FORM IF THE NDC IS NOT LISTED IN THE DRUG INDEX.
PC99	THIS DRUG IS NOT CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL, CURRENT ADMINISTRATIVE RULE, OR COLORADO DRUG INDEX FOR COVERAGE LIMITATIONS.
PD01	DOCUMENT THAT CLIENT HAS ACHIEVED GOOD ORAL HYGIENE, PERIODONTAL CASE TYPE 1 OR 2, AND IS MOTIVATED TO MAINTAIN SAME.
PD03	PLEASE PROVIDE AN ARTERIAL BLOOD GAS READING OR PULSE OXIMETRY RESULTS DONE ON ROOM AIR SIGNED AND DATED BY A MEDICAL DOCTOR. THIS SHOULD BE DONE WITHIN 60 DAYS OF REQUESTED SERVICE.
PD04	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 30 DAYS OF RECEIPT BY COLORADO MEDICAID.
PD07	SUBMIT A PHOTOCOPY OF A VALID PRESCRIPTION, ISSUED WITHIN THE PAST YEAR, OR COMPLETE SECTION B OF THE PRIOR AUTHORIZATION/DRUG ATTACHMENT (PA/DGA), F-11049.
PD10	BRAND MEDICALLY NECESSARY MUST BE IN THE PRESCRIBERS OWN HANDWRITING AND WRITTEN DIRECTLY ON THE PRESCRIPTION OR A SEPARATE ORDER ATTACHED TO THE ORIGINAL PRESCRIPTION.
PD12	COMPLETE DENTURES, PARTIAL DENTURES, DENTURE RELINES, AND FIXED PROSTHODONTIC SERVICES ARE NOT COVERED SERVICES FOR ADULTS FOR DATES OF SERVICE ON AND AFTER OCTOBER 1, 1995.
PD22	PLEASE COMPLETE ALL REQUIRED ELEMENTS ON THE PERSONAL CARE SCREENING TOOL (PCST), F-11133.
PD24	THIS PRIOR AUTHORIZATION REQUEST IS UNABLE TO BE PROCESSED. PLEASE RESUBMIT WITH ADDITIONAL REQUIRED FORMS, INCLUDING THE ENTIRE PERSONAL CARE SCREENING TOOL (PCST), F-11133; PERSONAL CARE ADDENDUM, F-11136; AND SUPPORTING DOCUMENTATION, AS DIRECTED.
PD25	THERE IS A PERSONAL CARE SCREENING TOOL (PCST), F-11133, COMPLETED BY ANOTHER AGENCY. CONTACT THE AGENCY TO TRANSFER SCREEN.
PD26	THERE IS A LIMITED TERM CARE FUNCTIONAL SCREEN (LTC-FS) COMPLETED BY ANOTHER AGENCY. THE PERSONAL CARE SCREENING TOOL (PCST), F-11133, INFORMATION IS IN CONFLICT WITH LTC-FS.
PD27	ONLY ONE LEVEL OF FUNCTION MAY BE SELECTED FOR ALL ELEMENTS EXCEPT TOILETING. COLORADO MEDICAID IS UNABLE TO PROCESS THE PRIOR AUTHORIZATION REQUEST.
PD28	NO UNITS MAY BE REQUESTED USING THIS PRIOR AUTHORIZATION PROCESS. PLEASE SUBMIT WITH THE APPROPRIATE ATTACHMENTS FOR REQUESTING SPECIFIC PERSONAL CARE WORKER UNITS.
PD29	CLIENT IS NOT ELIGIBLE FOR THE REQUESTED SERVICE(S) AS OF THE REQUESTED START DATE.
PD30	NO TRAVEL TIME MAY BE AUTHORIZED WHEN NO PERSONAL CARE WORKER SERVICE IS AUTHORIZED.
PD32	PROVIDER NOT CERTIFIED TO RENDER THE SERVICE(S) REQUESTED.
PD34	BASED ON THE DOCUMENTATION SUBMITTED, THIS REQUEST CAN NOT BE PRIOR AUTHORIZED. REFER TO THE PA MESSAGES FROM THE CONSULTANT FOR COMPLETE EXPLANATION.
PD98	PLEASE DOCUMENT HOW AND WHEN EACH PREVIOUSLY AUTHORIZED PRO RE NATA VISIT WAS USED.

Ambulation Devices

Denial Code	Long Description
0201	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
0233	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0235	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0237	CLIENT IDENTIFICATION NUMBER DOES NOT MATCH CLIENTS FIRST NAME.
0238	THE CLIENT IDENTIFICATION NUMBER DOES NOT MATCH THE CLIENTS LAST NAME.
0242	SECONDARY DIAGNOSIS CODE IS INVALID.
0248	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0249	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0251	PROCEDURE CODE MODIFIER IN FIRST POSITION IS INVALID.
0252	THE PROCEDURE CODE MODIFIER IN SECOND POSITION IS INVALID FOR REQUESTED START DATE OR DATE OF RECEIPT.
0253	THE PROCEDURE CODE MODIFIER IN THIRD POSITION IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
0258	THE PRIMARY DIAGNOSIS CODE IS REQUIRED.
0272	THE PRIMARY DIAGNSOSIS CODE IS INVALID.
0400	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0853	HCPCS - ANNUAL UPDATE
0885	NEVER EVENTS MODIFIERS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
0886	NEVER EVENTS DIAGNOSIS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
1000	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
1002	RENDERING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1003	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1007	RENDERING PROVIDER ID IS NOT ON FILE.
1047	THE RENDERING PROVIDERS CERTIFICATION HAS BEEN CANCELLED.
1048	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1801	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
1804	A CERTIFIED SUBSTANCE ABUSE DAY TREATMENT PROVIDER MUST SUBMIT A SUBSTANCE ABUSE DAY TREATMENT PROCEDURE CODE.
1806	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
1808	THE BILLING PROVIDER DOES NOT HAVE THE REQUIRED CERTIFICATION ADDENDUM ON FILE.
1900	THE BILLING PROVIDERS TAXONOMY CODE IS INVALID.
1901	THE RENDERING PROVIDERS TAXONOMY CODE IS INVALID.
1927	A NATIONAL PROVIDER IDENTIFIER IS REQUIRED FOR THE BILLING PROVIDER.
1934	A NATIONAL PROVIDER INDENTIFIER IS REQUIRED FOR THE RENDERING PROVIDER.
1936	THE BILLING PROVIDER NUMBER IS INVALID.
1937	THE RENDERING PROVIDER NUMBER IS INVALID.
1960	INTERNAL PROCESSING IS REQUIRED.
1963	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.
1964	THE BILLING PROVIDER INDICATED IS NOT ALLOWABLE AS A BILLING PROVIDER.
1965	RENDERING PROVIDER NUMBER IS MISSING/INVALID FOR THIS PROCEDURE PROVIDER.
1974	PRESCRIBING/REFERRING/ORDERING PROVIDER INDICATED IS NOT CERTIFIED AS A PRESCRIBING/REFERRING/ORDERING PROVIDER.
1975	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
1976	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
2001	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2003	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2017	THE CLIENT IS ENROLLED IN A MEDICAID OR OTHER MANAGED CARE PROGRAM.

Denial Code	Long Description
2037	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2603	CLIENT LOCKED-IN TO A PROVIDER OR ENROLLED IN A HOSPICE. CONTACT CLIENTS HOSPICE FOR PAYMENT OF SERVICES OR RESUBMIT WITH DOCUMENTATION OF UNRELATED NATURE OF CARE.
3324	THE MODIFIER HAS BEEN DISCONTINUED BY THE CENTERS OF MEDICARE AND MEDICAID SERVICES OR THE AMERICAN MEDICAL ASSOCIATION FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
3337	THE PROCEDURE CODE HAS BEEN TERMINATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AMERICAN MEDICAL ASSOCIATION, OR AMERICAN DENTAL ASSOCIATION FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT. RESUBMIT WITH VALID A PROCEDURE CODE.
3339	THE PROCEDURE BILLED IS NOT PAYABLE ACCORDING TO DEFICIT REDUCTION ACT (DEFRA) GUIDELINES.
3351	THE PROCEDURE IS NOT COVERED FOR CLIENTS WITH A NURSING HOME AUTHORIZATION ON THE REQUESTED START DATE OR DATE OF RECEIPT.
3353	THE PROCEDURE IS NOT A COVERED SERVICE FOR HOME AND COMMUNITY-BASED WAIVER CLIENTS.
4021	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4027	THE DIAGNOSIS CODE IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
4031	THE PROCEDURE SUBMITTED IS NOT APPROPRIATE FOR CLIENTS GENDER.
4032	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4034	THE PROCEDURE CODE HAS AN AGE RESTRICTION.
4036	THE PLACE OF SERVICE CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4040	THE PRIMARY DIAGNOSIS CODE IS NOT ON FILE.
4041	THE SECONDARY DIAGNOSIS IS NOT ON FILE.
4046	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4127	INTERNAL PROCESSING IS REQUIRED.
4131	INTERNAL PROCESSING IS REQUIRED.
4141	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4149	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4150	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4236	ETIOLOGY DIAGNOSIS CODE(S) (E-CODES) ARE INVALID AS THE PRIMARY DIAGNOSIS.
4244	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4245	THE FOURTH POSITION MODIFIER IS INVALID FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT.
4256	THE PROCEDURE CODE AND MODIFIER COMBINATION IS NOT PAYABLE FOR THE CLIENTS BENEFIT PLAN.
4257	THE MODIFIERS SUBMITTED ARE EITHER INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT OR THE MODIFIERS ARE MISSING.
4311	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4315	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4316	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4371	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4372	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4711	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR CLIENTS AGE.
4714	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS AGE.
4731	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS DIAGNOSIS.
4742	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4743	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4744	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4745	DIAGNOSIS AND/OR PROCEDURE AND/OR PLACE OF SERVICE (POS) CODE IS NOT COVERED FOR EXPRESS ENROLLMENT CLIENTS.
4746	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4801	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4802	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
4821	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
4871	PLEASE REFER TO PA MESSAGES FOR RETURN INFORMATION.

Denial Code	Long Description
4963	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS GENDER.
4990	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
7500	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
7509	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
P001	THE BILLING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THE SERVICES.
P002	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P003	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P005	THE PRIOR AUTHORIZATION CAN NOT BE END DATED. THE PRIOR AUTHORIZATION STATUS IS NOT APPROVED OR APPROVED WITH REVISIONS.
P006	PLEASE FURNISH THE PROCEDURE CODE AND CORRESPONDING DESCRIPTION.
P008	THE BILLING PROVIDER NUMBER IS INVALID.
P009	THE BILLING PROVIDER NUMBER IS INVALID.
P010	THE REQUESTED END DATE IS INVALID.
P011	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P012	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P013	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P014	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P015	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P016	THE REQUESTED START DATE IS MISSING OR INVALID.
P019	THE REQUESTED START DATE IS MISSING OR INVALID.
P020	THE RENDERING PROVIDER NUMBER IS INVALID.
P021	THE RENDERING PROVIDER NUMBER IS INVALID.
P022	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P023	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P024	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P026	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P027	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P030	FIRST MODIFIER IS INVALID.
P031	FIRST MODIFIER IS INVALID.
P032	SECOND MODIFIER IS INVALID.
P033	SECOND MODIFIER IS INVALID.
P034	THIRD MODIFIER IS INVALID.
P035	THIRD MODIFIER IS INVALID.
P036	FOURTH MODIFIER IS INVALID.
P037	FOURTH MODIFIER IS INVALID.
P038	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P039	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P040	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P041	CLIENTS FIRST NAME IS MISSING.
P042	CLIENTS LAST NAME IS MISSING.
P043	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P044	BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES REQUESTED.
P045	FIRST MODIFIER IS INVALID.
P046	SECOND MODIFIER IS INVALID.
P047	THIRD MODIFIER IS INVALID.
P048	FOURTH MODIFIER IS INVALID.

Denial Code	Long Description
P052	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P053	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P054	RENDERING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES FOR THE BENEFIT PLAN.
P055	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P061	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P062	THE CLIENT ID AND/OR NAME INDICATED ON THE PA REQUEST IS INCORRECT. THE CLIENT ID AND/OR NAME HAS BEEN UPDATED. PLEASE VERIFY THE ID AND/OR NAME IS CORRECT.
P064	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
P067	THE FREQUENCY OF HOURS REQUESTED ARE NOT APPROPRIATE FOR THIS CLIENT AND HAVE BEEN MODIFIED ACCORDINGLY.
P079	BILLING PROVIDER IS ON PAYMENT SUSPENSION DUE TO CREDIBLE ALLEGATION OF FRAUD.
P120	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAS BEEN REDUCED.
P121	THE SERVICE/ PROCEDURE REQUESTED IS NOT SUPPORTED BY SUBMITTED DOCUMENTATION.
P126	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
P128	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.
P138	SERVICE(S) DO NOT MEET COLORADO MEDICAID GUIDELINES.
P167	REQUESTED DOCUMENTATION HAS NOT BEEN SUBMITTED.
P178	THE SERVICE REQUESTED IS NOT MEDICALLY NECESSARY.
P179	THE MEDICAL NECESSITY FOR THIS SERVICE IS NOT SUPPORTED BY THE SUBMITTED DOCUMENTATION.
P233	THE DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE ADDITIONAL CARE.
P257	THIS CLIENTS FUNCTIONAL ASSESSMENT SCORES PLACE THIS CLIENT OUTSIDE ELIGIBILITY FOR DAY TREATMENT.
P274	OUR RECORDS INDICATE THIS CLIENT IS INVOLVED IN EFFECTIVE AND APPROPRIATE SERVICE ELSEWHERE.
P292	INTENSIVE REHABILITATION HOURS ARE NO LONGER APPROPRIATE AS INDICATED BY HISTORY, DIAGNOSIS, AND/ OR FUNCTIONAL ASSESSMENT SCORES.
P328	THE SERVICES REQUESTED INCLUDE NON-COVERED SERVICES, AND HOURS ARE REDUCED ACCORDINGLY.
P339	THE CLIENTS PAST HISTORY INDICATES REDUCED TREATMENT HOURS ARE WARRANTED.
P342	THE REQUEST DOES NOT MEET GENERALLY ACCEPTED CONDITIONS REQUIRING FLUORIDE TREATMENTS.
P346	SERVICES EXCEED COLORADO MEDICAID LIMITATION AND DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE MEDICAL NECESSITY OF THE SERVICE.
P349	THE SERVICE REQUESTED WAS PERFORMED LESS THAN FIVE YEARS AGO.
P353	THE EXISTING APPLIANCE HAS NOT BEEN WORN FOR THREE YEARS.
P367	THE CLIENT HAS BEEN TOTALLY WITHOUT TEETH AND AN APPLIANCE FOR FIVE YEARS.
P392	THE CLIENT IS MISSING AN ANTERIOR TOOTH AND/OR HAS TWO OR MORE POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P405	THE SERVICE(S) REQUESTED COULD ADEQUATELY BE PERFORMED IN THE DENTAL OFFICE.
P406	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE OF GOOD PERIODONTAL HEALTH (AMERICAN ACADEMY OF PERIODONTOLOGY PERIODONTAL CLASSIFICATION OF TYPE I OR II).
P407	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE VISIBLE ON RADIOGRAPHS THAT AT LEAST 50 PERCENT OF THE CLINICAL CROWN IS INTACT.
P409	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING SIX OR MORE TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED, INCLUDING THIRD MOLARS.
P410	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING ONE OR MORE ANTERIOR TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED.
P411	DOCUMENTATION DOES NOT SUPPORT THE NEED FOR PERIODONTIC SERVICES. POCKETS ARE LESS THAN 4MM AND/OR GREATER THAN 6MM FOR CLIENT AND/OR THE CLIENT IS UNDER THE AGE OF 13.
P412	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA.

Denial Code	Long Description
P413	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA. THIS PA HAS BEEN GRANTED AS APPROVED NOT APPROVED WITH REVISIONS. THE DURATION REQUESTED MAY HAVE BEEN REDUCED TO REFLECT COVERAGE LIMITATIONS, PRESCRIBER ORDERS, CONFLICTI
P417	THE SERVICE(S) REQUESTED COULD BE ADEQUATELY PERFORMED WITH LOCAL ANESTHESIA.
P437	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO POOR ORAL HYGIENE.
P444	THIS LINE ITEM IS A DUPLICATE OF ANOTHER LINE ITEM ON THIS PRIOR AUTHORIZATION (PA) REQUEST. PLEASE CORRECT.
P446	THIS IS A DUPLICATE OF AN EXISTING PRIOR AUTHORIZATION (PA) REQUEST. YOU MAY CONTACT PROVIDER SERVICES IF YOU REQUIRE ASSISTANCE. DUPLICATE PA REQUEST
P448	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO DECAY HISTORY.
P449	QUESTIONABLE LONG TERM PROGNOSIS DUE TO GUM AND BONE DISEASE.
P456	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO APPARENT ROOT INFECTION.
P457	OUR RECORDS INDICATE THIS CLIENT HAS EXCEEDED ESTABLISHED PROGRAM LIMITATIONS. COLORADO MEDICAID WILL NOT AUTHORIZE NEW DENTURES.
P458	DOCUMENTATION PROVIDED INDICATES A LESS ELABORATE PROCEDURE SHOULD BE CONSIDERED.
P502	RENTAL ONLY ALLOWED; MEDICAL NEED FOR PURCHASE HAS NOT BEEN DOCUMENTED.
P503	PURCHASE ONLY ALLOWED; MEDICAL NEED FOR RENTAL HAS NOT BEEN DOCUMENTED.
P504	OCCUPATIONAL THERAPY GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P505	THE SERVICE REQUESTED IS INCLUDED IN THE NURSING HOME RATE STRUCTURE.
P511	THIS NATIONAL DRUG CODE IS ONLY BILLABLE AS PART OF A COMPOUND DRUG.
P515	THE PRESENCE OF A HANDICAPPING MALOCCLUSION OR HANDICAPPING DENTOFACIAL DEFORMITY IS NOT SUPPORTED BY THE DOCUMENTATION SUBMITTED.
P521	THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVERED BY COLORADO MEDICAID.
P522	GASTRO-INTESTINAL SURGERY FOR THE PURPOSE OF WEIGHT CONTROL IS COVERED ONLY AS A LIFE THREATENING PROCEDURE.
P523	THE TREATMENT REQUEST IS NOT CONSISTENT WITH THE CLIENT'S DIAGNOSIS.
P524	PSYCHOTHERAPY PROVIDED IN THE CLIENTS HOME IS NOT A COVERED BENEFIT OF COLORADO MEDICAID .
P525	THE INFORMATION PROVIDED IS NOT CONSISTENT WITH THE INTENSITY OF SERVICES REQUESTED.
P526	INTENSIVE MULTIPLE MODALITY TREATMENT IS NOT CONSISTENT WITH THE INFORMATION PROVIDED.
P527	MULTIPLE PROVIDERS OF TREATMENT ARE NOT INDICATED FOR THIS CLIENT.
P528	THE DURATION OF TREATMENT SESSIONS EXCEED CURRENT COLORADO MEDICAID GUIDELINES.
P534	DOCUMENTATION OF POOR PHYSICAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P535	OTHER PHYSICAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P536	THE PHYSICAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P537	USE OF PHYSICAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P538	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF A PHYSICAL THERAPIST.
P539	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS AND LIVING ARRANGEMENT.
P540	GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P541	THE PROCEDURE(S) REQUESTED ARE NOT MEDICAL IN NATURE.
P542	DOCUMENTATION OF POOR OCCUPATIONAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P543	DOCUMENTATION OF POOR SPEECH THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P544	OTHER OCCUPATIONAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P546	THE OCCUPATIONAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.

Denial Code	Long Description
P547	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF PHYSICAL THERAPY.
P548	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P549	ACTIVITIES TO PROMOTE DIVERSION OR GENERAL MOTIVATION ARE NONCOVERED COLORADO MEDICAID SERVICES.
P550	REVISIONS OF THE REQUEST IS NECESSITATED BY THE CLIENTS MINIMAL PROGRESS.
P551	RESTORATIVE NURSING INVOLVEMENT COULD BE INCREASED.
P552	CLIENTS DEMONSTRATED RESPONSE TO CURRENT THERAPY DOES NOT WARRANT THE INTENSE FREQUENCY REQUESTED.
P553	MAINTENANCE IS TWO TIMES PER WEEK OR LESS.
P554	THE SPEECH THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P555	USE OF OCCUPATIONAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P556	USE OF SPEECH THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P557	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF AN OCCUPATIONAL THERAPIST.
P558	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
P559	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P560	THE MATERIALS/ SERVICES REQUESTED ARE PRINCIPALLY COSMETIC IN NATURE.
P561	THE LENS FORMULA DOES NOT JUSTIFY REPLACEMENT.
P562	THE CHANGE IN THE LENS FORMULA DOES NOT WARRANT MULTIPLE REPLACEMENTS.
P563	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P564	LENSES ONLY ARE APPROVED; PLEASE DISPENSE A CONTRACTED FRAME. THE NON-CONTRACTED FRAME IS NOT MEDICALLY JUSTIFIED.
P565	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P566	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P567	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF OCCUPATIONAL THERAPY.
P568	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF SPEECH THERAPY.
P569	LEVEL, INTENSITY, OR EXTENT OF SERVICE(S) REQUESTED HAS BEEN MODIFIED CONSISTENT WITH MEDICAL NEED AS DEFINED IN THE PLAN OF CARE.
P570	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P571	THE SERVICE ASKED FOR IS NOT COVERED BY COLORADO MEDICAID AS THESE TASKS CAN BE DONE BY NURSES OR ACTIVITY STAFF.
P572	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P573	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.
P574	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P575	MEDICAL NEED FOR EQUIPMENT/ SUPPLY REQUESTED IS NOT SUPPORTED BY DOCUMENTATION SUBMITTED.
P576	OTHER SPEECH THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P577	DOCUMENTATION SUBMITTED IDENTIFIES THAT THE CLIENT HAS FEWER THAN TWO POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P582	LESS EXPENSIVE ALTERNATIVE SERVICES ARE AVAILABLE FOR THIS CLIENT.
P634	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P711	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING PERIODONTAL SCALING AND ROOT PLANNING.
P712	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING GINGIVECTOMY.
P754	AN APPROVED SUBSTANCE ABUSE DAY TREATMENT PROGRAM CANNOT EXCEED A SIX WEEK PERIOD.

Denial Code	Long Description
P761	THE CLIENT DOES NOT APPEAR TO BE ABLE OR WILLING TO ABSTAIN FROM ALCOHOL/DRUG USAGE WHILE IN TREATMENT. THEREFORE, SUBSTANCE ABUSE DAY TREATMENT SERVICES ARE NOT APPROVED.
P764	THIS CLIENT HAS COMPLETED INTENSIVE SUBSTANCE ABUSE TREATMENT WITHIN THE PAST 12 MONTHS. THE DOCUMENTATION PROVIDED IS NOT ADEQUATE TO JUSTIFY ADDITIONAL INTENSIVE TREATMENT AT THIS TIME.
P785	A LESS THAN SIX-WEEK HEALING PERIOD HAS BEEN SPECIFIED FOR THIS PRIOR AUTHORIZATION. THEREFORE IT IS NOT NECESSARY TO WAIT THE FULL SIX WEEKS AFTER EXTRACTIONS BEFORE TAKING DENTURE IMPRESSIONS.
P818	SIX-WEEK HEALING TIME IS REQUIRED BETWEEN EDENTULATION AND FINAL IMPRESSIONS. PAYMENT FOR DENTURES WILL BE DENIED OR RECOUPED IF HEALING PERIOD IS NOT OBSERVED.
P849	COLORADO MEDICAID HAS DETERMINED THERE WERE (ARE) SEVERAL HOME HEALTH AGENCIES WILLING TO PROVIDE MEDICALLY NECESSARY SKILLED NURSING SERVICES TO THIS CLIENT.
P864	THE DOCUMENTATION YOU HAVE SUBMITTED DOES NOT MEET THE REQUIREMENTS OF COLORADO MEDICAID.
P873	THE MEDICAL NECESSITY FOR THE HOURS REQUESTED IS NOT SUPPORTED BY THE INFORMATION SUBMITTED.
P874	THE DOCUMENTATION SUBMITTED INDICATES THE TASKS SPECIFIED CAN BE COMPLETED DURING THE VISITS APPROVED.
P878	THE DOCUMENTATION SUBMITTED DOES NOT INDICATE THAT MEDICALLY ORIENTED TASKS ARE MEDICALLY NECESSARY; THEREFORE PERSONAL CARE SERVICES HAVE BEEN APPROVED.
P880	THE QUANTITY OF SERVICES AUTHORIZED FOR THIS CLIENTS PERSONAL CARE HAS BEEN AMENDED BASED ON INFORMATION RECEIVED FROM ONE OR MORE OF THESE SOURCES: THE CLIENT, THEIR PHYSICIAN, AND/OR THE IN-HOME VISIT BY STAFF OF THE OIG (OFFICE OF INSPECTOR GENERAL).
P885	THE USE OF THIS DRUG FOR THE INTENDED PURPOSE IS NOT COVERED BY COLORADO MEDICAID, CONSISTENT WITH COLORADO ADMINISTRATIVE CODE AND FEDERAL LAW.
P924	THE MEDICAL RECORDS SUBMITTED WITH THE CURRENT REQUEST CONFLICT OR DISAGREE WITH OUR MEDICAL RECORDS ON THIS CLIENT.
P950	INDEPENDENT NURSES, PLEASE NOTE PAYABLE SERVICES MAY NOT EXCEED 12 HOURS/DAY OR 60 HOURS/WEEK.
P951	SERVICES CAN ONLY BE AUTHORIZED THROUGH ONE YEAR FROM THE PRESCRIPTION DATE.
P952	LEAD INSPECTION IS A COVERED COLORADO MEDICAID SERVICE WHEN THE CHILD HAS BEEN SHOWN TO HAVE LEAD POISONING (E.G., CHILD HAS A BLOOD LEAD LEVEL > 19 UG/DL OR TWO CONSECUTIVE BLOOD LEAD LEVELS OF 15-19 UG/DL DONE AT LEAST 90 DAYS APART). THE INSPECTION MUS
P953	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P954	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P956	THE REQUEST CAN ONLY BE BACKDATED A MAXIMUM OF 14 DAYS FROM FIRST DATE RECEIVED BY COLORADO MEDICAID.
P957	COMPLETE PERIODONTAL CHARTING AT TIME OF SERVICE, AND SUBMIT CHARTING, COPY OF OPERATIVE REPORT, TOGETHER WITH A COPY OF THE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF), F-11035, TO PA UNIT ATTENTION DENTAL CONTSULTANT.
P958	NOTE THAT CODE D4341 HAS BEEN CHANGED. REFER TO THE DECISION NOTICE FOR AUTHORIZED QUANTITY.
P960	YOUR PA HAS BEEN APPROVED FOR 90 DAYS. THE 90 DAY APPROVAL DOES NOT IMPLY THE PA REQUEST MEETS PRIOR AUTHORIZATION CRITERIA. AFTER ADDITIONAL INFORMATION IS AVAILABLE IN INTERCHANGE, COLORADO MEDICAID WILL CREATE AN AMENDMENT REQUEST TO EXTEND THE PA FOR
P961	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P962	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
PA10	THE REQUESTED END DATE IS INVALID.
PA12	PLEASE FURNISH A WRITTEN DESCRIPTION OF THE CLIENTS DIAGNOSIS.

Denial Code	Long Description
PA13	PROVIDE DIAGNOSES WITH DATES OF ONSET.
PA14	IDENTIFY PROBLEMS TO BE TREATED.
PA15	THE AUDIOLOGISTS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1), F-11020, AND PRIOR AUTHORIZATION REQUEST/HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2), F-11021.
PA16	THE PHYSICIANS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION/PHYSICIAN OTOLOGICAL REPORT (PA/POR), F-11019.
PA17	SUBMIT BRIEF HISTORY WITH REFERRAL INFORMATION, LIVING SITUATION, FUNCTIONAL STATUS, AND OTHER PERTINENT INFORMATION. WHAT CHANGE OF STATUS RESULTED IN REFERRAL AT THIS TIME?
PA18	PLEASE FURNISH THE CLIENTS HEIGHT AND WEIGHT.
PA19	PLEASE SUBMIT CLINICAL INFORMATION SUFFICIENT TO VERIFY THE NEED FOR THE REQUESTED SERVICE(S).
PA20	PLEASE RESUBMIT WITH COMPLETE PERIODONTAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PA21	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL EDUCATIONAL PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA22	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL PROGRAM PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA23	REFER TO THE DURABLE MEDICAL EQUIPMENT INDEX FOR APPROPRIATE CODE AND DESCRIPTION. DO NOT USE AN "UNLISTED" CODE.
PA24	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUALIZED FAMILY SERVICE PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA25	INFORMATION ON THE REQUEST FORM IS ILLEGIBLE, AND THE REQUEST CANNOT BE PROCESSED.
PA26	RE-EVALUATE YOUR GOALS. EMPHASIS SHOULD BE ON FUNCTIONAL SELF-CARE. GOALS MUST BE RELATED TO FUNCTIONAL OUTCOME.
PA27	PLEASE CLARIFY THE NUMBER OF HOURS PER WEEK REQUESTED.
PA28	PLEASE CLARIFY THE NUMBER OF HOURS PER DAY REQUESTED.
PA29	PLEASE CLARIFY THE NUMBER OF VISITS PER DAY REQUESTED.
PA30	ATTACH SUPPORTIVE DOCUMENTATION; HOME EXERCISE PROGRAM AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA31	THE DIAGNOSIS CODE INDICATED ON THE REQUEST DOES NOT CORRESPOND TO THE DIAGNOSIS CODE DESCRIPTION.
PA32	PLEASE SUBMIT ADDITIONAL INFORMATION SUFFICIENT TO VERIFY APPROPRIATENESS AND NEED FOR TRANSPLANT.
PA33	PLEASE SUBMIT THE INITIAL AND PROGRESSIVE OBJECTIVE FINDINGS.
PA34	ATTACH SUPPORTIVE DOCUMENTATION, FACILITY PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA35	PLEASE SUBMIT THE CLIENTS ORIGINAL COMPLAINTS AND EXAMINATION FINDINGS.
PA36	ATTACH SUPPORTIVE DOCUMENTATION, IN-HOME AUTISM PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA37	PLEASE SUBMIT YOUR TREATMENT PLAN FOR THIS CLIENT.
PA38	ATTACH SUPPORTIVE DOCUMENTATION AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA39	INITIAL EVALUATIONS MUST BE PERFORMED BY AN OCCUPATIONAL THERAPIST REGISTERED (OTR), PER AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA) STANDARDS.
PA41	IDENTIFY THE PLACE OF SERVICE AND ITS EFFECT ON SUPPORTING THE DESIRED TREATMENT OUTCOME.
PA42	PLEASE INDICATE THE HOURS OF USE OF OXYGEN PER 24-HOUR PERIOD.
PA43	PROVIDE BASELINE DOCUMENTATION FOR THIS CLIENTS LIMITATIONS USING UNITS OF MEASUREMENT THAT ARE APPLIED CONSISTENTLY WHEN REPORTING STATUS.
PA44	IDENTIFY FUNCTIONAL LIMITATIONS AS THEY ARE RELATED TO IDENTIFIED CONDITIONS.
PA46	CORRELATE PLAN OF CARE TO REQUESTED PROCEDURE CODES.
PA47	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE FREQUENCY/DURATION REQUESTED.

Denial Code	Long Description
PA48	PLEASE PROVIDE THE NAME AND CREDENTIALS OF THE RENDERING PROVIDER.
PA50	COLORADO MEDICAID RECORDS INDICATE THE CLIENT OWNS A WHEELCHAIR. DOCUMENT THE REASON AND NEED FOR REPLACEMENT AND COST TO REPAIR CURRENT WHEELCHAIR.
PA51	PLEASE DISTINGUISH PRIMARY AND SUPPORTIVE MODALITIES.
PA52	PLEASE SUBMIT A PROGRESS REPORT.
PA53	MULTIPLE FAMILY CLIENTS TREATMENT BY THE SAME PROVIDER REQUIRES FURTHER INFORMATION DOCUMENTING COORDINATION OF TREATMENT PLAN.
PA54	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE MINUTES REQUESTED.
PA55	MEDICAL NECESSITY OF TREATMENT REQUIRES ADDITIONAL DOCUMENTATION.
PA56	GIVEN AGE, DIAGNOSES, CURRENT LEVEL OF FUNCTION, PAST RESPONSE TO TREATMENT, AND LIVING SITUATION, EXPAND ON POTENTIAL FOR SIGNIFICANT FUNCTIONAL PROGRESS WITHIN THE NEXT SIX MONTHS. EMPHASIZE WHY PROGRESS IS EXPECTED WITH SERVICES AT THIS TIME.
PA57	SUBMIT THE INITIAL FINDINGS. INCLUDE A COMPREHENSIVE EVALUATION.
PA58	SUBMIT PROGRESSIVE, OBJECTIVE FINDINGS. INCLUDE A PERTINENT RE-EVALUATION.
PA59	PLEASE SUPPLY INFORMATION REGARDING THE CLIENTS MEDICATION REQUIREMENTS, IF ANY.
PA60	PLEASE SPECIFY IF THE CLIENT IS IN AN EDUCATIONAL SETTING.
PA61	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA62	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
PA63	THE SKILLS OF A THERAPIST ARE PURPOSEFUL AND SKILLED INTERVENTIONS REQUIRED TO CONTINUALLY DESIGN, IMPLEMENT, REASSESS, MODIFY/GRADE, AND/OR DISCONTINUE A PLAN OF CARE IN A TIMELY MANNER, BASED ON THE COMPLEXITY OF THE CLIENTS MEDICAL CONDITION AND/OR CO
PA64	PLEASE SUBMIT A THERAPY PLAN OF CARE, INCLUDING A CURRENT, DATED EVALUATION.
PA65	A PLAN OF CARE SIGNED AND DATED BY THE PHYSICIAN IS REQUIRED.
PA66	THE SKILLS OF A THERAPIST ARE REQUIRED WHEN ONLY THE THERAPIST CAN SAFELY AND EFFECTIVELY DELIVER THE THERAPEUTIC PROCEDURES BECAUSE OF THEIR UNIQUE KNOWLEDGE, TRAINING, AND EXPERTISE. DESCRIBE THE REASON THAT SOMEONE OTHER THAN A THERAPIST CANNOT SAFELY
PA67	PLEASE SPECIFY IF THE CLIENTS WORK SITE DEMANDS GOOD BINAURAL HEARING.
PA68	DESCRIBE THE REASON, BASED ON THE CLIENTS COGNITIVE, PHYSICAL, COMMUNICATION, OR RESOURCE STATUS, THAT A HOME PROGRAM, EQUIPMENT, OR ENVIRONMENTAL ADAPTATIONS ALONE CANNOT MEET CLIENTS NEEDS.
PA69	PLEASE SPECIFY IF THE CLIENT HAS AN ACCOMPANYING DISABILITY THAT ADDS TO THE HEARING PROBLEM.
PA70	DISTINGUISH REQUESTED PROCEDURES AND GOALS FROM OTHER SERVICES THIS CLIENT RECEIVES. THEY MAY NOT BE DUPLICATIVE.
PA71	PLEASE INDICATE THE NUMBER OF DAYS REQUESTED.
PA73	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA74	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA75	PLEASE DOCUMENT CARRYOVER OF THE THERAPY PROGRAM TO NURSING.
PA76	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA79	PROVIDE EVIDENCE OF SIGNIFICANT FUNCTIONAL PROGRESS IN LAST SIX MONTHS.
PA84	THE GRANT DATE OF THIS REQUEST CANNOT BE PRIOR TO THE SIGNATURE DATE OF THE PRESCRIBING PHYSICIAN.
PA86	PROVIDE EVIDENCE OF SKILLS GAINED IN THERAPY CARRYING OVER TO OTHER SETTINGS WITHIN SIX MONTHS.
PA87	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE NUMBER OF SESSIONS REQUESTED.
PA88	THE REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL SCOPE OF PRACTICE.
PA89	PRIOR AUTHORIZATION IS NOT REQUIRED UNTIL LIMITATION OF SERVICE HAS BEEN REACHED.

Denial Code	Long Description
PA91	PLEASE SUBMIT REQUIRED X-RAYS.
PA92	PLEASE PROVIDE AN EXPLANATION FOR THE MATERIAL SUBMITTED WITH THE REQUEST.
PA95	PLEASE DESCRIBE HOW THE PROVISION OF THIS SERVICE WOULD PREVENT INSTITUTIONALIZATION OF THE CLIENT.
PA96	COULD THE EXISTING DENTURE(S) BE RELINED OR REBASED? IF NOT, PLEASE EXPLAIN WHY NOT.
PA97	REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL STANDARDS OF PRACTICE.
PA98	PLEASE INDICATE IF THE CLIENT IS CURRENTLY BEING TUBE FED.
PB02	PLEASE PROVIDE THE REQUIRED DATED SIGNATURES ON THE ATTACHMENTS.
PB03	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING THE LOSS/DESTRUCTION/THEFT OF THE HEARING AID.
PB04	DESCRIBE THE CLIENTS ABILITY TO STAND OR AMBULATE SUFFICIENTLY TO ACCOMPLISH SELF-CARE ACTIVITIES.
PB07	PLEASE SUBMIT AN ORTHODONTIC STUDY MODEL OR DIAGNOSTIC CASTS.
PB09	PLEASE PROVIDE A PHOTOGRAPH OF THE INVOLVED AREA(S).
PB10	PLEASE PROVIDE AN ESTIMATION (IN GRAMS) OF THE TOTAL AMOUNT OF TISSUE TO BE RESECTED.
PB11	PLEASE SUBMIT THE PLAN OF CARE FOR CO-TREATMENT.
PB12	FURNISH A DETAILED DESCRIPTION FOR THE PROCEDURE CODE REQUESTED.
PB13	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB15	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB18	PLEASE COMPLETE THE ATTACHED OUT-OF-STATE PROVIDER DATA SHEET, F-11001, AND RESUBMIT.
PB20	A SIGNED AND DATED PRESCRIPTION IS REQUIRED WITHIN THREE MONTHS OF RECEIPT BY COLORADO MEDICAID FOR INITIAL REQUESTS AND WITHIN 12 MONTHS OF RECEIPT BY COLORADO MEDICAID FOR SUBSEQUENT REQUESTS.
PB21	PLEASE COMPLETE THE APPROPRIATE PRIOR AUTHORIZATION ATTACHMENT. CONTACT PROVIDER SERVICES OR THE PRIOR AUTHORIZATION UNIT FOR ASSISTANCE.
PB23	PHYSICAL THERAPY ASSISTANT NOTES AND ALL FORMS SUBMITTED MUST BE COSIGNED BY A REGISTERED PHYSICAL THERAPIST.
PB31	ARE YOU REQUESTING A COMPLETE APPLIANCE, OR REPLACEMENT PARTS?
PB32	THE PROCEDURE CODE INDICATED ON THE REQUEST DOES NOT MATCH THE DESCRIPTION OF SERVICE; PLEASE CORRECT AND RESUBMIT.
PB35	THE SERVICE REQUESTED DOES NOT REQUIRE PRIOR AUTHORIZATION.
PB41	PLEASE FURNISH A CURRENT MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT, F-11090 (DATED WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID).
PB45	THE CERTIFICATION PERIOD ON THE PLAN OF CARE (POC) DOES NOT COVER THE REQUESTED GRANT/START DATE. PLEASE RESUBMIT YOUR REQUEST WITH A NEW POC.
PB49	A CERTIFIED OCCUPATIONAL THERAPY ASSISTANTS NOTES MUST BE COSIGNED BY AN OCCUPATIONAL THERAPIST REGISTERED.
PB51	ADDITIONAL INFORMATION IS REQUIRED ON PRIOR AUTHORIZATION TO ENABLE PRICING.
PB54	REQUESTED SERVICES DO NOT MATCH SERVICES ON THE PHYSICIANS ORDERS.
PB59	PLEASE PROVIDE AN INDIVIDUAL EDUCATIONAL PLAN (IEP), WHICH HAS BEEN SIGNED BY THE PROVIDER NO EARLIER THAN NINE MONTHS PRIOR TO RECEIPT AT COLORADO MEDICAID; OTHERWISE, DOCUMENT WHY NO IEP EXISTS.
PB65	PLEASE FURNISH THE ANTICIPATED TOTAL CHARGES FOR THIS REQUEST.
PB66	A PHOTOCOPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED; THE DATE MUST BE WITHIN SIX MONTHS OF RECEIPT BY COLORADO MEDICAID.
PB67	THE PRESCRIPTION DATE MUST INCLUDE MONTH, DAY, AND YEAR.
PB68	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID.
PB73	THE SERVICES IDENTIFIED ON THE PLAN OF CARE DO NOT APPEAR APPROPRIATE FOR THE PROCEDURE CODE(S) REQUESTED ON THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018.
PB74	THE CLIENT/PROVIDER DOES NOT HAVE RETROACTIVE ENROLLMENT.
PB75	THE REQUESTED START DATE IS MORE THAN 14 DAYS BEFORE OR 62 DAYS AFTER RECEIPT.
PB82	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.

Denial Code	Long Description
PB83	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A HOME HEALTH AIDE. PLEASE RESUBMIT AS A PERSONAL CARE WORKER OR PROVIDE ADDITIONAL DOCUMENTATION.
PB86	THE SERVICES REQUESTED ARE NOT BEING PROVIDED IN THE CLIENTS RESIDENCE. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL.
PB87	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A NURSE. PLEASE RESUBMIT AS A HOME HEALTH AIDE OR PROVIDE ADDITIONAL DOCUMENTATION.
PB92	PLEASE FURNISH THE CLIENTS COMPLETE ADDRESS.
PB94	IF THE CLIENT IS A RESIDENT OF A NURSING HOME, SUPPLY THE COMPLETE NAME AND ADDRESS OF THE NURSING HOME.
PB99	THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018, MUST BE SIGNED AND DATED.
PC01	PLEASE SUPPLY THE RENDERING PROVIDERS PROVIDER NUMBER.
PC03	THE DRUG ENFORCEMENT ADMINISTRATION NUMBER IS MISSING OR INVALID.
PC06	PLEASE DESCRIBE YOUR PROGRAM; INCLUDE ENTRY DATE, TERMINATION DATE, HOURS PER WEEK, AND NUMBER OF WEEKS OF PRIMARY INTENSIVE SERVICE REQUESTED.
PC07	PLEASE DESCRIBE YOUR "AFTERCARE/FOLLOW-UP" PLANS FOR THIS CLIENT.
PC08	PLEASE SUPPLY DOCUMENTATION OF PREVIOUS SUBSTANCE ABUSE SERVICES WITH DATE(S) AND OUTCOME.
PC09	PLEASE DESCRIBE IN DETAIL THE TREATMENT OBJECTIVES/GOALS FOR THIS CLIENT.
PC10	PLEASE DESCRIBE THE FAMILY SITUATION/DYNAMICS. EXPLAIN HOW THE FAMILY WILL BE INCORPORATED INTO THE CLIENTS PLAN OF CARE.
PC12	PLEASE EXPLAIN IF YOUR SERVICE ENCOURAGES THE CLIENT TO ATTEND SELF-HELP GROUPS.
PC13	PLEASE SUPPLY A SPECIFIC SCHEDULE OF ACTIVITIES, INCLUDING DAY, TIME OF DAY, LENGTH OF SESSION, AND SERVICE TO BE RENDERED DURING THAT TIME.
PC15	PLEASE FURNISH DIAGNOSTIC RATIONALE.
PC17	PLEASE DOCUMENT IF THE CLIENT EVER RECEIVED SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT.
PC19	PLEASE FURNISH MORE EXTENSIVE AND IN-DEPTH HISTORICAL AND PSYCHOSOCIAL DATA.
PC20	PLEASE SUPPLY THE DATE THE CLIENT BECAME TOTALLY ENDENTULOUS.
PC23	PLEASE SUBMIT A PHYSICIANS STATEMENT REGARDING THE MEDICAL NECESSITY OF DENTURES FOR THIS CLIENT. THE PHYSICIANS STATEMENT MUST DOCUMENT THE MEDICAL NEED FOR DENTURES.
PC24	THE SERVICE REQUESTED WAS PREVIOUSLY AUTHORIZED. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT INDICATING THIS FACT IS REQUIRED.
PC25	PLEASE SUPPLY SUFFICIENT MITIGATING CIRCUMSTANCES TO WARRANT THE CONSTRUCTION OF NEW DENTURES(S).
PC26	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
PC28	PLEASE SUBMIT A PHYSICIANS STATEMENT INDICATING DENTURES ARE NECESSARY FOR THIS NURSING HOME CLIENT.
PC29	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING LOSS OR DESTRUCTION OF DENTURE(S). INCLUDE SIGNED STATEMENT FROM CLIENT OR FACILITY DIRECTOR REGARDING HOW, WHEN AND WHERE LOST.
PC30	PLEASE PROVIDE COMPLETE INTRAORAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PC31	PLEASE DESCRIBE ANY RELATED DEFORMITIES OF THE FEET.
PC34	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD WITH REQUESTED DME ITEM(S) AND DOCUMENT IF THE CLIENT CAN USE SAFELY AND INDEPENDENTLY.
PC35	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD AND DESCRIBE THE RESULTS AND EFFECTIVENESS OF THE SERVICE REQUESTED.
PC39	PLEASE INDICATE LITER FLOW PER MINUTE, HOURS OF USE PER 24 HOUR PERIOD, AND THE EXPECTED DURATION OF NEED.
PC40	THE ITEM DOES NOT REQUIRE PRIOR AUTHORIZATION UNTIL THE LIFE EXPECTANCY HAS BEEN REACHED.
PC41	PLEASE SUPPLY INFORMATION INDICATING THE NECESSITY OF POSITIONING THE CLIENT'S BODY IN MULTIPLE POSITIONS.

Denial Code	Long Description
PC42	PLEASE INDICATE IF THE BED HEIGHT MUST BE CHANGED TO ALLOW FOR SAFE TRANSFER OR ADEQUATE BED CARE.
PC43	SUPPLY A PHYSICIANS STATEMENT INDICATING TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR UNIT HAS REDUCED PAIN, IMPROVED/INCREASED THE CLIENTS ACTIVITY LEVEL, AND/OR REDUCED CLIENTS USE OF PAIN MEDICATION.
PC44	A CURRENT AUTHORIZATION FOR THIS SERVICE IS ON FILE FOR ANOTHER PROVIDER. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT OF THAT FACT IS REQUIRED BY THE CLIENT OF FIRST PROVIDER.
PC59	DOCUMENT DECLINE OR PROGRESS IN SPECIFIC, MEASURABLE, OBJECTIVE TERMS.
PC60	DOCUMENT IF CLIENT HAS DEMONSTRATED A GOOD APPOINTMENT COMPLIANCE RECORD.
PC61	THE PHYSICIANS SIGNATURE DATE MUST NOT EXCEED 90 DAYS FROM THE DATE OF RECEIPT BY COLORADO MEDICAID.
PC62	REQUESTS FOR A CONTINUATION OF THERAPY SHOULD NOT BE SUBMITTED MORE THAN FOUR WEEKS PRIOR TO THE EXPIRATION DATE OF THE CURRENT AUTHORIZATION.
PC63	PLEASE FURNISH THE STYLE AND MANUFACTURER OF THE FRAME.
PC64	PLEASE FURNISH THE CLIENTS LENS FORMULA.
PC66	ALL REQUESTS FOR TINTS REQUIRE DOCUMENTATION OF THE VISUAL OR MEDICAL CONDITION RELATED TO PHOTOPHOBIA.
PC67	PLEASE DOCUMENT THE REASON AND JUSTIFICATION FOR REPLACEMENT BEYOND THE FIRST LENS/FRAME.
PC68	DOCUMENT IF ALL REMAINING MAXILLARY AND/OR MANDIBULAR TEETH ARE DECAY-FREE, PROPERLY RESTORED, AND PERIODONTICALLY SOUND.
PC72	SUPPLY MORE DETAIL REGARDING PROGRESS (ATTACHMENT OF GOALS, ETC.). CORRELATE PROGRESS TO PREVIOUS GOALS AND IDENTIFIED LIMITATIONS.
PC77	PLEASE SUBMIT A PLAN OF CARE DESCRIBING THE SERVICES THAT WOULD BE PROVIDED.
PC78	PLEASE DOCUMENT SPECIFIC, MEASURABLE GOALS.
PC82	THE PRIOR AUTHORIZATION (PA) SYSTEM CAN PROCESS ONLY 26 DETAILS PER PA REQUEST. PLEASE RESUBMIT YOUR REQUEST WITH NO MORE THAN 26 DETAILS.
PC83	PLEASE SUPPLY A PHYSICIANS PRESCRIPTION DATED WITHIN ONE MONTH OF REQUESTED SUBSTANCE ABUSE DAY TREATMENT.
PC84	PLEASE PROVIDE INFORMATION INDICATING THIS CLIENT IS APPROPRIATELY DETOXIFIED FROM ALCOHOL AND/OR OTHER DRUGS.
PC85	PLEASE PROVIDE INFORMATION TO INDICATE THE CLIENTS ABILITY TO ABSTAIN FROM ALCOHOL OR DRUGS WHILE IN THE SUBSTANCE ABUSE DAY TREATMENT PROGRAM.
PC86	PLEASE INDICATE IF THIS CLIENT IS WILLING TO PARTICIPATE IN AFTERCARE OR CONTINUING CARE SERVICES.
PC87	PROVIDE MORE INFORMATION ON TREATMENT HISTORY; INCLUDE SERVICE PROVIDED, DATES, AND OUTCOME. PROVIDE DETAIL OF PREVIOUS TREATMENT.
PC88	PLEASE PROVIDE MORE RATIONALE FOR THE APPROPRIATENESS AND MEDICAL NECESSITY OF SUBSTANCE ABUSE DAY TREATMENT.
PC89	PROVIDE A TREATMENT PLAN THAT CONTAINS MEASURABLE GOALS AND OBJECTIVES CORRESPONDING TO THE IDENTIFIED DEFICIT.
PC91	PLEASE PROVIDE MORE INFORMATION ON FAMILY INVOLVEMENT TREATMENT.
PC92	PLEASE PROVIDE MORE HISTORY AND EXPLANATION ABOUT THE ISSUE OF ABSTINENCE FOR THIS CLIENT.
PC94	PLEASE PROVIDE THE ANTICIPATED BEGINNING DATE AND/OR THE ESTIMATED SUBSTANCE ABUSE DAY TREATMENT DISCHARGE DATE.
PC95	PLEASE SUPPLY JUSTIFICATION FOR BEGINNING CLIENT IN SERVICE PRIOR TO AUTHORIZATION BEING OBTAINED.
PC96	THE INITIAL THREE HOURS OF SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IN A CALENDAR YEAR DO NOT REQUIRE PRIOR AUTHORIZATION.
PC97	REIMBURSEMENT FOR INITIAL SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IS LIMITED TO THREE HOURS IN A CALENDAR YEAR AND DOES NOT REQUIRE PRIOR AUTHORIZATION.
PC98	THIS DRUG IS CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE BILL USING THE APPROPRIATE NATIONAL DRUG CODE (NDC) OR SUBMIT A COMPLETED DRUG ADDITION REQUEST FORM IF THE NDC IS NOT LISTED IN THE DRUG INDEX.

Denial Code	Long Description
PC99	THIS DRUG IS NOT CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL, CURRENT ADMINISTRATIVE RULE, OR COLORADO DRUG INDEX FOR COVERAGE LIMITATIONS.
PD01	DOCUMENT THAT CLIENT HAS ACHIEVED GOOD ORAL HYGIENE, PERIODONTAL CASE TYPE 1 OR 2, AND IS MOTIVATED TO MAINTAIN SAME.
PD03	PLEASE PROVIDE AN ARTERIAL BLOOD GAS READING OR PULSE OXIMETRY RESULTS DONE ON ROOM AIR SIGNED AND DATED BY A MEDICAL DOCTOR. THIS SHOULD BE DONE WITHIN 60 DAYS OF REQUESTED SERVICE.
PD04	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 30 DAYS OF RECEIPT BY COLORADO MEDICAID.
PD07	SUBMIT A PHOTOCOPY OF A VALID PRESCRIPTION, ISSUED WITHIN THE PAST YEAR, OR COMPLETE SECTION B OF THE PRIOR AUTHORIZATION/DRUG ATTACHMENT (PA/DGA), F-11049.
PD10	BRAND MEDICALLY NECESSARY MUST BE IN THE PRESCRIBERS OWN HANDWRITING AND WRITTEN DIRECTLY ON THE PRESCRIPTION OR A SEPARATE ORDER ATTACHED TO THE ORIGINAL PRESCRIPTION.
PD12	COMPLETE DENTURES, PARTIAL DENTURES, DENTURE RELINES, AND FIXED PROSTHODONTIC SERVICES ARE NOT COVERED SERVICES FOR ADULTS FOR DATES OF SERVICE ON AND AFTER OCTOBER 1, 1995.
PD22	PLEASE COMPLETE ALL REQUIRED ELEMENTS ON THE PERSONAL CARE SCREENING TOOL (PCST), F-11133.
PD24	THIS PRIOR AUTHORIZATION REQUEST IS UNABLE TO BE PROCESSED. PLEASE RESUBMIT WITH ADDITIONAL REQUIRED FORMS, INCLUDING THE ENTIRE PERSONAL CARE SCREENING TOOL (PCST), F-11133; PERSONAL CARE ADDENDUM, F-11136; AND SUPPORTING DOCUMENTATION, AS DIRECTED.
PD25	THERE IS A PERSONAL CARE SCREENING TOOL (PCST), F-11133, COMPLETED BY ANOTHER AGENCY. CONTACT THE AGENCY TO TRANSFER SCREEN.
PD26	THERE IS A LIMITED TERM CARE FUNCTIONAL SCREEN (LTC-FS) COMPLETED BY ANOTHER AGENCY. THE PERSONAL CARE SCREENING TOOL (PCST), F-11133, INFORMATION IS IN CONFLICT WITH LTC-FS.
PD27	ONLY ONE LEVEL OF FUNCTION MAY BE SELECTED FOR ALL ELEMENTS EXCEPT TOILETING. COLORADO MEDICAID IS UNABLE TO PROCESS THE PRIOR AUTHORIZATION REQUEST.
PD28	NO UNITS MAY BE REQUESTED USING THIS PRIOR AUTHORIZATION PROCESS. PLEASE SUBMIT WITH THE APPROPRIATE ATTACHMENTS FOR REQUESTING SPECIFIC PERSONAL CARE WORKER UNITS.
PD29	CLIENT IS NOT ELIGIBLE FOR THE REQUESTED SERVICE(S) AS OF THE REQUESTED START DATE.
PD30	NO TRAVEL TIME MAY BE AUTHORIZED WHEN NO PERSONAL CARE WORKER SERVICE IS AUTHORIZED.
PD32	PROVIDER NOT CERTIFIED TO RENDER THE SERVICE(S) REQUESTED.
PD34	BASED ON THE DOCUMENTATION SUBMITTED, THIS REQUEST CAN NOT BE PRIOR AUTHORIZED. REFER TO THE PA MESSAGES FROM THE CONSULTANT FOR COMPLETE EXPLANATION.
PD98	PLEASE DOCUMENT HOW AND WHEN EACH PREVIOUSLY AUTHORIZED PRO RE NATA VISIT WAS USED.

Audiology

Denial Code	Long Description
0201	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
0233	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0235	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0237	CLIENT IDENTIFICATION NUMBER DOES NOT MATCH CLIENTS FIRST NAME.
0238	THE CLIENT IDENTIFICATION NUMBER DOES NOT MATCH THE CLIENTS LAST NAME.
0242	SECONDARY DIAGNOSIS CODE IS INVALID.
0248	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0249	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0251	PROCEDURE CODE MODIFIER IN FIRST POSITION IS INVALID.
0252	THE PROCEDURE CODE MODIFIER IN SECOND POSITION IS INVALID FOR REQUESTED START DATE OR DATE OF RECEIPT.

Denial Code	Long Description
0253	THE PROCEDURE CODE MODIFIER IN THIRD POSITION IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
0258	THE PRIMARY DIAGNOSIS CODE IS REQUIRED.
0272	THE PRIMARY DIAGNSOSIS CODE IS INVALID.
0400	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0853	HCPCS - ANNUAL UPDATE
0885	NEVER EVENTS MODIFIERS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
0886	NEVER EVENTS DIAGNOSIS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
1000	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
1002	RENDERING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1003	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1007	RENDERING PROVIDER ID IS NOT ON FILE.
1047	THE RENDERING PROVIDERS CERTIFICATION HAS BEEN CANCELLED.
1048	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1801	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
1804	A CERTIFIED SUBSTANCE ABUSE DAY TREATMENT PROVIDER MUST SUBMIT A SUBSTANCE ABUSE DAY TREATMENT PROCEDURE CODE.
1806	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
1808	THE BILLING PROVIDER DOES NOT HAVE THE REQUIRED CERTIFICATION ADDENDUM ON FILE.
1900	THE BILLING PROVIDERS TAXONOMY CODE IS INVALID.
1901	THE RENDERING PROVIDERS TAXONOMY CODE IS INVALID.
1927	A NATIONAL PROVIDER IDENTIFIER IS REQUIRED FOR THE BILLING PROVIDER.
1934	A NATIONAL PROVIDER INDENTIFIER IS REQUIRED FOR THE RENDERING PROVIDER.
1936	THE BILLING PROVIDER NUMBER IS INVALID.
1937	THE RENDERING PROVIDER NUMBER IS INVALID.
1960	INTERNAL PROCESSING IS REQUIRED.
1963	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.
1964	THE BILLING PROVIDER INDICATED IS NOT ALLOWABLE AS A BILLING PROVIDER.
1965	RENDERING PROVIDER NUMBER IS MISSING/INVALID FOR THIS PROCEDURE PROVIDER.
1974	PRESCRIBING/REFERRING/ORDERING PROVIDER INDICATED IS NOT CERTIFIED AS A PRESCRIBING/REFERRING/ORDERING PROVIDER.
1975	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
1976	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
2001	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2003	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2017	THE CLIENT IS ENROLLED IN A MEDICAID OR OTHER MANAGED CARE PROGRAM.
2037	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2603	CLIENT LOCKED-IN TO A PROVIDER OR ENROLLED IN A HOSPICE. CONTACT CLIENTS HOSPICE FOR PAYMENT OF SERVICES OR RESUBMIT WITH DOCUMENTATION OF UNRELATED NATURE OF CARE.
3324	THE MODIFIER HAS BEEN DISCONTINUED BY THE CENTERS OF MEDICARE AND MEDICAID SERVICES OR THE AMERICAN MEDICAL ASSOCIATION FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
3337	THE PROCEDURE CODE HAS BEEN TERMINATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AMERICAN MEDICAL ASSOCIATION, OR AMERICAN DENTAL ASSOCIATION FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT. RESUBMIT WITH VALID A PROCEDURE CODE.
3339	THE PROCEDURE BILLED IS NOT PAYABLE ACCORDING TO DEFICIT REDUCTION ACT (DEFRA) GUIDELINES.
3351	THE PROCEDURE IS NOT COVERED FOR CLIENTS WITH A NURSING HOME AUTHORIZATION ON THE REQUESTED START DATE OR DATE OF RECEIPT.
3353	THE PROCEDURE IS NOT A COVERED SERVICE FOR HOME AND COMMUNITY-BASED WAIVER CLIENTS.
4021	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4027	THE DIAGNOSIS CODE IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
4031	THE PROCEDURE SUBMITTED IS NOT APPROPRIATE FOR CLIENTS GENDER.
4032	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.

Denial Code	Long Description
4034	THE PROCEDURE CODE HAS AN AGE RESTRICTION.
4036	THE PLACE OF SERVICE CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4040	THE PRIMARY DIAGNOSIS CODE IS NOT ON FILE.
4041	THE SECONDARY DIAGNOSIS IS NOT ON FILE.
4046	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4127	INTERNAL PROCESSING IS REQUIRED.
4131	INTERNAL PROCESSING IS REQUIRED.
4141	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4149	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4150	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4236	ETIOLOGY DIAGNOSIS CODE(S) (E-CODES) ARE INVALID AS THE PRIMARY DIAGNOSIS.
4244	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4245	THE FOURTH POSITION MODIFIER IS INVALID FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT.
4256	THE PROCEDURE CODE AND MODIFIER COMBINATION IS NOT PAYABLE FOR THE CLIENTS BENEFIT PLAN.
4257	THE MODIFIERS SUBMITTED ARE EITHER INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT OR THE MODIFIERS ARE MISSING.
4311	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4315	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4316	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4371	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4372	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4711	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR CLIENTS AGE.
4714	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS AGE.
4731	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS DIAGNOSIS.
4742	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4743	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4744	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4745	DIAGNOSIS AND/OR PROCEDURE AND/OR PLACE OF SERVICE (POS) CODE IS NOT COVERED FOR EXPRESS ENROLLMENT CLIENTS.
4746	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4801	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4802	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
4821	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
4871	PLEASE REFER TO PA MESSAGES FOR RETURN INFORMATION.
4963	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS GENDER.
4990	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
7500	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
7509	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
P001	THE BILLING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THE SERVICES.
P002	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P003	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P005	THE PRIOR AUTHORIZATION CAN NOT BE END DATED. THE PRIOR AUTHORIZATION STATUS IS NOT APPROVED OR APPROVED WITH REVISIONS.
P006	PLEASE FURNISH THE PROCEDURE CODE AND CORRESPONDING DESCRIPTION.
P008	THE BILLING PROVIDER NUMBER IS INVALID.
P009	THE BILLING PROVIDER NUMBER IS INVALID.
P010	THE REQUESTED END DATE IS INVALID.
P011	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.

Denial Code	Long Description
P012	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P013	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P014	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P015	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P016	THE REQUESTED START DATE IS MISSING OR INVALID.
P019	THE REQUESTED START DATE IS MISSING OR INVALID.
P020	THE RENDERING PROVIDER NUMBER IS INVALID.
P021	THE RENDERING PROVIDER NUMBER IS INVALID.
P022	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P023	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P024	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P026	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P027	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P030	FIRST MODIFIER IS INVALID.
P031	FIRST MODIFIER IS INVALID.
P032	SECOND MODIFIER IS INVALID.
P033	SECOND MODIFIER IS INVALID.
P034	THIRD MODIFIER IS INVALID.
P035	THIRD MODIFIER IS INVALID.
P036	FOURTH MODIFIER IS INVALID.
P037	FOURTH MODIFIER IS INVALID.
P038	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P039	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P040	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P041	CLIENTS FIRST NAME IS MISSING.
P042	CLIENTS LAST NAME IS MISSING.
P043	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P044	BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES REQUESTED.
P045	FIRST MODIFIER IS INVALID.
P046	SECOND MODIFIER IS INVALID.
P047	THIRD MODIFIER IS INVALID.
P048	FOURTH MODIFIER IS INVALID.
P052	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P053	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P054	RENDERING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES FOR THE BENEFIT PLAN.
P055	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P061	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P062	THE CLIENT ID AND/OR NAME INDICATED ON THE PA REQUEST IS INCORRECT. THE CLIENT ID AND/OR NAME HAS BEEN UPDATED. PLEASE VERIFY THE ID AND/OR NAME IS CORRECT.
P064	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
P067	THE FREQUENCY OF HOURS REQUESTED ARE NOT APPROPRIATE FOR THIS CLIENT AND HAVE BEEN MODIFIED ACCORDINGLY.
P079	BILLING PROVIDER IS ON PAYMENT SUSPENSION DUE TO CREDIBLE ALLEGATION OF FRAUD.
P120	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAS BEEN REDUCED.

Denial Code	Long Description
P121	THE SERVICE/ PROCEDURE REQUESTED IS NOT SUPPORTED BY SUBMITTED DOCUMENTATION.
P126	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
P128	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.
P138	SERVICE(S) DO NOT MEET COLORADO MEDICAID GUIDELINES.
P167	REQUESTED DOCUMENTATION HAS NOT BEEN SUBMITTED.
P178	THE SERVICE REQUESTED IS NOT MEDICALLY NECESSARY.
P179	THE MEDICAL NECESSITY FOR THIS SERVICE IS NOT SUPPORTED BY THE SUBMITTED DOCUMENTATION.
P233	THE DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE ADDITIONAL CARE.
P257	THIS CLIENTS FUNCTIONAL ASSESSMENT SCORES PLACE THIS CLIENT OUTSIDE ELIGIBILITY FOR DAY TREATMENT.
P274	OUR RECORDS INDICATE THIS CLIENT IS INVOLVED IN EFFECTIVE AND APPROPRIATE SERVICE ELSEWHERE.
P292	INTENSIVE REHABILITATION HOURS ARE NO LONGER APPROPRIATE AS INDICATED BY HISTORY, DIAGNOSIS, AND/ OR FUNCTIONAL ASSESSMENT SCORES.
P328	THE SERVICES REQUESTED INCLUDE NON-COVERED SERVICES, AND HOURS ARE REDUCED ACCORDINGLY.
P339	THE CLIENTS PAST HISTORY INDICATES REDUCED TREATMENT HOURS ARE WARRANTED.
P342	THE REQUEST DOES NOT MEET GENERALLY ACCEPTED CONDITIONS REQUIRING FLUORIDE TREATMENTS.
P346	SERVICES EXCEED COLORADO MEDICAID LIMITATION AND DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE MEDICAL NECESSITY OF THE SERVICE.
P349	THE SERVICE REQUESTED WAS PERFORMED LESS THAN FIVE YEARS AGO.
P353	THE EXISTING APPLIANCE HAS NOT BEEN WORN FOR THREE YEARS.
P367	THE CLIENT HAS BEEN TOTALLY WITHOUT TEETH AND AN APPLIANCE FOR FIVE YEARS.
P392	THE CLIENT IS MISSING AN ANTERIOR TOOTH AND/OR HAS TWO OR MORE POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P405	THE SERVICE(S) REQUESTED COULD ADEQUATELY BE PERFORMED IN THE DENTAL OFFICE.
P406	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE OF GOOD PERIODONTAL HEALTH (AMERICAN ACADEMY OF PERIODONTOLOGY PERIODONTAL CLASSIFICATION OF TYPE I OR II).
P407	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE VISIBLE ON RADIOGRAPHS THAT AT LEAST 50 PERCENT OF THE CLINICAL CROWN IS INTACT.
P409	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING SIX OR MORE TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED, INCLUDING THIRD MOLARS.
P410	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING ONE OR MORE ANTERIOR TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED.
P411	DOCUMENTATION DOES NOT SUPPORT THE NEED FOR PERIODONTIC SERVICES. POCKETS ARE LESS THAN 4MM AND/OR GREATER THAN 6MM FOR CLIENT AND/OR THE CLIENT IS UNDER THE AGE OF 13.
P412	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA.
P413	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA. THIS PA HAS BEEN GRANTED AS APPROVED NOT APPROVED WITH REVISIONS. THE DURATION REQUESTED MAY HAVE BEEN REDUCED TO REFLECT COVERAGE LIMITATIONS, PRESCRIBER ORDERS, CONFLICTI
P417	THE SERVICE(S) REQUESTED COULD BE ADEQUATELY PERFORMED WITH LOCAL ANESTHESIA.
P437	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO POOR ORAL HYGIENE.
P444	THIS LINE ITEM IS A DUPLICATE OF ANOTHER LINE ITEM ON THIS PRIOR AUTHORIZATION (PA) REQUEST. PLEASE CORRECT.
P446	THIS IS A DUPLICATE OF AN EXISTING PRIOR AUTHORIZATION (PA) REQUEST. YOU MAY CONTACT PROVIDER SERVICES IF YOU REQUIRE ASSISTANCE. DUPLICATE PA REQUEST
P448	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO DECAY HISTORY.
P449	QUESTIONABLE LONG TERM PROGNOSIS DUE TO GUM AND BONE DISEASE.
P456	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO APPARENT ROOT INFECTION.
P457	OUR RECORDS INDICATE THIS CLIENT HAS EXCEEDED ESTABLISHED PROGRAM LIMITATIONS. COLORADO MEDICAID WILL NOT AUTHORIZE NEW DENTURES.
P458	DOCUMENTATION PROVIDED INDICATES A LESS ELABORATE PROCEDURE SHOULD BE CONSIDERED.
P502	RENTAL ONLY ALLOWED; MEDICAL NEED FOR PURCHASE HAS NOT BEEN DOCUMENTED.
P503	PURCHASE ONLY ALLOWED; MEDICAL NEED FOR RENTAL HAS NOT BEEN DOCUMENTED.

Denial Code	Long Description
P504	OCCUPATIONAL THERAPY GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P505	THE SERVICE REQUESTED IS INCLUDED IN THE NURSING HOME RATE STRUCTURE.
P511	THIS NATIONAL DRUG CODE IS ONLY BILLABLE AS PART OF A COMPOUND DRUG.
P515	THE PRESENCE OF A HANDICAPPING MALOCCLUSION OR HANDICAPPING DENTOFACIAL DEFORMITY IS NOT SUPPORTED BY THE DOCUMENTATION SUBMITTED.
P521	THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVERED BY COLORADO MEDICAID.
P522	GASTRO-INTESTINAL SURGERY FOR THE PURPOSE OF WEIGHT CONTROL IS COVERED ONLY AS A LIFE THREATENING PROCEDURE.
P523	THE TREATMENT REQUEST IS NOT CONSISTENT WITH THE CLIENT'S DIAGNOSIS.
P524	PSYCHOTHERAPY PROVIDED IN THE CLIENTS HOME IS NOT A COVERED BENEFIT OF COLORADO MEDICAID .
P525	THE INFORMATION PROVIDED IS NOT CONSISTENT WITH THE INTENSITY OF SERVICES REQUESTED.
P526	INTENSIVE MULTIPLE MODALITY TREATMENT IS NOT CONSISTENT WITH THE INFORMATION PROVIDED.
P527	MULTIPLE PROVIDERS OF TREATMENT ARE NOT INDICATED FOR THIS CLIENT.
P528	THE DURATION OF TREATMENT SESSIONS EXCEED CURRENT COLORADO MEDICAID GUIDELINES.
P534	DOCUMENTATION OF POOR PHYSICAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P535	OTHER PHYSICAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P536	THE PHYSICAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P537	USE OF PHYSICAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P538	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF A PHYSICAL THERAPIST.
P539	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS AND LIVING ARRANGEMENT.
P540	GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P541	THE PROCEDURE(S) REQUESTED ARE NOT MEDICAL IN NATURE.
P542	DOCUMENTATION OF POOR OCCUPATIONAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P543	DOCUMENTATION OF POOR SPEECH THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P544	OTHER OCCUPATIONAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P546	THE OCCUPATIONAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P547	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF PHYSICAL THERAPY.
P548	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P549	ACTIVITIES TO PROMOTE DIVERSION OR GENERAL MOTIVATION ARE NONCOVERED COLORADO MEDICAID SERVICES.
P550	REVISIONS OF THE REQUEST IS NECESSITATED BY THE CLIENTS MINIMAL PROGRESS.
P551	RESTORATIVE NURSING INVOLVEMENT COULD BE INCREASED.
P552	CLIENTS DEMONSTRATED RESPONSE TO CURRENT THERAPY DOES NOT WARRANT THE INTENSE FREQUENCY REQUESTED.
P553	MAINTENANCE IS TWO TIMES PER WEEK OR LESS.
P554	THE SPEECH THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P555	USE OF OCCUPATIONAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P556	USE OF SPEECH THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P557	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF AN OCCUPATIONAL THERAPIST.
P558	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.

Denial Code	Long Description
P559	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P560	THE MATERIALS/ SERVICES REQUESTED ARE PRINCIPALLY COSMETIC IN NATURE.
P561	THE LENS FORMULA DOES NOT JUSTIFY REPLACEMENT.
P562	THE CHANGE IN THE LENS FORMULA DOES NOT WARRANT MULTIPLE REPLACEMENTS.
P563	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P564	LENSES ONLY ARE APPROVED; PLEASE DISPENSE A CONTRACTED FRAME. THE NON-CONTRACTED FRAME IS NOT MEDICALLY JUSTIFIED.
P565	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P566	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P567	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF OCCUPATIONAL THERAPY.
P568	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF SPEECH THERAPY.
P569	LEVEL, INTENSITY, OR EXTENT OF SERVICE(S) REQUESTED HAS BEEN MODIFIED CONSISTENT WITH MEDICAL NEED AS DEFINED IN THE PLAN OF CARE.
P570	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P571	THE SERVICE ASKED FOR IS NOT COVERED BY COLORADO MEDICAID AS THESE TASKS CAN BE DONE BY NURSES OR ACTIVITY STAFF.
P572	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P573	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.
P574	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P575	MEDICAL NEED FOR EQUIPMENT/ SUPPLY REQUESTED IS NOT SUPPORTED BY DOCUMENTATION SUBMITTED.
P576	OTHER SPEECH THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P577	DOCUMENTATION SUBMITTED IDENTIFIES THAT THE CLIENT HAS FEWER THAN TWO POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P582	LESS EXPENSIVE ALTERNATIVE SERVICES ARE AVAILABLE FOR THIS CLIENT.
P634	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P711	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING PERIODONTAL SCALING AND ROOT PLANNING.
P712	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING GINGIVECTOMY.
P754	AN APPROVED SUBSTANCE ABUSE DAY TREATMENT PROGRAM CANNOT EXCEED A SIX WEEK PERIOD.
P761	THE CLIENT DOES NOT APPEAR TO BE ABLE OR WILLING TO ABSTAIN FROM ALCOHOL/DRUG USAGE WHILE IN TREATMENT. THEREFORE, SUBSTANCE ABUSE DAY TREATMENT SERVICES ARE NOT APPROVED.
P764	THIS CLIENT HAS COMPLETED INTENSIVE SUBSTANCE ABUSE TREATMENT WITHIN THE PAST 12 MONTHS. THE DOCUMENTATION PROVIDED IS NOT ADEQUATE TO JUSTIFY ADDITIONAL INTENSIVE TREATMENT AT THIS TIME.
P785	A LESS THAN SIX-WEEK HEALING PERIOD HAS BEEN SPECIFIED FOR THIS PRIOR AUTHORIZATION. THEREFORE IT IS NOT NECESSARY TO WAIT THE FULL SIX WEEKS AFTER EXTRACTIONS BEFORE TAKING DENTURE IMPRESSIONS.
P818	SIX-WEEK HEALING TIME IS REQUIRED BETWEEN EDENTULATION AND FINAL IMPRESSIONS. PAYMENT FOR DENTURES WILL BE DENIED OR RECOUPED IF HEALING PERIOD IS NOT OBSERVED.
P849	COLORADO MEDICAID HAS DETERMINED THERE WERE (ARE) SEVERAL HOME HEALTH AGENCIES WILLING TO PROVIDE MEDICALLY NECESSARY SKILLED NURSING SERVICES TO THIS CLIENT.
P864	THE DOCUMENTATION YOU HAVE SUBMITTED DOES NOT MEET THE REQUIREMENTS OF COLORADO MEDICAID.
P873	THE MEDICAL NECESSITY FOR THE HOURS REQUESTED IS NOT SUPPORTED BY THE INFORMATION SUBMITTED.
P874	THE DOCUMENTATION SUBMITTED INDICATES THE TASKS SPECIFIED CAN BE COMPLETED DURING THE VISITS APPROVED.

Denial Code	Long Description
P878	THE DOCUMENTATION SUBMITTED DOES NOT INDICATE THAT MEDICALLY ORIENTED TASKS ARE MEDICALLY NECESSARY; THEREFORE PERSONAL CARE SERVICES HAVE BEEN APPROVED.
P880	THE QUANTITY OF SERVICES AUTHORIZED FOR THIS CLIENTS PERSONAL CARE HAS BEEN AMENDED BASED ON INFORMATION RECEIVED FROM ONE OR MORE OF THESE SOURCES: THE CLIENT, THEIR PHYSICIAN, AND/OR THE IN-HOME VISIT BY STAFF OF THE OIG (OFFICE OF INSPECTOR GENERAL).
P885	THE USE OF THIS DRUG FOR THE INTENDED PURPOSE IS NOT COVERED BY COLORADO MEDICAID, CONSISTENT WITH COLORADO ADMINISTRATIVE CODE AND FEDERAL LAW.
P924	THE MEDICAL RECORDS SUBMITTED WITH THE CURRENT REQUEST CONFLICT OR DISAGREE WITH OUR MEDICAL RECORDS ON THIS CLIENT.
P950	INDEPENDENT NURSES, PLEASE NOTE PAYABLE SERVICES MAY NOT EXCEED 12 HOURS/DAY OR 60 HOURS/WEEK.
P951	SERVICES CAN ONLY BE AUTHORIZED THROUGH ONE YEAR FROM THE PRESCRIPTION DATE.
P952	LEAD INSPECTION IS A COVERED COLORADO MEDICAID SERVICE WHEN THE CHILD HAS BEEN SHOWN TO HAVE LEAD POISONING (E.G., CHILD HAS A BLOOD LEAD LEVEL > 19 UG/DL OR TWO CONSECUTIVE BLOOD LEAD LEVELS OF 15-19 UG/DL DONE AT LEAST 90 DAYS APART). THE INSPECTION MUS
P953	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P954	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P956	THE REQUEST CAN ONLY BE BACKDATED A MAXIMUM OF 14 DAYS FROM FIRST DATE RECEIVED BY COLORADO MEDICAID.
P957	COMPLETE PERIODONTAL CHARTING AT TIME OF SERVICE, AND SUBMIT CHARTING, COPY OF OPERATIVE REPORT, TOGETHER WITH A COPY OF THE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF), F-11035, TO PA UNIT ATTENTION DENTAL CONTSULTANT.
P958	NOTE THAT CODE D4341 HAS BEEN CHANGED. REFER TO THE DECISION NOTICE FOR AUTHORIZED QUANTITY.
P960	YOUR PA HAS BEEN APPROVED FOR 90 DAYS. THE 90 DAY APPROVAL DOES NOT IMPLY THE PA REQUEST MEETS PRIOR AUTHORIZATION CRITERIA. AFTER ADDITIONAL INFORMATION IS AVAILABLE IN INTERCHANGE, COLORADO MEDICAID WILL CREATE AN AMENDMENT REQUEST TO EXTEND THE PA FOR
P961	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P962	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
PA10	THE REQUESTED END DATE IS INVALID.
PA12	PLEASE FURNISH A WRITTEN DESCRIPTION OF THE CLIENTS DIAGNOSIS.
PA13	PROVIDE DIAGNOSES WITH DATES OF ONSET.
PA14	IDENTIFY PROBLEMS TO BE TREATED.
PA15	THE AUDIOLOGISTS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1), F-11020, AND PRIOR AUTHORIZATION REQUEST/HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2), F-11021.
PA16	THE PHYSICIANS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION/PHYSICIAN OTOLOGICAL REPORT (PA/POR), F-11019.
PA17	SUBMIT BRIEF HISTORY WITH REFERRAL INFORMATION, LIVING SITUATION, FUNCTIONAL STATUS, AND OTHER PERTINENT INFORMATION. WHAT CHANGE OF STATUS RESULTED IN REFERRAL AT THIS TIME?
PA18	PLEASE FURNISH THE CLIENTS HEIGHT AND WEIGHT.
PA19	PLEASE SUBMIT CLINICAL INFORMATION SUFFICIENT TO VERIFY THE NEED FOR THE REQUESTED SERVICE(S).
PA20	PLEASE RESUBMIT WITH COMPLETE PERIODONTAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PA21	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL EDUCATIONAL PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA22	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL PROGRAM PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.

Denial Code	Long Description
PA23	REFER TO THE DURABLE MEDICAL EQUIPMENT INDEX FOR APPROPRIATE CODE AND DESCRIPTION. DO NOT USE AN "UNLISTED" CODE.
PA24	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUALIZED FAMILY SERVICE PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA25	INFORMATION ON THE REQUEST FORM IS ILLEGIBLE, AND THE REQUEST CANNOT BE PROCESSED.
PA26	RE-EVALUATE YOUR GOALS. EMPHASIS SHOULD BE ON FUNCTIONAL SELF-CARE. GOALS MUST BE RELATED TO FUNCTIONAL OUTCOME.
PA27	PLEASE CLARIFY THE NUMBER OF HOURS PER WEEK REQUESTED.
PA28	PLEASE CLARIFY THE NUMBER OF HOURS PER DAY REQUESTED.
PA29	PLEASE CLARIFY THE NUMBER OF VISITS PER DAY REQUESTED.
PA30	ATTACH SUPPORTIVE DOCUMENTATION; HOME EXERCISE PROGRAM AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA31	THE DIAGNOSIS CODE INDICATED ON THE REQUEST DOES NOT CORRESPOND TO THE DIAGNOSIS CODE DESCRIPTION.
PA32	PLEASE SUBMIT ADDITIONAL INFORMATION SUFFICIENT TO VERIFY APPROPRIATENESS AND NEED FOR TRANSPLANT.
PA33	PLEASE SUBMIT THE INITIAL AND PROGRESSIVE OBJECTIVE FINDINGS.
PA34	ATTACH SUPPORTIVE DOCUMENTATION, FACILITY PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA35	PLEASE SUBMIT THE CLIENTS ORIGINAL COMPLAINTS AND EXAMINATION FINDINGS.
PA36	ATTACH SUPPORTIVE DOCUMENTATION, IN-HOME AUTISM PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA37	PLEASE SUBMIT YOUR TREATMENT PLAN FOR THIS CLIENT.
PA38	ATTACH SUPPORTIVE DOCUMENTATION AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA39	INITIAL EVALUATIONS MUST BE PERFORMED BY AN OCCUPATIONAL THERAPIST REGISTERED (OTR), PER AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA) STANDARDS.
PA41	IDENTIFY THE PLACE OF SERVICE AND ITS EFFECT ON SUPPORTING THE DESIRED TREATMENT OUTCOME.
PA42	PLEASE INDICATE THE HOURS OF USE OF OXYGEN PER 24-HOUR PERIOD.
PA43	PROVIDE BASELINE DOCUMENTATION FOR THIS CLIENTS LIMITATIONS USING UNITS OF MEASUREMENT THAT ARE APPLIED CONSISTENTLY WHEN REPORTING STATUS.
PA44	IDENTIFY FUNCTIONAL LIMITATIONS AS THEY ARE RELATED TO IDENTIFIED CONDITIONS.
PA46	CORRELATE PLAN OF CARE TO REQUESTED PROCEDURE CODES.
PA47	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE FREQUENCY/DURATION REQUESTED.
PA48	PLEASE PROVIDE THE NAME AND CREDENTIALS OF THE RENDERING PROVIDER.
PA50	COLORADO MEDICAID RECORDS INDICATE THE CLIENT OWNS A WHEELCHAIR. DOCUMENT THE REASON AND NEED FOR REPLACEMENT AND COST TO REPAIR CURRENT WHEELCHAIR.
PA51	PLEASE DISTINGUISH PRIMARY AND SUPPORTIVE MODALITIES.
PA52	PLEASE SUBMIT A PROGRESS REPORT.
PA53	MULTIPLE FAMILY CLIENTS TREATMENT BY THE SAME PROVIDER REQUIRES FURTHER INFORMATION DOCUMENTING COORDINATION OF TREATMENT PLAN.
PA54	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE MINUTES REQUESTED.
PA55	MEDICAL NECESSITY OF TREATMENT REQUIRES ADDITIONAL DOCUMENTATION.
PA56	GIVEN AGE, DIAGNOSES, CURRENT LEVEL OF FUNCTION, PAST RESPONSE TO TREATMENT, AND LIVING SITUATION, EXPAND ON POTENTIAL FOR SIGNIFICANT FUNCTIONAL PROGRESS WITHIN THE NEXT SIX MONTHS. EMPHASIZE WHY PROGRESS IS EXPECTED WITH SERVICES AT THIS TIME.
PA57	SUBMIT THE INITIAL FINDINGS. INCLUDE A COMPREHENSIVE EVALUATION.
PA58	SUBMIT PROGRESSIVE, OBJECTIVE FINDINGS. INCLUDE A PERTINENT RE-EVALUATION.
PA59	PLEASE SUPPLY INFORMATION REGARDING THE CLIENTS MEDICATION REQUIREMENTS, IF ANY.
PA60	PLEASE SPECIFY IF THE CLIENT IS IN AN EDUCATIONAL SETTING.
PA61	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).

Denial Code	Long Description
PA62	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
PA63	THE SKILLS OF A THERAPIST ARE PURPOSEFUL AND SKILLED INTERVENTIONS REQUIRED TO CONTINUALLY DESIGN, IMPLEMENT, REASSESS, MODIFY/GRADE, AND/OR DISCONTINUE A PLAN OF CARE IN A TIMELY MANNER, BASED ON THE COMPLEXITY OF THE CLIENTS MEDICAL CONDITION AND/OR CO
PA64	PLEASE SUBMIT A THERAPY PLAN OF CARE, INCLUDING A CURRENT, DATED EVALUATION.
PA65	A PLAN OF CARE SIGNED AND DATED BY THE PHYSICIAN IS REQUIRED.
PA66	THE SKILLS OF A THERAPIST ARE REQUIRED WHEN ONLY THE THERAPIST CAN SAFELY AND EFFECTIVELY DELIVER THE THERAPEUTIC PROCEDURES BECAUSE OF THEIR UNIQUE KNOWLEDGE, TRAINING, AND EXPERTISE. DESCRIBE THE REASON THAT SOMEONE OTHER THAN A THERAPIST CANNOT SAFELY
PA67	PLEASE SPECIFY IF THE CLIENTS WORK SITE DEMANDS GOOD BINAURAL HEARING.
PA68	DESCRIBE THE REASON, BASED ON THE CLIENTS COGNITIVE, PHYSICAL, COMMUNICATION, OR RESOURCE STATUS, THAT A HOME PROGRAM, EQUIPMENT, OR ENVIRONMENTAL ADAPTATIONS ALONE CANNOT MEET CLIENTS NEEDS.
PA69	PLEASE SPECIFY IF THE CLIENT HAS AN ACCOMPANYING DISABILITY THAT ADDS TO THE HEARING PROBLEM.
PA70	DISTINGUISH REQUESTED PROCEDURES AND GOALS FROM OTHER SERVICES THIS CLIENT RECEIVES. THEY MAY NOT BE DUPLICATIVE.
PA71	PLEASE INDICATE THE NUMBER OF DAYS REQUESTED.
PA73	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA74	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA75	PLEASE DOCUMENT CARRYOVER OF THE THERAPY PROGRAM TO NURSING.
PA76	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA79	PROVIDE EVIDENCE OF SIGNIFICANT FUNCTIONAL PROGRESS IN LAST SIX MONTHS.
PA84	THE GRANT DATE OF THIS REQUEST CANNOT BE PRIOR TO THE SIGNATURE DATE OF THE PRESCRIBING PHYSICIAN.
PA86	PROVIDE EVIDENCE OF SKILLS GAINED IN THERAPY CARRYING OVER TO OTHER SETTINGS WITHIN SIX MONTHS.
PA87	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE NUMBER OF SESSIONS REQUESTED.
PA88	THE REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL SCOPE OF PRACTICE.
PA89	PRIOR AUTHORIZATION IS NOT REQUIRED UNTIL LIMITATION OF SERVICE HAS BEEN REACHED.
PA91	PLEASE SUBMIT REQUIRED X-RAYS.
PA92	PLEASE PROVIDE AN EXPLANATION FOR THE MATERIAL SUBMITTED WITH THE REQUEST.
PA95	PLEASE DESCRIBE HOW THE PROVISION OF THIS SERVICE WOULD PREVENT INSTITUTIONALIZATION OF THE CLIENT.
PA96	COULD THE EXISTING DENTURE(S) BE RELINED OR REBASED? IF NOT, PLEASE EXPLAIN WHY NOT.
PA97	REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL STANDARDS OF PRACTICE.
PA98	PLEASE INDICATE IF THE CLIENT IS CURRENTLY BEING TUBE FED.
PB02	PLEASE PROVIDE THE REQUIRED DATED SIGNATURES ON THE ATTACHMENTS.
PB03	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING THE LOSS/DESTRUCTION/THEFT OF THE HEARING AID.
PB04	DESCRIBE THE CLIENTS ABILITY TO STAND OR AMBULATE SUFFICIENTLY TO ACCOMPLISH SELF-CARE ACTIVITIES.
PB07	PLEASE SUBMIT AN ORTHODONTIC STUDY MODEL OR DIAGNOSTIC CASTS.
PB09	PLEASE PROVIDE A PHOTOGRAPH OF THE INVOLVED AREA(S).
PB10	PLEASE PROVIDE AN ESTIMATION (IN GRAMS) OF THE TOTAL AMOUNT OF TISSUE TO BE RESECTED.
PB11	PLEASE SUBMIT THE PLAN OF CARE FOR CO-TREATMENT.
PB12	FURNISH A DETAILED DESCRIPTION FOR THE PROCEDURE CODE REQUESTED.
PB13	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB15	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.

Denial Code	Long Description
PB18	PLEASE COMPLETE THE ATTACHED OUT-OF-STATE PROVIDER DATA SHEET, F-11001, AND RESUBMIT.
PB20	A SIGNED AND DATED PRESCRIPTION IS REQUIRED WITHIN THREE MONTHS OF RECEIPT BY COLORADO MEDICAID FOR INITIAL REQUESTS AND WITHIN 12 MONTHS OF RECEIPT BY COLORADO MEDICAID FOR SUBSEQUENT REQUESTS.
PB21	PLEASE COMPLETE THE APPROPRIATE PRIOR AUTHORIZATION ATTACHMENT. CONTACT PROVIDER SERVICES OR THE PRIOR AUTHORIZATION UNIT FOR ASSISTANCE.
PB23	PHYSICAL THERAPY ASSISTANT NOTES AND ALL FORMS SUBMITTED MUST BE COSIGNED BY A REGISTERED PHYSICAL THERAPIST.
PB31	ARE YOU REQUESTING A COMPLETE APPLIANCE, OR REPLACEMENT PARTS?
PB32	THE PROCEDURE CODE INDICATED ON THE REQUEST DOES NOT MATCH THE DESCRIPTION OF SERVICE; PLEASE CORRECT AND RESUBMIT.
PB35	THE SERVICE REQUESTED DOES NOT REQUIRE PRIOR AUTHORIZATION.
PB41	PLEASE FURNISH A CURRENT MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT, F-11090 (DATED WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID).
PB45	THE CERTIFICATION PERIOD ON THE PLAN OF CARE (POC) DOES NOT COVER THE REQUESTED GRANT/START DATE. PLEASE RESUBMIT YOUR REQUEST WITH A NEW POC.
PB49	A CERTIFIED OCCUPATIONAL THERAPY ASSISTANTS NOTES MUST BE COSIGNED BY AN OCCUPATIONAL THERAPIST REGISTERED.
PB51	ADDITIONAL INFORMATION IS REQUIRED ON PRIOR AUTHORIZATION TO ENABLE PRICING.
PB54	REQUESTED SERVICES DO NOT MATCH SERVICES ON THE PHYSICIANS ORDERS.
PB59	PLEASE PROVIDE AN INDIVIDUAL EDUCATIONAL PLAN (IEP), WHICH HAS BEEN SIGNED BY THE PROVIDER NO EARLIER THAN NINE MONTHS PRIOR TO RECEIPT AT COLORADO MEDICAID; OTHERWISE, DOCUMENT WHY NO IEP EXISTS.
PB65	PLEASE FURNISH THE ANTICIPATED TOTAL CHARGES FOR THIS REQUEST.
PB66	A PHOTOCOPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED; THE DATE MUST BE WITHIN SIX MONTHS OF RECEIPT BY COLORADO MEDICAID.
PB67	THE PRESCRIPTION DATE MUST INCLUDE MONTH, DAY, AND YEAR.
PB68	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID.
PB73	THE SERVICES IDENTIFIED ON THE PLAN OF CARE DO NOT APPEAR APPROPRIATE FOR THE PROCEDURE CODE(S) REQUESTED ON THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018.
PB74	THE CLIENT/PROVIDER DOES NOT HAVE RETROACTIVE ENROLLMENT.
PB75	THE REQUESTED START DATE IS MORE THAN 14 DAYS BEFORE OR 62 DAYS AFTER RECEIPT.
PB82	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
PB83	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A HOME HEALTH AIDE. PLEASE RESUBMIT AS A PERSONAL CARE WORKER OR PROVIDE ADDITIONAL DOCUMENTATION.
PB86	THE SERVICES REQUESTED ARE NOT BEING PROVIDED IN THE CLIENTS RESIDENCE. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL.
PB87	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A NURSE. PLEASE RESUBMIT AS A HOME HEALTH AIDE OR PROVIDE ADDITIONAL DOCUMENTATION.
PB92	PLEASE FURNISH THE CLIENTS COMPLETE ADDRESS.
PB94	IF THE CLIENT IS A RESIDENT OF A NURSING HOME, SUPPLY THE COMPLETE NAME AND ADDRESS OF THE NURSING HOME.
PB99	THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018, MUST BE SIGNED AND DATED.
PC01	PLEASE SUPPLY THE RENDERING PROVIDERS PROVIDER NUMBER.
PC03	THE DRUG ENFORCEMENT ADMINISTRATION NUMBER IS MISSING OR INVALID.
PC06	PLEASE DESCRIBE YOUR PROGRAM; INCLUDE ENTRY DATE, TERMINATION DATE, HOURS PER WEEK, AND NUMBER OF WEEKS OF PRIMARY INTENSIVE SERVICE REQUESTED.
PC07	PLEASE DESCRIBE YOUR "AFTERCARE/FOLLOW-UP" PLANS FOR THIS CLIENT.
PC08	PLEASE SUPPLY DOCUMENTATION OF PREVIOUS SUBSTANCE ABUSE SERVICES WITH DATE(S) AND OUTCOME.
PC09	PLEASE DESCRIBE IN DETAIL THE TREATMENT OBJECTIVES/GOALS FOR THIS CLIENT.

Denial Code	Long Description
PC10	PLEASE DESCRIBE THE FAMILY SITUATION/DYNAMICS. EXPLAIN HOW THE FAMILY WILL BE INCORPORATED INTO THE CLIENTS PLAN OF CARE.
PC12	PLEASE EXPLAIN IF YOUR SERVICE ENCOURAGES THE CLIENT TO ATTEND SELF-HELP GROUPS.
PC13	PLEASE SUPPLY A SPECIFIC SCHEDULE OF ACTIVITIES, INCLUDING DAY, TIME OF DAY, LENGTH OF SESSION, AND SERVICE TO BE RENDERED DURING THAT TIME.
PC15	PLEASE FURNISH DIAGNOSTIC RATIONALE.
PC17	PLEASE DOCUMENT IF THE CLIENT EVER RECEIVED SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT.
PC19	PLEASE FURNISH MORE EXTENSIVE AND IN-DEPTH HISTORICAL AND PSYCHOSOCIAL DATA.
PC20	PLEASE SUPPLY THE DATE THE CLIENT BECAME TOTALLY ENDENTULOUS.
PC23	PLEASE SUBMIT A PHYSICIANS STATEMENT REGARDING THE MEDICAL NECESSITY OF DENTURES FOR THIS CLIENT. THE PHYSICIANS STATEMENT MUST DOCUMENT THE MEDICAL NEED FOR DENTURES.
PC24	THE SERVICE REQUESTED WAS PREVIOUSLY AUTHORIZED. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT INDICATING THIS FACT IS REQUIRED.
PC25	PLEASE SUPPLY SUFFICIENT MITIGATING CIRCUMSTANCES TO WARRANT THE CONSTRUCTION OF NEW DENTURES(S).
PC26	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
PC28	PLEASE SUBMIT A PHYSICIANS STATEMENT INDICATING DENTURES ARE NECESSARY FOR THIS NURSING HOME CLIENT.
PC29	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING LOSS OR DESTRUCTION OF DENTURE(S). INCLUDE SIGNED STATEMENT FROM CLIENT OR FACILITY DIRECTOR REGARDING HOW, WHEN AND WHERE LOST.
PC30	PLEASE PROVIDE COMPLETE INTRAORAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PC31	PLEASE DESCRIBE ANY RELATED DEFORMITIES OF THE FEET.
PC34	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD WITH REQUESTED DME ITEM(S) AND DOCUMENT IF THE CLIENT CAN USE SAFELY AND INDEPENDENTLY.
PC35	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD AND DESCRIBE THE RESULTS AND EFFECTIVENESS OF THE SERVICE REQUESTED.
PC39	PLEASE INDICATE LITER FLOW PER MINUTE, HOURS OF USE PER 24 HOUR PERIOD, AND THE EXPECTED DURATION OF NEED.
PC40	THE ITEM DOES NOT REQUIRE PRIOR AUTHORIZATION UNTIL THE LIFE EXPECTANCY HAS BEEN REACHED.
PC41	PLEASE SUPPLY INFORMATION INDICATING THE NECESSITY OF POSITIONING THE CLIENT'S BODY IN MULTIPLE POSITIONS.
PC42	PLEASE INDICATE IF THE BED HEIGHT MUST BE CHANGED TO ALLOW FOR SAFE TRANSFER OR ADEQUATE BED CARE.
PC43	SUPPLY A PHYSICIANS STATEMENT INDICATING TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR UNIT HAS REDUCED PAIN, IMPROVED/INCREASED THE CLIENTS ACTIVITY LEVEL, AND/OR REDUCED CLIENTS USE OF PAIN MEDICATION.
PC44	A CURRENT AUTHORIZATION FOR THIS SERVICE IS ON FILE FOR ANOTHER PROVIDER. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT OF THAT FACT IS REQUIRED BY THE CLIENT OF FIRST PROVIDER.
PC59	DOCUMENT DECLINE OR PROGRESS IN SPECIFIC, MEASURABLE, OBJECTIVE TERMS.
PC60	DOCUMENT IF CLIENT HAS DEMONSTRATED A GOOD APPOINTMENT COMPLIANCE RECORD.
PC61	THE PHYSICIANS SIGNATURE DATE MUST NOT EXCEED 90 DAYS FROM THE DATE OF RECEIPT BY COLORADO MEDICAID.
PC62	REQUESTS FOR A CONTINUATION OF THERAPY SHOULD NOT BE SUBMITTED MORE THAN FOUR WEEKS PRIOR TO THE EXPIRATION DATE OF THE CURRENT AUTHORIZATION.
PC63	PLEASE FURNISH THE STYLE AND MANUFACTURER OF THE FRAME.
PC64	PLEASE FURNISH THE CLIENTS LENS FORMULA.
PC66	ALL REQUESTS FOR TINTS REQUIRE DOCUMENTATION OF THE VISUAL OR MEDICAL CONDITION RELATED TO PHOTOPHOBIA.
PC67	PLEASE DOCUMENT THE REASON AND JUSTIFICATION FOR REPLACEMENT BEYOND THE FIRST LENS/FRAME.
PC68	DOCUMENT IF ALL REMAINING MAXILLARY AND/OR MANDIBULAR TEETH ARE DECAY-FREE, PROPERLY RESTORED, AND PERIODONTICALLY SOUND.

Denial Code	Long Description
PC72	SUPPLY MORE DETAIL REGARDING PROGRESS (ATTACHMENT OF GOALS, ETC.). CORRELATE PROGRESS TO PREVIOUS GOALS AND IDENTIFIED LIMITATIONS.
PC77	PLEASE SUBMIT A PLAN OF CARE DESCRIBING THE SERVICES THAT WOULD BE PROVIDED.
PC78	PLEASE DOCUMENT SPECIFIC, MEASURABLE GOALS.
PC82	THE PRIOR AUTHORIZATION (PA) SYSTEM CAN PROCESS ONLY 26 DETAILS PER PA REQUEST. PLEASE RESUBMIT YOUR REQUEST WITH NO MORE THAN 26 DETAILS.
PC83	PLEASE SUPPLY A PHYSICIANS PRESCRIPTION DATED WITHIN ONE MONTH OF REQUESTED SUBSTANCE ABUSE DAY TREATMENT.
PC84	PLEASE PROVIDE INFORMATION INDICATING THIS CLIENT IS APPROPRIATELY DETOXIFIED FROM ALCOHOL AND/OR OTHER DRUGS.
PC85	PLEASE PROVIDE INFORMATION TO INDICATE THE CLIENTS ABILITY TO ABSTAIN FROM ALCOHOL OR DRUGS WHILE IN THE SUBSTANCE ABUSE DAY TREATMENT PROGRAM.
PC86	PLEASE INDICATE IF THIS CLIENT IS WILLING TO PARTICIPATE IN AFTERCARE OR CONTINUING CARE SERVICES.
PC87	PROVIDE MORE INFORMATION ON TREATMENT HISTORY; INCLUDE SERVICE PROVIDED, DATES, AND OUTCOME. PROVIDE DETAIL OF PREVIOUS TREATMENT.
PC88	PLEASE PROVIDE MORE RATIONALE FOR THE APPROPRIATENESS AND MEDICAL NECESSITY OF SUBSTANCE ABUSE DAY TREATMENT.
PC89	PROVIDE A TREATMENT PLAN THAT CONTAINS MEASURABLE GOALS AND OBJECTIVES CORRESPONDING TO THE IDENTIFIED DEFICIT.
PC91	PLEASE PROVIDE MORE INFORMATION ON FAMILY INVOLVEMENT TREATMENT.
PC92	PLEASE PROVIDE MORE HISTORY AND EXPLANATION ABOUT THE ISSUE OF ABSTINENCE FOR THIS CLIENT.
PC94	PLEASE PROVIDE THE ANTICIPATED BEGINNING DATE AND/OR THE ESTIMATED SUBSTANCE ABUSE DAY TREATMENT DISCHARGE DATE.
PC95	PLEASE SUPPLY JUSTIFICATION FOR BEGINNING CLIENT IN SERVICE PRIOR TO AUTHORIZATION BEING OBTAINED.
PC96	THE INITIAL THREE HOURS OF SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IN A CALENDAR YEAR DO NOT REQUIRE PRIOR AUTHORIZATION.
PC97	REIMBURSEMENT FOR INITIAL SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IS LIMITED TO THREE HOURS IN A CALENDAR YEAR AND DOES NOT REQUIRE PRIOR AUTHORIZATION.
PC98	THIS DRUG IS CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE BILL USING THE APPROPRIATE NATIONAL DRUG CODE (NDC) OR SUBMIT A COMPLETED DRUG ADDITION REQUEST FORM IF THE NDC IS NOT LISTED IN THE DRUG INDEX.
PC99	THIS DRUG IS NOT CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL, CURRENT ADMINISTRATIVE RULE, OR COLORADO DRUG INDEX FOR COVERAGE LIMITATIONS.
PD01	DOCUMENT THAT CLIENT HAS ACHIEVED GOOD ORAL HYGIENE, PERIODONTAL CASE TYPE 1 OR 2, AND IS MOTIVATED TO MAINTAIN SAME.
PD03	PLEASE PROVIDE AN ARTERIAL BLOOD GAS READING OR PULSE OXIMETRY RESULTS DONE ON ROOM AIR SIGNED AND DATED BY A MEDICAL DOCTOR. THIS SHOULD BE DONE WITHIN 60 DAYS OF REQUESTED SERVICE.
PD04	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 30 DAYS OF RECEIPT BY COLORADO MEDICAID.
PD07	SUBMIT A PHOTOCOPY OF A VALID PRESCRIPTION, ISSUED WITHIN THE PAST YEAR, OR COMPLETE SECTION B OF THE PRIOR AUTHORIZATION/DRUG ATTACHMENT (PA/DGA), F-11049.
PD10	BRAND MEDICALLY NECESSARY MUST BE IN THE PRESCRIBERS OWN HANDWRITING AND WRITTEN DIRECTLY ON THE PRESCRIPTION OR A SEPARATE ORDER ATTACHED TO THE ORIGINAL PRESCRIPTION.
PD12	COMPLETE DENTURES, PARTIAL DENTURES, DENTURE RELINES, AND FIXED PROSTHODONTIC SERVICES ARE NOT COVERED SERVICES FOR ADULTS FOR DATES OF SERVICE ON AND AFTER OCTOBER 1, 1995.
PD22	PLEASE COMPLETE ALL REQUIRED ELEMENTS ON THE PERSONAL CARE SCREENING TOOL (PCST), F-11133.
PD24	THIS PRIOR AUTHORIZATION REQUEST IS UNABLE TO BE PROCESSED. PLEASE RESUBMIT WITH ADDITIONAL REQUIRED FORMS, INCLUDING THE ENTIRE PERSONAL CARE SCREENING TOOL (PCST), F-11133; PERSONAL CARE ADDENDUM, F-11136; AND SUPPORTING DOCUMENTATION, AS DIRECTED.

Denial Code	Long Description
PD25	THERE IS A PERSONAL CARE SCREENING TOOL (PCST), F-11133, COMPLETED BY ANOTHER AGENCY. CONTACT THE AGENCY TO TRANSFER SCREEN.
PD26	THERE IS A LIMITED TERM CARE FUNCTIONAL SCREEN (LTC-FS) COMPLETED BY ANOTHER AGENCY. THE PERSONAL CARE SCREENING TOOL (PCST), F-11133, INFORMATION IS IN CONFLICT WITH LTC-FS.
PD27	ONLY ONE LEVEL OF FUNCTION MAY BE SELECTED FOR ALL ELEMENTS EXCEPT TOILETING. COLORADO MEDICAID IS UNABLE TO PROCESS THE PRIOR AUTHORIZATION REQUEST.
PD28	NO UNITS MAY BE REQUESTED USING THIS PRIOR AUTHORIZATION PROCESS. PLEASE SUBMIT WITH THE APPROPRIATE ATTACHMENTS FOR REQUESTING SPECIFIC PERSONAL CARE WORKER UNITS.
PD29	CLIENT IS NOT ELIGIBLE FOR THE REQUESTED SERVICE(S) AS OF THE REQUESTED START DATE.
PD30	NO TRAVEL TIME MAY BE AUTHORIZED WHEN NO PERSONAL CARE WORKER SERVICE IS AUTHORIZED.
PD32	PROVIDER NOT CERTIFIED TO RENDER THE SERVICE(S) REQUESTED.
PD34	BASED ON THE DOCUMENTATION SUBMITTED, THIS REQUEST CAN NOT BE PRIOR AUTHORIZED. REFER TO THE PA MESSAGES FROM THE CONSULTANT FOR COMPLETE EXPLANATION.
PD98	PLEASE DOCUMENT HOW AND WHEN EACH PREVIOUSLY AUTHORIZED PRO RE NATA VISIT WAS USED.

Bedroom, Bathroom

Denial Code	Long Description
0201	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
0233	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0235	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0237	CLIENT IDENTIFICATION NUMBER DOES NOT MATCH CLIENTS FIRST NAME.
0238	THE CLIENT IDENTIFICATION NUMBER DOES NOT MATCH THE CLIENTS LAST NAME.
0242	SECONDARY DIAGNOSIS CODE IS INVALID.
0248	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0249	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0251	PROCEDURE CODE MODIFIER IN FIRST POSITION IS INVALID.
0252	THE PROCEDURE CODE MODIFIER IN SECOND POSITION IS INVALID FOR REQUESTED START DATE OR DATE OF RECEIPT.
0253	THE PROCEDURE CODE MODIFIER IN THIRD POSITION IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
0258	THE PRIMARY DIAGNOSIS CODE IS REQUIRED.
0272	THE PRIMARY DIAGNSOSIS CODE IS INVALID.
0400	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0853	HCPCS - ANNUAL UPDATE
0885	NEVER EVENTS MODIFIERS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
0886	NEVER EVENTS DIAGNOSIS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
1000	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
1002	RENDERING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1003	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1007	RENDERING PROVIDER ID IS NOT ON FILE.
1047	THE RENDERING PROVIDERS CERTIFICATION HAS BEEN CANCELLED.
1048	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1801	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
1804	A CERTIFIED SUBSTANCE ABUSE DAY TREATMENT PROVIDER MUST SUBMIT A SUBSTANCE ABUSE DAY TREATMENT PROCEDURE CODE.
1806	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
1808	THE BILLING PROVIDER DOES NOT HAVE THE REQUIRED CERTIFICATION ADDENDUM ON FILE.

Denial Code	Long Description
1900	THE BILLING PROVIDERS TAXONOMY CODE IS INVALID.
1901	THE RENDERING PROVIDERS TAXONOMY CODE IS INVALID.
1927	A NATIONAL PROVIDER IDENTIFIER IS REQUIRED FOR THE BILLING PROVIDER.
1934	A NATIONAL PROVIDER INDENTIFIER IS REQUIRED FOR THE RENDERING PROVIDER.
1936	THE BILLING PROVIDER NUMBER IS INVALID.
1937	THE RENDERING PROVIDER NUMBER IS INVALID.
1960	INTERNAL PROCESSING IS REQUIRED.
1963	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.
1964	THE BILLING PROVIDER INDICATED IS NOT ALLOWABLE AS A BILLING PROVIDER.
1965	RENDERING PROVIDER NUMBER IS MISSING/INVALID FOR THIS PROCEDURE PROVIDER.
1974	PRESCRIBING/REFERRING/ORDERING PROVIDER INDICATED IS NOT CERTIFIED AS A PRESCRIBING/REFERRING/ORDERING PROVIDER.
1975	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
1976	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
2001	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2003	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2017	THE CLIENT IS ENROLLED IN A MEDICAID OR OTHER MANAGED CARE PROGRAM.
2037	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2603	CLIENT LOCKED-IN TO A PROVIDER OR ENROLLED IN A HOSPICE. CONTACT CLIENTS HOSPICE FOR PAYMENT OF SERVICES OR RESUBMIT WITH DOCUMENTATION OF UNRELATED NATURE OF CARE.
3324	THE MODIFIER HAS BEEN DISCONTINUED BY THE CENTERS OF MEDICARE AND MEDICAID SERVICES OR THE AMERICAN MEDICAL ASSOCIATION FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
3337	THE PROCEDURE CODE HAS BEEN TERMINATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AMERICAN MEDICAL ASSOCIATION, OR AMERICAN DENTAL ASSOCIATION FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT. RESUBMIT WITH VALID A PROCEDURE CODE.
3339	THE PROCEDURE BILLED IS NOT PAYABLE ACCORDING TO DEFICIT REDUCTION ACT (DEFRA) GUIDELINES.
3351	THE PROCEDURE IS NOT COVERED FOR CLIENTS WITH A NURSING HOME AUTHORIZATION ON THE REQUESTED START DATE OR DATE OF RECEIPT.
3353	THE PROCEDURE IS NOT A COVERED SERVICE FOR HOME AND COMMUNITY-BASED WAIVER CLIENTS.
4021	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4027	THE DIAGNOSIS CODE IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
4031	THE PROCEDURE SUBMITTED IS NOT APPROPRIATE FOR CLIENTS GENDER.
4032	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4034	THE PROCEDURE CODE HAS AN AGE RESTRICTION.
4036	THE PLACE OF SERVICE CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4040	THE PRIMARY DIAGNOSIS CODE IS NOT ON FILE.
4041	THE SECONDARY DIAGNOSIS IS NOT ON FILE.
4046	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4127	INTERNAL PROCESSING IS REQUIRED.
4131	INTERNAL PROCESSING IS REQUIRED.
4141	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4149	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4150	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4236	ETIOLOGY DIAGNOSIS CODE(S) (E-CODES) ARE INVALID AS THE PRIMARY DIAGNOSIS.
4244	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4245	THE FOURTH POSITION MODIFIER IS INVALID FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT.
4256	THE PROCEDURE CODE AND MODIFIER COMBINATION IS NOT PAYABLE FOR THE CLIENTS BENEFIT PLAN.
4257	THE MODIFIERS SUBMITTED ARE EITHER INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT OR THE MODIFIERS ARE MISSING.
4311	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4315	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4316	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.

Denial Code	Long Description
4371	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4372	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4711	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR CLIENTS AGE.
4714	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS AGE.
4731	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS DIAGNOSIS.
4742	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4743	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4744	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4745	DIAGNOSIS AND/OR PROCEDURE AND/OR PLACE OF SERVICE (POS) CODE IS NOT COVERED FOR EXPRESS ENROLLMENT CLIENTS.
4746	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4801	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4802	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
4821	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
4871	PLEASE REFER TO PA MESSAGES FOR RETURN INFORMATION.
4963	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS GENDER.
4990	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
7500	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
7509	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
P001	THE BILLING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THE SERVICES.
P002	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P003	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P005	THE PRIOR AUTHORIZATION CAN NOT BE END DATED. THE PRIOR AUTHORIZATION STATUS IS NOT APPROVED OR APPROVED WITH REVISIONS.
P006	PLEASE FURNISH THE PROCEDURE CODE AND CORRESPONDING DESCRIPTION.
P008	THE BILLING PROVIDER NUMBER IS INVALID.
P009	THE BILLING PROVIDER NUMBER IS INVALID.
P010	THE REQUESTED END DATE IS INVALID.
P011	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P012	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P013	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P014	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P015	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P016	THE REQUESTED START DATE IS MISSING OR INVALID.
P019	THE REQUESTED START DATE IS MISSING OR INVALID.
P020	THE RENDERING PROVIDER NUMBER IS INVALID.
P021	THE RENDERING PROVIDER NUMBER IS INVALID.
P022	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P023	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P024	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P026	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P027	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P030	FIRST MODIFIER IS INVALID.
P031	FIRST MODIFIER IS INVALID.
P032	SECOND MODIFIER IS INVALID.
P033	SECOND MODIFIER IS INVALID.

Denial Code	Long Description
P034	THIRD MODIFIER IS INVALID.
P035	THIRD MODIFIER IS INVALID.
P036	FOURTH MODIFIER IS INVALID.
P037	FOURTH MODIFIER IS INVALID.
P038	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P039	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P040	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P041	CLIENTS FIRST NAME IS MISSING.
P042	CLIENTS LAST NAME IS MISSING.
P043	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P044	BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES REQUESTED.
P045	FIRST MODIFIER IS INVALID.
P046	SECOND MODIFIER IS INVALID.
P047	THIRD MODIFIER IS INVALID.
P048	FOURTH MODIFIER IS INVALID.
P052	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P053	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P054	RENDERING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES FOR THE BENEFIT PLAN.
P055	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P061	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P062	THE CLIENT ID AND/OR NAME INDICATED ON THE PA REQUEST IS INCORRECT. THE CLIENT ID AND/OR NAME HAS BEEN UPDATED. PLEASE VERIFY THE ID AND/OR NAME IS CORRECT.
P064	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
P067	THE FREQUENCY OF HOURS REQUESTED ARE NOT APPROPRIATE FOR THIS CLIENT AND HAVE BEEN MODIFIED ACCORDINGLY.
P079	BILLING PROVIDER IS ON PAYMENT SUSPENSION DUE TO CREDIBLE ALLEGATION OF FRAUD.
P120	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAS BEEN REDUCED.
P121	THE SERVICE/ PROCEDURE REQUESTED IS NOT SUPPORTED BY SUBMITTED DOCUMENTATION.
P126	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
P128	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.
P138	SERVICE(S) DO NOT MEET COLORADO MEDICAID GUIDELINES.
P167	REQUESTED DOCUMENTATION HAS NOT BEEN SUBMITTED.
P178	THE SERVICE REQUESTED IS NOT MEDICALLY NECESSARY.
P179	THE MEDICAL NECESSITY FOR THIS SERVICE IS NOT SUPPORTED BY THE SUBMITTED DOCUMENTATION.
P233	THE DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE ADDITIONAL CARE.
P257	THIS CLIENTS FUNCTIONAL ASSESSMENT SCORES PLACE THIS CLIENT OUTSIDE ELIGIBILITY FOR DAY TREATMENT.
P274	OUR RECORDS INDICATE THIS CLIENT IS INVOLVED IN EFFECTIVE AND APPROPRIATE SERVICE ELSEWHERE.
P292	INTENSIVE REHABILITATION HOURS ARE NO LONGER APPROPRIATE AS INDICATED BY HISTORY, DIAGNOSIS, AND/ OR FUNCTIONAL ASSESSMENT SCORES.
P328	THE SERVICES REQUESTED INCLUDE NON-COVERED SERVICES, AND HOURS ARE REDUCED ACCORDINGLY.
P339	THE CLIENTS PAST HISTORY INDICATES REDUCED TREATMENT HOURS ARE WARRANTED.
P342	THE REQUEST DOES NOT MEET GENERALLY ACCEPTED CONDITIONS REQUIRING FLUORIDE TREATMENTS.
P346	SERVICES EXCEED COLORADO MEDICAID LIMITATION AND DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE MEDICAL NECESSITY OF THE SERVICE.
P349	THE SERVICE REQUESTED WAS PERFORMED LESS THAN FIVE YEARS AGO.
P353	THE EXISTING APPLIANCE HAS NOT BEEN WORN FOR THREE YEARS.

Denial Code	Long Description
P367	THE CLIENT HAS BEEN TOTALLY WITHOUT TEETH AND AN APPLIANCE FOR FIVE YEARS.
P392	THE CLIENT IS MISSING AN ANTERIOR TOOTH AND/OR HAS TWO OR MORE POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P405	THE SERVICE(S) REQUESTED COULD ADEQUATELY BE PERFORMED IN THE DENTAL OFFICE.
P406	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE OF GOOD PERIODONTAL HEALTH (AMERICAN ACADEMY OF PERIODONTOLOGY PERIODONTAL CLASSIFICATION OF TYPE I OR II).
P407	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE VISIBLE ON RADIOGRAPHS THAT AT LEAST 50 PERCENT OF THE CLINICAL CROWN IS INTACT.
P409	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING SIX OR MORE TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED, INCLUDING THIRD MOLARS.
P410	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING ONE OR MORE ANTERIOR TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED.
P411	DOCUMENTATION DOES NOT SUPPORT THE NEED FOR PERIODONTIC SERVICES. POCKETS ARE LESS THAN 4MM AND/OR GREATER THAN 6MM FOR CLIENT AND/OR THE CLIENT IS UNDER THE AGE OF 13.
P412	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA.
P413	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA. THIS PA HAS BEEN GRANTED AS APPROVED NOT APPROVED WITH REVISIONS. THE DURATION REQUESTED MAY HAVE BEEN REDUCED TO REFLECT COVERAGE LIMITATIONS, PRESCRIBER ORDERS, CONFLICTI
P417	THE SERVICE(S) REQUESTED COULD BE ADEQUATELY PERFORMED WITH LOCAL ANESTHESIA.
P437	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO POOR ORAL HYGIENE.
P444	THIS LINE ITEM IS A DUPLICATE OF ANOTHER LINE ITEM ON THIS PRIOR AUTHORIZATION (PA) REQUEST. PLEASE CORRECT.
P446	THIS IS A DUPLICATE OF AN EXISTING PRIOR AUTHORIZATION (PA) REQUEST. YOU MAY CONTACT PROVIDER SERVICES IF YOU REQUIRE ASSISTANCE. DUPLICATE PA REQUEST
P448	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO DECAY HISTORY.
P449	QUESTIONABLE LONG TERM PROGNOSIS DUE TO GUM AND BONE DISEASE.
P456	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO APPARENT ROOT INFECTION.
P457	OUR RECORDS INDICATE THIS CLIENT HAS EXCEEDED ESTABLISHED PROGRAM LIMITATIONS. COLORADO MEDICAID WILL NOT AUTHORIZE NEW DENTURES.
P458	DOCUMENTATION PROVIDED INDICATES A LESS ELABORATE PROCEDURE SHOULD BE CONSIDERED.
P502	RENTAL ONLY ALLOWED; MEDICAL NEED FOR PURCHASE HAS NOT BEEN DOCUMENTED.
P503	PURCHASE ONLY ALLOWED; MEDICAL NEED FOR RENTAL HAS NOT BEEN DOCUMENTED.
P504	OCCUPATIONAL THERAPY GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P505	THE SERVICE REQUESTED IS INCLUDED IN THE NURSING HOME RATE STRUCTURE.
P511	THIS NATIONAL DRUG CODE IS ONLY BILLABLE AS PART OF A COMPOUND DRUG.
P515	THE PRESENCE OF A HANDICAPPING MALOCCLUSION OR HANDICAPPING DENTOFACIAL DEFORMITY IS NOT SUPPORTED BY THE DOCUMENTATION SUBMITTED.
P521	THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVERED BY COLORADO MEDICAID.
P522	GASTRO-INTESTINAL SURGERY FOR THE PURPOSE OF WEIGHT CONTROL IS COVERED ONLY AS A LIFE THREATENING PROCEDURE.
P523	THE TREATMENT REQUEST IS NOT CONSISTENT WITH THE CLIENT'S DIAGNOSIS.
P524	PSYCHOTHERAPY PROVIDED IN THE CLIENTS HOME IS NOT A COVERED BENEFIT OF COLORADO MEDICAID .
P525	THE INFORMATION PROVIDED IS NOT CONSISTENT WITH THE INTENSITY OF SERVICES REQUESTED.
P526	INTENSIVE MULTIPLE MODALITY TREATMENT IS NOT CONSISTENT WITH THE INFORMATION PROVIDED.
P527	MULTIPLE PROVIDERS OF TREATMENT ARE NOT INDICATED FOR THIS CLIENT.
P528	THE DURATION OF TREATMENT SESSIONS EXCEED CURRENT COLORADO MEDICAID GUIDELINES.
P534	DOCUMENTATION OF POOR PHYSICAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P535	OTHER PHYSICAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P536	THE PHYSICAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.

Denial Code	Long Description
P537	USE OF PHYSICAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P538	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF A PHYSICAL THERAPIST.
P539	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS AND LIVING ARRANGEMENT.
P540	GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P541	THE PROCEDURE(S) REQUESTED ARE NOT MEDICAL IN NATURE.
P542	DOCUMENTATION OF POOR OCCUPATIONAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P543	DOCUMENTATION OF POOR SPEECH THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P544	OTHER OCCUPATIONAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P546	THE OCCUPATIONAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P547	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF PHYSICAL THERAPY.
P548	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P549	ACTIVITIES TO PROMOTE DIVERSION OR GENERAL MOTIVATION ARE NONCOVERED COLORADO MEDICAID SERVICES.
P550	REVISIONS OF THE REQUEST IS NECESSITATED BY THE CLIENTS MINIMAL PROGRESS.
P551	RESTORATIVE NURSING INVOLVEMENT COULD BE INCREASED.
P552	CLIENTS DEMONSTRATED RESPONSE TO CURRENT THERAPY DOES NOT WARRANT THE INTENSE FREQUENCY REQUESTED.
P553	MAINTENANCE IS TWO TIMES PER WEEK OR LESS.
P554	THE SPEECH THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P555	USE OF OCCUPATIONAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P556	USE OF SPEECH THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P557	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF AN OCCUPATIONAL THERAPIST.
P558	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
P559	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P560	THE MATERIALS/ SERVICES REQUESTED ARE PRINCIPALLY COSMETIC IN NATURE.
P561	THE LENS FORMULA DOES NOT JUSTIFY REPLACEMENT.
P562	THE CHANGE IN THE LENS FORMULA DOES NOT WARRANT MULTIPLE REPLACEMENTS.
P563	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P564	LENSES ONLY ARE APPROVED; PLEASE DISPENSE A CONTRACTED FRAME. THE NON-CONTRACTED FRAME IS NOT MEDICALLY JUSTIFIED.
P565	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P566	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P567	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF OCCUPATIONAL THERAPY.
P568	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF SPEECH THERAPY.
P569	LEVEL, INTENSITY, OR EXTENT OF SERVICE(S) REQUESTED HAS BEEN MODIFIED CONSISTENT WITH MEDICAL NEED AS DEFINED IN THE PLAN OF CARE.
P570	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P571	THE SERVICE ASKED FOR IS NOT COVERED BY COLORADO MEDICAID AS THESE TASKS CAN BE DONE BY NURSES OR ACTIVITY STAFF.
P572	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.

Denial Code	Long Description
P573	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.
P574	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P575	MEDICAL NEED FOR EQUIPMENT/ SUPPLY REQUESTED IS NOT SUPPORTED BY DOCUMENTATION SUBMITTED.
P576	OTHER SPEECH THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P577	DOCUMENTATION SUBMITTED IDENTIFIES THAT THE CLIENT HAS FEWER THAN TWO POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P582	LESS EXPENSIVE ALTERNATIVE SERVICES ARE AVAILABLE FOR THIS CLIENT.
P634	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P711	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING PERIODONTAL SCALING AND ROOT PLANNING.
P712	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING GINGIVECTOMY.
P754	AN APPROVED SUBSTANCE ABUSE DAY TREATMENT PROGRAM CANNOT EXCEED A SIX WEEK PERIOD.
P761	THE CLIENT DOES NOT APPEAR TO BE ABLE OR WILLING TO ABSTAIN FROM ALCOHOL/DRUG USAGE WHILE IN TREATMENT. THEREFORE, SUBSTANCE ABUSE DAY TREATMENT SERVICES ARE NOT APPROVED.
P764	THIS CLIENT HAS COMPLETED INTENSIVE SUBSTANCE ABUSE TREATMENT WITHIN THE PAST 12 MONTHS. THE DOCUMENTATION PROVIDED IS NOT ADEQUATE TO JUSTIFY ADDITIONAL INTENSIVE TREATMENT AT THIS TIME.
P785	A LESS THAN SIX-WEEK HEALING PERIOD HAS BEEN SPECIFIED FOR THIS PRIOR AUTHORIZATION. THEREFORE IT IS NOT NECESSARY TO WAIT THE FULL SIX WEEKS AFTER EXTRACTIONS BEFORE TAKING DENTURE IMPRESSIONS.
P818	SIX-WEEK HEALING TIME IS REQUIRED BETWEEN EDENTULATION AND FINAL IMPRESSIONS. PAYMENT FOR DENTURES WILL BE DENIED OR RECOUPED IF HEALING PERIOD IS NOT OBSERVED.
P849	COLORADO MEDICAID HAS DETERMINED THERE WERE (ARE) SEVERAL HOME HEALTH AGENCIES WILLING TO PROVIDE MEDICALLY NECESSARY SKILLED NURSING SERVICES TO THIS CLIENT.
P864	THE DOCUMENTATION YOU HAVE SUBMITTED DOES NOT MEET THE REQUIREMENTS OF COLORADO MEDICAID.
P873	THE MEDICAL NECESSITY FOR THE HOURS REQUESTED IS NOT SUPPORTED BY THE INFORMATION SUBMITTED.
P874	THE DOCUMENTATION SUBMITTED INDICATES THE TASKS SPECIFIED CAN BE COMPLETED DURING THE VISITS APPROVED.
P878	THE DOCUMENTATION SUBMITTED DOES NOT INDICATE THAT MEDICALLY ORIENTED TASKS ARE MEDICALLY NECESSARY; THEREFORE PERSONAL CARE SERVICES HAVE BEEN APPROVED.
P880	THE QUANTITY OF SERVICES AUTHORIZED FOR THIS CLIENTS PERSONAL CARE HAS BEEN AMENDED BASED ON INFORMATION RECEIVED FROM ONE OR MORE OF THESE SOURCES: THE CLIENT, THEIR PHYSICIAN, AND/OR THE IN-HOME VISIT BY STAFF OF THE OIG (OFFICE OF INSPECTOR GENERAL).
P885	THE USE OF THIS DRUG FOR THE INTENDED PURPOSE IS NOT COVERED BY COLORADO MEDICAID, CONSISTENT WITH COLORADO ADMINISTRATIVE CODE AND FEDERAL LAW.
P924	THE MEDICAL RECORDS SUBMITTED WITH THE CURRENT REQUEST CONFLICT OR DISAGREE WITH OUR MEDICAL RECORDS ON THIS CLIENT.
P950	INDEPENDENT NURSES, PLEASE NOTE PAYABLE SERVICES MAY NOT EXCEED 12 HOURS/DAY OR 60 HOURS/WEEK.
P951	SERVICES CAN ONLY BE AUTHORIZED THROUGH ONE YEAR FROM THE PRESCRIPTION DATE.
P952	LEAD INSPECTION IS A COVERED COLORADO MEDICAID SERVICE WHEN THE CHILD HAS BEEN SHOWN TO HAVE LEAD POISONING (E.G., CHILD HAS A BLOOD LEAD LEVEL > 19 UG/DL OR TWO CONSECUTIVE BLOOD LEAD LEVELS OF 15-19 UG/DL DONE AT LEAST 90 DAYS APART). THE INSPECTION MUS
P953	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P954	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P956	THE REQUEST CAN ONLY BE BACKDATED A MAXIMUM OF 14 DAYS FROM FIRST DATE RECEIVED BY COLORADO MEDICAID.

Denial Code	Long Description
P957	COMPLETE PERIODONTAL CHARTING AT TIME OF SERVICE, AND SUBMIT CHARTING, COPY OF OPERATIVE REPORT, TOGETHER WITH A COPY OF THE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF), F-11035, TO PA UNIT ATTENTION DENTAL CONTSULTANT.
P958	NOTE THAT CODE D4341 HAS BEEN CHANGED. REFER TO THE DECISION NOTICE FOR AUTHORIZED QUANTITY.
P960	YOUR PA HAS BEEN APPROVED FOR 90 DAYS. THE 90 DAY APPROVAL DOES NOT IMPLY THE PA REQUEST MEETS PRIOR AUTHORIZATION CRITERIA. AFTER ADDITIONAL INFORMATION IS AVAILABLE IN INTERCHANGE, COLORADO MEDICAID WILL CREATE AN AMENDMENT REQUEST TO EXTEND THE PA FOR
P961	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P962	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
PA10	THE REQUESTED END DATE IS INVALID.
PA12	PLEASE FURNISH A WRITTEN DESCRIPTION OF THE CLIENTS DIAGNOSIS.
PA13	PROVIDE DIAGNOSES WITH DATES OF ONSET.
PA14	IDENTIFY PROBLEMS TO BE TREATED.
PA15	THE AUDIOLOGISTS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1), F-11020, AND PRIOR AUTHORIZATION REQUEST/HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2), F-11021.
PA16	THE PHYSICIANS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION/PHYSICIAN OTOLOGICAL REPORT (PA/POR), F-11019.
PA17	SUBMIT BRIEF HISTORY WITH REFERRAL INFORMATION, LIVING SITUATION, FUNCTIONAL STATUS, AND OTHER PERTINENT INFORMATION. WHAT CHANGE OF STATUS RESULTED IN REFERRAL AT THIS TIME?
PA18	PLEASE FURNISH THE CLIENTS HEIGHT AND WEIGHT.
PA19	PLEASE SUBMIT CLINICAL INFORMATION SUFFICIENT TO VERIFY THE NEED FOR THE REQUESTED SERVICE(S).
PA20	PLEASE RESUBMIT WITH COMPLETE PERIODONTAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PA21	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL EDUCATIONAL PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA22	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL PROGRAM PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA23	REFER TO THE DURABLE MEDICAL EQUIPMENT INDEX FOR APPROPRIATE CODE AND DESCRIPTION. DO NOT USE AN "UNLISTED" CODE.
PA24	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUALIZED FAMILY SERVICE PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA25	INFORMATION ON THE REQUEST FORM IS ILLEGIBLE, AND THE REQUEST CANNOT BE PROCESSED.
PA26	RE-EVALUATE YOUR GOALS. EMPHASIS SHOULD BE ON FUNCTIONAL SELF-CARE. GOALS MUST BE RELATED TO FUNCTIONAL OUTCOME.
PA27	PLEASE CLARIFY THE NUMBER OF HOURS PER WEEK REQUESTED.
PA28	PLEASE CLARIFY THE NUMBER OF HOURS PER DAY REQUESTED.
PA29	PLEASE CLARIFY THE NUMBER OF VISITS PER DAY REQUESTED.
PA30	ATTACH SUPPORTIVE DOCUMENTATION; HOME EXERCISE PROGRAM AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA31	THE DIAGNOSIS CODE INDICATED ON THE REQUEST DOES NOT CORRESPOND TO THE DIAGNOSIS CODE DESCRIPTION.
PA32	PLEASE SUBMIT ADDITIONAL INFORMATION SUFFICIENT TO VERIFY APPROPRIATENESS AND NEED FOR TRANSPLANT.
PA33	PLEASE SUBMIT THE INITIAL AND PROGRESSIVE OBJECTIVE FINDINGS.
PA34	ATTACH SUPPORTIVE DOCUMENTATION, FACILITY PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA35	PLEASE SUBMIT THE CLIENTS ORIGINAL COMPLAINTS AND EXAMINATION FINDINGS.

Denial Code	Long Description
PA36	ATTACH SUPPORTIVE DOCUMENTATION, IN-HOME AUTISM PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA37	PLEASE SUBMIT YOUR TREATMENT PLAN FOR THIS CLIENT.
PA38	ATTACH SUPPORTIVE DOCUMENTATION AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA39	INITIAL EVALUATIONS MUST BE PERFORMED BY AN OCCUPATIONAL THERAPIST REGISTERED (OTR), PER AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA) STANDARDS.
PA41	IDENTIFY THE PLACE OF SERVICE AND ITS EFFECT ON SUPPORTING THE DESIRED TREATMENT OUTCOME.
PA42	PLEASE INDICATE THE HOURS OF USE OF OXYGEN PER 24-HOUR PERIOD.
PA43	PROVIDE BASELINE DOCUMENTATION FOR THIS CLIENTS LIMITATIONS USING UNITS OF MEASUREMENT THAT ARE APPLIED CONSISTENTLY WHEN REPORTING STATUS.
PA44	IDENTIFY FUNCTIONAL LIMITATIONS AS THEY ARE RELATED TO IDENTIFIED CONDITIONS.
PA46	CORRELATE PLAN OF CARE TO REQUESTED PROCEDURE CODES.
PA47	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE FREQUENCY/DURATION REQUESTED.
PA48	PLEASE PROVIDE THE NAME AND CREDENTIALS OF THE RENDERING PROVIDER.
PA50	COLORADO MEDICAID RECORDS INDICATE THE CLIENT OWNS A WHEELCHAIR. DOCUMENT THE REASON AND NEED FOR REPLACEMENT AND COST TO REPAIR CURRENT WHEELCHAIR.
PA51	PLEASE DISTINGUISH PRIMARY AND SUPPORTIVE MODALITIES.
PA52	PLEASE SUBMIT A PROGRESS REPORT.
PA53	MULTIPLE FAMILY CLIENTS TREATMENT BY THE SAME PROVIDER REQUIRES FURTHER INFORMATION DOCUMENTING COORDINATION OF TREATMENT PLAN.
PA54	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE MINUTES REQUESTED.
PA55	MEDICAL NECESSITY OF TREATMENT REQUIRES ADDITIONAL DOCUMENTATION.
PA56	GIVEN AGE, DIAGNOSES, CURRENT LEVEL OF FUNCTION, PAST RESPONSE TO TREATMENT, AND LIVING SITUATION, EXPAND ON POTENTIAL FOR SIGNIFICANT FUNCTIONAL PROGRESS WITHIN THE NEXT SIX MONTHS. EMPHASIZE WHY PROGRESS IS EXPECTED WITH SERVICES AT THIS TIME.
PA57	SUBMIT THE INITIAL FINDINGS. INCLUDE A COMPREHENSIVE EVALUATION.
PA58	SUBMIT PROGRESSIVE, OBJECTIVE FINDINGS. INCLUDE A PERTINENT RE-EVALUATION.
PA59	PLEASE SUPPLY INFORMATION REGARDING THE CLIENTS MEDICATION REQUIREMENTS, IF ANY.
PA60	PLEASE SPECIFY IF THE CLIENT IS IN AN EDUCATIONAL SETTING.
PA61	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA62	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
PA63	THE SKILLS OF A THERAPIST ARE PURPOSEFUL AND SKILLED INTERVENTIONS REQUIRED TO CONTINUALLY DESIGN, IMPLEMENT, REASSESS, MODIFY/GRADE, AND/OR DISCONTINUE A PLAN OF CARE IN A TIMELY MANNER, BASED ON THE COMPLEXITY OF THE CLIENTS MEDICAL CONDITION AND/OR CO
PA64	PLEASE SUBMIT A THERAPY PLAN OF CARE, INCLUDING A CURRENT, DATED EVALUATION.
PA65	A PLAN OF CARE SIGNED AND DATED BY THE PHYSICIAN IS REQUIRED.
PA66	THE SKILLS OF A THERAPIST ARE REQUIRED WHEN ONLY THE THERAPIST CAN SAFELY AND EFFECTIVELY DELIVER THE THERAPEUTIC PROCEDURES BECAUSE OF THEIR UNIQUE KNOWLEDGE, TRAINING, AND EXPERTISE. DESCRIBE THE REASON THAT SOMEONE OTHER THAN A THERAPIST CANNOT SAFELY
PA67	PLEASE SPECIFY IF THE CLIENTS WORK SITE DEMANDS GOOD BINAURAL HEARING.
PA68	DESCRIBE THE REASON, BASED ON THE CLIENTS COGNITIVE, PHYSICAL, COMMUNICATION, OR RESOURCE STATUS, THAT A HOME PROGRAM, EQUIPMENT, OR ENVIRONMENTAL ADAPTATIONS ALONE CANNOT MEET CLIENTS NEEDS.
PA69	PLEASE SPECIFY IF THE CLIENT HAS AN ACCOMPANYING DISABILITY THAT ADDS TO THE HEARING PROBLEM.
PA70	DISTINGUISH REQUESTED PROCEDURES AND GOALS FROM OTHER SERVICES THIS CLIENT RECEIVES. THEY MAY NOT BE DUPLICATIVE.
PA71	PLEASE INDICATE THE NUMBER OF DAYS REQUESTED.

Denial Code	Long Description
PA73	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA74	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA75	PLEASE DOCUMENT CARRYOVER OF THE THERAPY PROGRAM TO NURSING.
PA76	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA79	PROVIDE EVIDENCE OF SIGNIFICANT FUNCTIONAL PROGRESS IN LAST SIX MONTHS.
PA84	THE GRANT DATE OF THIS REQUEST CANNOT BE PRIOR TO THE SIGNATURE DATE OF THE PRESCRIBING PHYSICIAN.
PA86	PROVIDE EVIDENCE OF SKILLS GAINED IN THERAPY CARRYING OVER TO OTHER SETTINGS WITHIN SIX MONTHS.
PA87	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE NUMBER OF SESSIONS REQUESTED.
PA88	THE REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL SCOPE OF PRACTICE.
PA89	PRIOR AUTHORIZATION IS NOT REQUIRED UNTIL LIMITATION OF SERVICE HAS BEEN REACHED.
PA91	PLEASE SUBMIT REQUIRED X-RAYS.
PA92	PLEASE PROVIDE AN EXPLANATION FOR THE MATERIAL SUBMITTED WITH THE REQUEST.
PA95	PLEASE DESCRIBE HOW THE PROVISION OF THIS SERVICE WOULD PREVENT INSTITUTIONALIZATION OF THE CLIENT.
PA96	COULD THE EXISTING DENTURE(S) BE RELINED OR REBASED? IF NOT, PLEASE EXPLAIN WHY NOT.
PA97	REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL STANDARDS OF PRACTICE.
PA98	PLEASE INDICATE IF THE CLIENT IS CURRENTLY BEING TUBE FED.
PB02	PLEASE PROVIDE THE REQUIRED DATED SIGNATURES ON THE ATTACHMENTS.
PB03	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING THE LOSS/DESTRUCTION/THEFT OF THE HEARING AID.
PB04	DESCRIBE THE CLIENTS ABILITY TO STAND OR AMBULATE SUFFICIENTLY TO ACCOMPLISH SELF-CARE ACTIVITIES.
PB07	PLEASE SUBMIT AN ORTHODONTIC STUDY MODEL OR DIAGNOSTIC CASTS.
PB09	PLEASE PROVIDE A PHOTOGRAPH OF THE INVOLVED AREA(S).
PB10	PLEASE PROVIDE AN ESTIMATION (IN GRAMS) OF THE TOTAL AMOUNT OF TISSUE TO BE RESECTED.
PB11	PLEASE SUBMIT THE PLAN OF CARE FOR CO-TREATMENT.
PB12	FURNISH A DETAILED DESCRIPTION FOR THE PROCEDURE CODE REQUESTED.
PB13	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB15	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB18	PLEASE COMPLETE THE ATTACHED OUT-OF-STATE PROVIDER DATA SHEET, F-11001, AND RESUBMIT.
PB20	A SIGNED AND DATED PRESCRIPTION IS REQUIRED WITHIN THREE MONTHS OF RECEIPT BY COLORADO MEDICAID FOR INITIAL REQUESTS AND WITHIN 12 MONTHS OF RECEIPT BY COLORADO MEDICAID FOR SUBSEQUENT REQUESTS.
PB21	PLEASE COMPLETE THE APPROPRIATE PRIOR AUTHORIZATION ATTACHMENT. CONTACT PROVIDER SERVICES OR THE PRIOR AUTHORIZATION UNIT FOR ASSISTANCE.
PB23	PHYSICAL THERAPY ASSISTANT NOTES AND ALL FORMS SUBMITTED MUST BE COSIGNED BY A REGISTERED PHYSICAL THERAPIST.
PB31	ARE YOU REQUESTING A COMPLETE APPLIANCE, OR REPLACEMENT PARTS?
PB32	THE PROCEDURE CODE INDICATED ON THE REQUEST DOES NOT MATCH THE DESCRIPTION OF SERVICE; PLEASE CORRECT AND RESUBMIT.
PB35	THE SERVICE REQUESTED DOES NOT REQUIRE PRIOR AUTHORIZATION.
PB41	PLEASE FURNISH A CURRENT MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT, F-11090 (DATED WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID).
PB45	THE CERTIFICATION PERIOD ON THE PLAN OF CARE (POC) DOES NOT COVER THE REQUESTED GRANT/START DATE. PLEASE RESUBMIT YOUR REQUEST WITH A NEW POC.
PB49	A CERTIFIED OCCUPATIONAL THERAPY ASSISTANTS NOTES MUST BE COSIGNED BY AN OCCUPATIONAL THERAPIST REGISTERED.
PB51	ADDITIONAL INFORMATION IS REQUIRED ON PRIOR AUTHORIZATION TO ENABLE PRICING.

Denial Code	Long Description
PB54	REQUESTED SERVICES DO NOT MATCH SERVICES ON THE PHYSICIANS ORDERS.
PB59	PLEASE PROVIDE AN INDIVIDUAL EDUCATIONAL PLAN (IEP), WHICH HAS BEEN SIGNED BY THE PROVIDER NO EARLIER THAN NINE MONTHS PRIOR TO RECEIPT AT COLORADO MEDICAID; OTHERWISE, DOCUMENT WHY NO IEP EXISTS.
PB65	PLEASE FURNISH THE ANTICIPATED TOTAL CHARGES FOR THIS REQUEST.
PB66	A PHOTOCOPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED; THE DATE MUST BE WITHIN SIX MONTHS OF RECEIPT BY COLORADO MEDICAID.
PB67	THE PRESCRIPTION DATE MUST INCLUDE MONTH, DAY, AND YEAR.
PB68	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID.
PB73	THE SERVICES IDENTIFIED ON THE PLAN OF CARE DO NOT APPEAR APPROPRIATE FOR THE PROCEDURE CODE(S) REQUESTED ON THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018.
PB74	THE CLIENT/PROVIDER DOES NOT HAVE RETROACTIVE ENROLLMENT.
PB75	THE REQUESTED START DATE IS MORE THAN 14 DAYS BEFORE OR 62 DAYS AFTER RECEIPT.
PB82	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
PB83	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A HOME HEALTH AIDE. PLEASE RESUBMIT AS A PERSONAL CARE WORKER OR PROVIDE ADDITIONAL DOCUMENTATION.
PB86	THE SERVICES REQUESTED ARE NOT BEING PROVIDED IN THE CLIENTS RESIDENCE. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL.
PB87	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A NURSE. PLEASE RESUBMIT AS A HOME HEALTH AIDE OR PROVIDE ADDITIONAL DOCUMENTATION.
PB92	PLEASE FURNISH THE CLIENTS COMPLETE ADDRESS.
PB94	IF THE CLIENT IS A RESIDENT OF A NURSING HOME, SUPPLY THE COMPLETE NAME AND ADDRESS OF THE NURSING HOME.
PB99	THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018, MUST BE SIGNED AND DATED.
PC01	PLEASE SUPPLY THE RENDERING PROVIDERS PROVIDER NUMBER.
PC03	THE DRUG ENFORCEMENT ADMINISTRATION NUMBER IS MISSING OR INVALID.
PC06	PLEASE DESCRIBE YOUR PROGRAM; INCLUDE ENTRY DATE, TERMINATION DATE, HOURS PER WEEK, AND NUMBER OF WEEKS OF PRIMARY INTENSIVE SERVICE REQUESTED.
PC07	PLEASE DESCRIBE YOUR "AFTERCARE/FOLLOW-UP" PLANS FOR THIS CLIENT.
PC08	PLEASE SUPPLY DOCUMENTATION OF PREVIOUS SUBSTANCE ABUSE SERVICES WITH DATE(S) AND OUTCOME.
PC09	PLEASE DESCRIBE IN DETAIL THE TREATMENT OBJECTIVES/GOALS FOR THIS CLIENT.
PC10	PLEASE DESCRIBE THE FAMILY SITUATION/DYNAMICS. EXPLAIN HOW THE FAMILY WILL BE INCORPORATED INTO THE CLIENTS PLAN OF CARE.
PC12	PLEASE EXPLAIN IF YOUR SERVICE ENCOURAGES THE CLIENT TO ATTEND SELF-HELP GROUPS.
PC13	PLEASE SUPPLY A SPECIFIC SCHEDULE OF ACTIVITIES, INCLUDING DAY, TIME OF DAY, LENGTH OF SESSION, AND SERVICE TO BE RENDERED DURING THAT TIME.
PC15	PLEASE FURNISH DIAGNOSTIC RATIONALE.
PC17	PLEASE DOCUMENT IF THE CLIENT EVER RECEIVED SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT.
PC19	PLEASE FURNISH MORE EXTENSIVE AND IN-DEPTH HISTORICAL AND PSYCHOSOCIAL DATA.
PC20	PLEASE SUPPLY THE DATE THE CLIENT BECAME TOTALLY ENDENTULOUS.
PC23	PLEASE SUBMIT A PHYSICIANS STATEMENT REGARDING THE MEDICAL NECESSITY OF DENTURES FOR THIS CLIENT. THE PHYSICIANS STATEMENT MUST DOCUMENT THE MEDICAL NEED FOR DENTURES.
PC24	THE SERVICE REQUESTED WAS PREVIOUSLY AUTHORIZED. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT INDICATING THIS FACT IS REQUIRED.
PC25	PLEASE SUPPLY SUFFICIENT MITIGATING CIRCUMSTANCES TO WARRANT THE CONSTRUCTION OF NEW DENTURES(S).
PC26	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
PC28	PLEASE SUBMIT A PHYSICIANS STATEMENT INDICATING DENTURES ARE NECESSARY FOR THIS NURSING HOME CLIENT.

Denial Code	Long Description
PC29	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING LOSS OR DESTRUCTION OF DENTURE(S). INCLUDE SIGNED STATEMENT FROM CLIENT OR FACILITY DIRECTOR REGARDING HOW, WHEN AND WHERE LOST.
PC30	PLEASE PROVIDE COMPLETE INTRAORAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PC31	PLEASE DESCRIBE ANY RELATED DEFORMITIES OF THE FEET.
PC34	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD WITH REQUESTED DME ITEM(S) AND DOCUMENT IF THE CLIENT CAN USE SAFELY AND INDEPENDENTLY.
PC35	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD AND DESCRIBE THE RESULTS AND EFFECTIVENESS OF THE SERVICE REQUESTED.
PC39	PLEASE INDICATE LITER FLOW PER MINUTE, HOURS OF USE PER 24 HOUR PERIOD, AND THE EXPECTED DURATION OF NEED.
PC40	THE ITEM DOES NOT REQUIRE PRIOR AUTHORIZATION UNTIL THE LIFE EXPECTANCY HAS BEEN REACHED.
PC41	PLEASE SUPPLY INFORMATION INDICATING THE NECESSITY OF POSITIONING THE CLIENT'S BODY IN MULTIPLE POSITIONS.
PC42	PLEASE INDICATE IF THE BED HEIGHT MUST BE CHANGED TO ALLOW FOR SAFE TRANSFER OR ADEQUATE BED CARE.
PC43	SUPPLY A PHYSICIANS STATEMENT INDICATING TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR UNIT HAS REDUCED PAIN, IMPROVED/INCREASED THE CLIENTS ACTIVITY LEVEL, AND/OR REDUCED CLIENTS USE OF PAIN MEDICATION.
PC44	A CURRENT AUTHORIZATION FOR THIS SERVICE IS ON FILE FOR ANOTHER PROVIDER. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT OF THAT FACT IS REQUIRED BY THE CLIENT OF FIRST PROVIDER.
PC59	DOCUMENT DECLINE OR PROGRESS IN SPECIFIC, MEASURABLE, OBJECTIVE TERMS.
PC60	DOCUMENT IF CLIENT HAS DEMONSTRATED A GOOD APPOINTMENT COMPLIANCE RECORD.
PC61	THE PHYSICIANS SIGNATURE DATE MUST NOT EXCEED 90 DAYS FROM THE DATE OF RECEIPT BY COLORADO MEDICAID.
PC62	REQUESTS FOR A CONTINUATION OF THERAPY SHOULD NOT BE SUBMITTED MORE THAN FOUR WEEKS PRIOR TO THE EXPIRATION DATE OF THE CURRENT AUTHORIZATION.
PC63	PLEASE FURNISH THE STYLE AND MANUFACTURER OF THE FRAME.
PC64	PLEASE FURNISH THE CLIENTS LENS FORMULA.
PC66	ALL REQUESTS FOR TINTS REQUIRE DOCUMENTATION OF THE VISUAL OR MEDICAL CONDITION RELATED TO PHOTOPHOBIA.
PC67	PLEASE DOCUMENT THE REASON AND JUSTIFICATION FOR REPLACEMENT BEYOND THE FIRST LENS/FRAME.
PC68	DOCUMENT IF ALL REMAINING MAXILLARY AND/OR MANDIBULAR TEETH ARE DECAY-FREE, PROPERLY RESTORED, AND PERIODONTICALLY SOUND.
PC72	SUPPLY MORE DETAIL REGARDING PROGRESS (ATTACHMENT OF GOALS, ETC.). CORRELATE PROGRESS TO PREVIOUS GOALS AND IDENTIFIED LIMITATIONS.
PC77	PLEASE SUBMIT A PLAN OF CARE DESCRIBING THE SERVICES THAT WOULD BE PROVIDED.
PC78	PLEASE DOCUMENT SPECIFIC, MEASURABLE GOALS.
PC82	THE PRIOR AUTHORIZATION (PA) SYSTEM CAN PROCESS ONLY 26 DETAILS PER PA REQUEST. PLEASE RESUBMIT YOUR REQUEST WITH NO MORE THAN 26 DETAILS.
PC83	PLEASE SUPPLY A PHYSICIANS PRESCRIPTION DATED WITHIN ONE MONTH OF REQUESTED SUBSTANCE ABUSE DAY TREATMENT.
PC84	PLEASE PROVIDE INFORMATION INDICATING THIS CLIENT IS APPROPRIATELY DETOXIFIED FROM ALCOHOL AND/OR OTHER DRUGS.
PC85	PLEASE PROVIDE INFORMATION TO INDICATE THE CLIENTS ABILITY TO ABSTAIN FROM ALCOHOL OR DRUGS WHILE IN THE SUBSTANCE ABUSE DAY TREATMENT PROGRAM.
PC86	PLEASE INDICATE IF THIS CLIENT IS WILLING TO PARTICIPATE IN AFTERCARE OR CONTINUING CARE SERVICES.
PC87	PROVIDE MORE INFORMATION ON TREATMENT HISTORY; INCLUDE SERVICE PROVIDED, DATES, AND OUTCOME. PROVIDE DETAIL OF PREVIOUS TREATMENT.
PC88	PLEASE PROVIDE MORE RATIONALE FOR THE APPROPRIATENESS AND MEDICAL NECESSITY OF SUBSTANCE ABUSE DAY TREATMENT.

Denial Code	Long Description
PC89	PROVIDE A TREATMENT PLAN THAT CONTAINS MEASURABLE GOALS AND OBJECTIVES CORRESPONDING TO THE IDENTIFIED DEFICIT.
PC91	PLEASE PROVIDE MORE INFORMATION ON FAMILY INVOLVEMENT TREATMENT.
PC92	PLEASE PROVIDE MORE HISTORY AND EXPLANATION ABOUT THE ISSUE OF ABSTINENCE FOR THIS CLIENT.
PC94	PLEASE PROVIDE THE ANTICIPATED BEGINNING DATE AND/OR THE ESTIMATED SUBSTANCE ABUSE DAY TREATMENT DISCHARGE DATE.
PC95	PLEASE SUPPLY JUSTIFICATION FOR BEGINNING CLIENT IN SERVICE PRIOR TO AUTHORIZATION BEING OBTAINED.
PC96	THE INITIAL THREE HOURS OF SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IN A CALENDAR YEAR DO NOT REQUIRE PRIOR AUTHORIZATION.
PC97	REIMBURSEMENT FOR INITIAL SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IS LIMITED TO THREE HOURS IN A CALENDAR YEAR AND DOES NOT REQUIRE PRIOR AUTHORIZATION.
PC98	THIS DRUG IS CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE BILL USING THE APPROPRIATE NATIONAL DRUG CODE (NDC) OR SUBMIT A COMPLETED DRUG ADDITION REQUEST FORM IF THE NDC IS NOT LISTED IN THE DRUG INDEX.
PC99	THIS DRUG IS NOT CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL, CURRENT ADMINISTRATIVE RULE, OR COLORADO DRUG INDEX FOR COVERAGE LIMITATIONS.
PD01	DOCUMENT THAT CLIENT HAS ACHIEVED GOOD ORAL HYGIENE, PERIODONTAL CASE TYPE 1 OR 2, AND IS MOTIVATED TO MAINTAIN SAME.
PD03	PLEASE PROVIDE AN ARTERIAL BLOOD GAS READING OR PULSE OXIMETRY RESULTS DONE ON ROOM AIR SIGNED AND DATED BY A MEDICAL DOCTOR. THIS SHOULD BE DONE WITHIN 60 DAYS OF REQUESTED SERVICE.
PD04	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 30 DAYS OF RECEIPT BY COLORADO MEDICAID.
PD07	SUBMIT A PHOTOCOPY OF A VALID PRESCRIPTION, ISSUED WITHIN THE PAST YEAR, OR COMPLETE SECTION B OF THE PRIOR AUTHORIZATION/DRUG ATTACHMENT (PA/DGA), F-11049.
PD10	BRAND MEDICALLY NECESSARY MUST BE IN THE PRESCRIBERS OWN HANDWRITING AND WRITTEN DIRECTLY ON THE PRESCRIPTION OR A SEPARATE ORDER ATTACHED TO THE ORIGINAL PRESCRIPTION.
PD12	COMPLETE DENTURES, PARTIAL DENTURES, DENTURE RELINES, AND FIXED PROSTHODONTIC SERVICES ARE NOT COVERED SERVICES FOR ADULTS FOR DATES OF SERVICE ON AND AFTER OCTOBER 1, 1995.
PD22	PLEASE COMPLETE ALL REQUIRED ELEMENTS ON THE PERSONAL CARE SCREENING TOOL (PCST), F-11133.
PD24	THIS PRIOR AUTHORIZATION REQUEST IS UNABLE TO BE PROCESSED. PLEASE RESUBMIT WITH ADDITIONAL REQUIRED FORMS, INCLUDING THE ENTIRE PERSONAL CARE SCREENING TOOL (PCST), F-11133; PERSONAL CARE ADDENDUM, F-11136; AND SUPPORTING DOCUMENTATION, AS DIRECTED.
PD25	THERE IS A PERSONAL CARE SCREENING TOOL (PCST), F-11133, COMPLETED BY ANOTHER AGENCY. CONTACT THE AGENCY TO TRANSFER SCREEN.
PD26	THERE IS A LIMITED TERM CARE FUNCTIONAL SCREEN (LTC-FS) COMPLETED BY ANOTHER AGENCY. THE PERSONAL CARE SCREENING TOOL (PCST), F-11133, INFORMATION IS IN CONFLICT WITH LTC-FS.
PD27	ONLY ONE LEVEL OF FUNCTION MAY BE SELECTED FOR ALL ELEMENTS EXCEPT TOILETING. COLORADO MEDICAID IS UNABLE TO PROCESS THE PRIOR AUTHORIZATION REQUEST.
PD28	NO UNITS MAY BE REQUESTED USING THIS PRIOR AUTHORIZATION PROCESS. PLEASE SUBMIT WITH THE APPROPRIATE ATTACHMENTS FOR REQUESTING SPECIFIC PERSONAL CARE WORKER UNITS.
PD29	CLIENT IS NOT ELIGIBLE FOR THE REQUESTED SERVICE(S) AS OF THE REQUESTED START DATE.
PD30	NO TRAVEL TIME MAY BE AUTHORIZED WHEN NO PERSONAL CARE WORKER SERVICE IS AUTHORIZED.
PD32	PROVIDER NOT CERTIFIED TO RENDER THE SERVICE(S) REQUESTED.
PD34	BASED ON THE DOCUMENTATION SUBMITTED, THIS REQUEST CAN NOT BE PRIOR AUTHORIZED. REFER TO THE PA MESSAGES FROM THE CONSULTANT FOR COMPLETE EXPLANATION.
PD98	PLEASE DOCUMENT HOW AND WHEN EACH PREVIOUSLY AUTHORIZED PRO RE NATA VISIT WAS USED.

Brain Injury (BI)

Denial Code	Long Description
0201	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
0233	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0235	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0237	CLIENT IDENTIFICATION NUMBER DOES NOT MATCH CLIENTS FIRST NAME.
0238	THE CLIENT IDENTIFICATION NUMBER DOES NOT MATCH THE CLIENTS LAST NAME.
0242	SECONDARY DIAGNOSIS CODE IS INVALID.
0248	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0249	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0251	PROCEDURE CODE MODIFIER IN FIRST POSITION IS INVALID.
0252	THE PROCEDURE CODE MODIFIER IN SECOND POSITION IS INVALID FOR REQUESTED START DATE OR DATE OF RECEIPT.
0253	THE PROCEDURE CODE MODIFIER IN THIRD POSITION IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
0258	THE PRIMARY DIAGNOSIS CODE IS REQUIRED.
0272	THE PRIMARY DIAGNSOSIS CODE IS INVALID.
0400	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0853	HCPCS - ANNUAL UPDATE
0885	NEVER EVENTS MODIFIERS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
0886	NEVER EVENTS DIAGNOSIS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
1000	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
1002	RENDERING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1003	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1007	RENDERING PROVIDER ID IS NOT ON FILE.
1047	THE RENDERING PROVIDERS CERTIFICATION HAS BEEN CANCELLED.
1048	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1801	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
1804	A CERTIFIED SUBSTANCE ABUSE DAY TREATMENT PROVIDER MUST SUBMIT A SUBSTANCE ABUSE DAY TREATMENT PROCEDURE CODE.
1806	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
1808	THE BILLING PROVIDER DOES NOT HAVE THE REQUIRED CERTIFICATION ADDENDUM ON FILE.
1900	THE BILLING PROVIDERS TAXONOMY CODE IS INVALID.
1901	THE RENDERING PROVIDERS TAXONOMY CODE IS INVALID.
1927	A NATIONAL PROVIDER IDENTIFIER IS REQUIRED FOR THE BILLING PROVIDER.
1934	A NATIONAL PROVIDER INDENTIFIER IS REQUIRED FOR THE RENDERING PROVIDER.
1936	THE BILLING PROVIDER NUMBER IS INVALID.
1937	THE RENDERING PROVIDER NUMBER IS INVALID.
1960	INTERNAL PROCESSING IS REQUIRED.
1963	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.
1964	THE BILLING PROVIDER INDICATED IS NOT ALLOWABLE AS A BILLING PROVIDER.
1965	RENDERING PROVIDER NUMBER IS MISSING/INVALID FOR THIS PROCEDURE PROVIDER.
1974	PRESCRIBING/REFERRING/ORDERING PROVIDER INDICATED IS NOT CERTIFIED AS A PRESCRIBING/REFERRING/ORDERING PROVIDER.
1975	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
1976	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
2001	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2003	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2017	THE CLIENT IS ENROLLED IN A MEDICAID OR OTHER MANAGED CARE PROGRAM.

Denial Code	Long Description
2037	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2603	CLIENT LOCKED-IN TO A PROVIDER OR ENROLLED IN A HOSPICE. CONTACT CLIENTS HOSPICE FOR PAYMENT OF SERVICES OR RESUBMIT WITH DOCUMENTATION OF UNRELATED NATURE OF CARE.
3324	THE MODIFIER HAS BEEN DISCONTINUED BY THE CENTERS OF MEDICARE AND MEDICAID SERVICES OR THE AMERICAN MEDICAL ASSOCIATION FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
3337	THE PROCEDURE CODE HAS BEEN TERMINATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AMERICAN MEDICAL ASSOCIATION, OR AMERICAN DENTAL ASSOCIATION FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT. RESUBMIT WITH VALID A PROCEDURE CODE.
3339	THE PROCEDURE BILLED IS NOT PAYABLE ACCORDING TO DEFICIT REDUCTION ACT (DEFRA) GUIDELINES.
3351	THE PROCEDURE IS NOT COVERED FOR CLIENTS WITH A NURSING HOME AUTHORIZATION ON THE REQUESTED START DATE OR DATE OF RECEIPT.
3353	THE PROCEDURE IS NOT A COVERED SERVICE FOR HOME AND COMMUNITY-BASED WAIVER CLIENTS.
4021	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4027	THE DIAGNOSIS CODE IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
4031	THE PROCEDURE SUBMITTED IS NOT APPROPRIATE FOR CLIENTS GENDER.
4032	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4034	THE PROCEDURE CODE HAS AN AGE RESTRICTION.
4036	THE PLACE OF SERVICE CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4040	THE PRIMARY DIAGNOSIS CODE IS NOT ON FILE.
4041	THE SECONDARY DIAGNOSIS IS NOT ON FILE.
4046	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4127	INTERNAL PROCESSING IS REQUIRED.
4131	INTERNAL PROCESSING IS REQUIRED.
4141	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4149	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4150	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4236	ETIOLOGY DIAGNOSIS CODE(S) (E-CODES) ARE INVALID AS THE PRIMARY DIAGNOSIS.
4244	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4245	THE FOURTH POSITION MODIFIER IS INVALID FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT.
4256	THE PROCEDURE CODE AND MODIFIER COMBINATION IS NOT PAYABLE FOR THE CLIENTS BENEFIT PLAN.
4257	THE MODIFIERS SUBMITTED ARE EITHER INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT OR THE MODIFIERS ARE MISSING.
4311	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4315	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4316	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4371	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4372	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4711	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR CLIENTS AGE.
4714	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS AGE.
4731	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS DIAGNOSIS.
4742	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4743	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4744	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4745	DIAGNOSIS AND/OR PROCEDURE AND/OR PLACE OF SERVICE (POS) CODE IS NOT COVERED FOR EXPRESS ENROLLMENT CLIENTS.
4746	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4801	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4802	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
4821	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
4871	PLEASE REFER TO PA MESSAGES FOR RETURN INFORMATION.

Denial Code	Long Description
4963	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS GENDER.
4990	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
7500	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
7509	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
P001	THE BILLING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THE SERVICES.
P002	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P003	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P005	THE PRIOR AUTHORIZATION CAN NOT BE END DATED. THE PRIOR AUTHORIZATION STATUS IS NOT APPROVED OR APPROVED WITH REVISIONS.
P006	PLEASE FURNISH THE PROCEDURE CODE AND CORRESPONDING DESCRIPTION.
P008	THE BILLING PROVIDER NUMBER IS INVALID.
P009	THE BILLING PROVIDER NUMBER IS INVALID.
P010	THE REQUESTED END DATE IS INVALID.
P011	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P012	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P013	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P014	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P015	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P016	THE REQUESTED START DATE IS MISSING OR INVALID.
P019	THE REQUESTED START DATE IS MISSING OR INVALID.
P020	THE RENDERING PROVIDER NUMBER IS INVALID.
P021	THE RENDERING PROVIDER NUMBER IS INVALID.
P022	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P023	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P024	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P026	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P027	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P030	FIRST MODIFIER IS INVALID.
P031	FIRST MODIFIER IS INVALID.
P032	SECOND MODIFIER IS INVALID.
P033	SECOND MODIFIER IS INVALID.
P034	THIRD MODIFIER IS INVALID.
P035	THIRD MODIFIER IS INVALID.
P036	FOURTH MODIFIER IS INVALID.
P037	FOURTH MODIFIER IS INVALID.
P038	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P039	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P040	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P041	CLIENTS FIRST NAME IS MISSING.
P042	CLIENTS LAST NAME IS MISSING.
P043	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P044	BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES REQUESTED.
P045	FIRST MODIFIER IS INVALID.
P046	SECOND MODIFIER IS INVALID.
P047	THIRD MODIFIER IS INVALID.
P048	FOURTH MODIFIER IS INVALID.

Denial Code	Long Description
P052	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P053	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P054	RENDERING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES FOR THE BENEFIT PLAN.
P055	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P061	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P062	THE CLIENT ID AND/OR NAME INDICATED ON THE PA REQUEST IS INCORRECT. THE CLIENT ID AND/OR NAME HAS BEEN UPDATED. PLEASE VERIFY THE ID AND/OR NAME IS CORRECT.
P064	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
P067	THE FREQUENCY OF HOURS REQUESTED ARE NOT APPROPRIATE FOR THIS CLIENT AND HAVE BEEN MODIFIED ACCORDINGLY.
P079	BILLING PROVIDER IS ON PAYMENT SUSPENSION DUE TO CREDIBLE ALLEGATION OF FRAUD.
P120	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAS BEEN REDUCED.
P121	THE SERVICE/ PROCEDURE REQUESTED IS NOT SUPPORTED BY SUBMITTED DOCUMENTATION.
P126	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
P128	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.
P138	SERVICE(S) DO NOT MEET COLORADO MEDICAID GUIDELINES.
P167	REQUESTED DOCUMENTATION HAS NOT BEEN SUBMITTED.
P178	THE SERVICE REQUESTED IS NOT MEDICALLY NECESSARY.
P179	THE MEDICAL NECESSITY FOR THIS SERVICE IS NOT SUPPORTED BY THE SUBMITTED DOCUMENTATION.
P233	THE DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE ADDITIONAL CARE.
P257	THIS CLIENTS FUNCTIONAL ASSESSMENT SCORES PLACE THIS CLIENT OUTSIDE ELIGIBILITY FOR DAY TREATMENT.
P274	OUR RECORDS INDICATE THIS CLIENT IS INVOLVED IN EFFECTIVE AND APPROPRIATE SERVICE ELSEWHERE.
P292	INTENSIVE REHABILITATION HOURS ARE NO LONGER APPROPRIATE AS INDICATED BY HISTORY, DIAGNOSIS, AND/ OR FUNCTIONAL ASSESSMENT SCORES.
P328	THE SERVICES REQUESTED INCLUDE NON-COVERED SERVICES, AND HOURS ARE REDUCED ACCORDINGLY.
P339	THE CLIENTS PAST HISTORY INDICATES REDUCED TREATMENT HOURS ARE WARRANTED.
P342	THE REQUEST DOES NOT MEET GENERALLY ACCEPTED CONDITIONS REQUIRING FLUORIDE TREATMENTS.
P346	SERVICES EXCEED COLORADO MEDICAID LIMITATION AND DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE MEDICAL NECESSITY OF THE SERVICE.
P349	THE SERVICE REQUESTED WAS PERFORMED LESS THAN FIVE YEARS AGO.
P353	THE EXISTING APPLIANCE HAS NOT BEEN WORN FOR THREE YEARS.
P367	THE CLIENT HAS BEEN TOTALLY WITHOUT TEETH AND AN APPLIANCE FOR FIVE YEARS.
P392	THE CLIENT IS MISSING AN ANTERIOR TOOTH AND/OR HAS TWO OR MORE POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P405	THE SERVICE(S) REQUESTED COULD ADEQUATELY BE PERFORMED IN THE DENTAL OFFICE.
P406	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE OF GOOD PERIODONTAL HEALTH (AMERICAN ACADEMY OF PERIODONTOLOGY PERIODONTAL CLASSIFICATION OF TYPE I OR II).
P407	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE VISIBLE ON RADIOGRAPHS THAT AT LEAST 50 PERCENT OF THE CLINICAL CROWN IS INTACT.
P409	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING SIX OR MORE TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED, INCLUDING THIRD MOLARS.
P410	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING ONE OR MORE ANTERIOR TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED.
P411	DOCUMENTATION DOES NOT SUPPORT THE NEED FOR PERIODONTIC SERVICES. POCKETS ARE LESS THAN 4MM AND/OR GREATER THAN 6MM FOR CLIENT AND/OR THE CLIENT IS UNDER THE AGE OF 13.
P412	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA.

Denial Code	Long Description
P413	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA. THIS PA HAS BEEN GRANTED AS APPROVED NOT APPROVED WITH REVISIONS. THE DURATION REQUESTED MAY HAVE BEEN REDUCED TO REFLECT COVERAGE LIMITATIONS, PRESCRIBER ORDERS, CONFLICTI
P417	THE SERVICE(S) REQUESTED COULD BE ADEQUATELY PERFORMED WITH LOCAL ANESTHESIA.
P437	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO POOR ORAL HYGIENE.
P444	THIS LINE ITEM IS A DUPLICATE OF ANOTHER LINE ITEM ON THIS PRIOR AUTHORIZATION (PA) REQUEST. PLEASE CORRECT.
P446	THIS IS A DUPLICATE OF AN EXISTING PRIOR AUTHORIZATION (PA) REQUEST. YOU MAY CONTACT PROVIDER SERVICES IF YOU REQUIRE ASSISTANCE. DUPLICATE PA REQUEST
P448	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO DECAY HISTORY.
P449	QUESTIONABLE LONG TERM PROGNOSIS DUE TO GUM AND BONE DISEASE.
P456	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO APPARENT ROOT INFECTION.
P457	OUR RECORDS INDICATE THIS CLIENT HAS EXCEEDED ESTABLISHED PROGRAM LIMITATIONS. COLORADO MEDICAID WILL NOT AUTHORIZE NEW DENTURES.
P458	DOCUMENTATION PROVIDED INDICATES A LESS ELABORATE PROCEDURE SHOULD BE CONSIDERED.
P502	RENTAL ONLY ALLOWED; MEDICAL NEED FOR PURCHASE HAS NOT BEEN DOCUMENTED.
P503	PURCHASE ONLY ALLOWED; MEDICAL NEED FOR RENTAL HAS NOT BEEN DOCUMENTED.
P504	OCCUPATIONAL THERAPY GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P505	THE SERVICE REQUESTED IS INCLUDED IN THE NURSING HOME RATE STRUCTURE.
P511	THIS NATIONAL DRUG CODE IS ONLY BILLABLE AS PART OF A COMPOUND DRUG.
P515	THE PRESENCE OF A HANDICAPPING MALOCCLUSION OR HANDICAPPING DENTOFACIAL DEFORMITY IS NOT SUPPORTED BY THE DOCUMENTATION SUBMITTED.
P521	THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVERED BY COLORADO MEDICAID.
P522	GASTRO-INTESTINAL SURGERY FOR THE PURPOSE OF WEIGHT CONTROL IS COVERED ONLY AS A LIFE THREATENING PROCEDURE.
P523	THE TREATMENT REQUEST IS NOT CONSISTENT WITH THE CLIENT'S DIAGNOSIS.
P524	PSYCHOTHERAPY PROVIDED IN THE CLIENTS HOME IS NOT A COVERED BENEFIT OF COLORADO MEDICAID .
P525	THE INFORMATION PROVIDED IS NOT CONSISTENT WITH THE INTENSITY OF SERVICES REQUESTED.
P526	INTENSIVE MULTIPLE MODALITY TREATMENT IS NOT CONSISTENT WITH THE INFORMATION PROVIDED.
P527	MULTIPLE PROVIDERS OF TREATMENT ARE NOT INDICATED FOR THIS CLIENT.
P528	THE DURATION OF TREATMENT SESSIONS EXCEED CURRENT COLORADO MEDICAID GUIDELINES.
P534	DOCUMENTATION OF POOR PHYSICAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P535	OTHER PHYSICAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P536	THE PHYSICAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P537	USE OF PHYSICAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P538	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF A PHYSICAL THERAPIST.
P539	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS AND LIVING ARRANGEMENT.
P540	GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P541	THE PROCEDURE(S) REQUESTED ARE NOT MEDICAL IN NATURE.
P542	DOCUMENTATION OF POOR OCCUPATIONAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P543	DOCUMENTATION OF POOR SPEECH THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P544	OTHER OCCUPATIONAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P546	THE OCCUPATIONAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.

Denial Code	Long Description
P547	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF PHYSICAL THERAPY.
P548	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P549	ACTIVITIES TO PROMOTE DIVERSION OR GENERAL MOTIVATION ARE NONCOVERED COLORADO MEDICAID SERVICES.
P550	REVISIONS OF THE REQUEST IS NECESSITATED BY THE CLIENTS MINIMAL PROGRESS.
P551	RESTORATIVE NURSING INVOLVEMENT COULD BE INCREASED.
P552	CLIENTS DEMONSTRATED RESPONSE TO CURRENT THERAPY DOES NOT WARRANT THE INTENSE FREQUENCY REQUESTED.
P553	MAINTENANCE IS TWO TIMES PER WEEK OR LESS.
P554	THE SPEECH THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P555	USE OF OCCUPATIONAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P556	USE OF SPEECH THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P557	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF AN OCCUPATIONAL THERAPIST.
P558	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
P559	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P560	THE MATERIALS/ SERVICES REQUESTED ARE PRINCIPALLY COSMETIC IN NATURE.
P561	THE LENS FORMULA DOES NOT JUSTIFY REPLACEMENT.
P562	THE CHANGE IN THE LENS FORMULA DOES NOT WARRANT MULTIPLE REPLACEMENTS.
P563	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P564	LENSES ONLY ARE APPROVED; PLEASE DISPENSE A CONTRACTED FRAME. THE NON-CONTRACTED FRAME IS NOT MEDICALLY JUSTIFIED.
P565	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P566	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P567	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF OCCUPATIONAL THERAPY.
P568	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF SPEECH THERAPY.
P569	LEVEL, INTENSITY, OR EXTENT OF SERVICE(S) REQUESTED HAS BEEN MODIFIED CONSISTENT WITH MEDICAL NEED AS DEFINED IN THE PLAN OF CARE.
P570	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P571	THE SERVICE ASKED FOR IS NOT COVERED BY COLORADO MEDICAID AS THESE TASKS CAN BE DONE BY NURSES OR ACTIVITY STAFF.
P572	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P573	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.
P574	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P575	MEDICAL NEED FOR EQUIPMENT/ SUPPLY REQUESTED IS NOT SUPPORTED BY DOCUMENTATION SUBMITTED.
P576	OTHER SPEECH THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P577	DOCUMENTATION SUBMITTED IDENTIFIES THAT THE CLIENT HAS FEWER THAN TWO POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P582	LESS EXPENSIVE ALTERNATIVE SERVICES ARE AVAILABLE FOR THIS CLIENT.
P634	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P711	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING PERIODONTAL SCALING AND ROOT PLANNING.
P712	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING GINGIVECTOMY.
P754	AN APPROVED SUBSTANCE ABUSE DAY TREATMENT PROGRAM CANNOT EXCEED A SIX WEEK PERIOD.

Denial Code	Long Description
P761	THE CLIENT DOES NOT APPEAR TO BE ABLE OR WILLING TO ABSTAIN FROM ALCOHOL/DRUG USAGE WHILE IN TREATMENT. THEREFORE, SUBSTANCE ABUSE DAY TREATMENT SERVICES ARE NOT APPROVED.
P764	THIS CLIENT HAS COMPLETED INTENSIVE SUBSTANCE ABUSE TREATMENT WITHIN THE PAST 12 MONTHS. THE DOCUMENTATION PROVIDED IS NOT ADEQUATE TO JUSTIFY ADDITIONAL INTENSIVE TREATMENT AT THIS TIME.
P785	A LESS THAN SIX-WEEK HEALING PERIOD HAS BEEN SPECIFIED FOR THIS PRIOR AUTHORIZATION. THEREFORE IT IS NOT NECESSARY TO WAIT THE FULL SIX WEEKS AFTER EXTRACTIONS BEFORE TAKING DENTURE IMPRESSIONS.
P818	SIX-WEEK HEALING TIME IS REQUIRED BETWEEN EDENTULATION AND FINAL IMPRESSIONS. PAYMENT FOR DENTURES WILL BE DENIED OR RECOUPED IF HEALING PERIOD IS NOT OBSERVED.
P849	COLORADO MEDICAID HAS DETERMINED THERE WERE (ARE) SEVERAL HOME HEALTH AGENCIES WILLING TO PROVIDE MEDICALLY NECESSARY SKILLED NURSING SERVICES TO THIS CLIENT.
P864	THE DOCUMENTATION YOU HAVE SUBMITTED DOES NOT MEET THE REQUIREMENTS OF COLORADO MEDICAID.
P873	THE MEDICAL NECESSITY FOR THE HOURS REQUESTED IS NOT SUPPORTED BY THE INFORMATION SUBMITTED.
P874	THE DOCUMENTATION SUBMITTED INDICATES THE TASKS SPECIFIED CAN BE COMPLETED DURING THE VISITS APPROVED.
P878	THE DOCUMENTATION SUBMITTED DOES NOT INDICATE THAT MEDICALLY ORIENTED TASKS ARE MEDICALLY NECESSARY; THEREFORE PERSONAL CARE SERVICES HAVE BEEN APPROVED.
P880	THE QUANTITY OF SERVICES AUTHORIZED FOR THIS CLIENTS PERSONAL CARE HAS BEEN AMENDED BASED ON INFORMATION RECEIVED FROM ONE OR MORE OF THESE SOURCES: THE CLIENT, THEIR PHYSICIAN, AND/OR THE IN-HOME VISIT BY STAFF OF THE OIG (OFFICE OF INSPECTOR GENERAL).
P885	THE USE OF THIS DRUG FOR THE INTENDED PURPOSE IS NOT COVERED BY COLORADO MEDICAID, CONSISTENT WITH COLORADO ADMINISTRATIVE CODE AND FEDERAL LAW.
P924	THE MEDICAL RECORDS SUBMITTED WITH THE CURRENT REQUEST CONFLICT OR DISAGREE WITH OUR MEDICAL RECORDS ON THIS CLIENT.
P950	INDEPENDENT NURSES, PLEASE NOTE PAYABLE SERVICES MAY NOT EXCEED 12 HOURS/DAY OR 60 HOURS/WEEK.
P951	SERVICES CAN ONLY BE AUTHORIZED THROUGH ONE YEAR FROM THE PRESCRIPTION DATE.
P952	LEAD INSPECTION IS A COVERED COLORADO MEDICAID SERVICE WHEN THE CHILD HAS BEEN SHOWN TO HAVE LEAD POISONING (E.G., CHILD HAS A BLOOD LEAD LEVEL > 19 UG/DL OR TWO CONSECUTIVE BLOOD LEAD LEVELS OF 15-19 UG/DL DONE AT LEAST 90 DAYS APART). THE INSPECTION MUS
P953	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P954	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P956	THE REQUEST CAN ONLY BE BACKDATED A MAXIMUM OF 14 DAYS FROM FIRST DATE RECEIVED BY COLORADO MEDICAID.
P957	COMPLETE PERIODONTAL CHARTING AT TIME OF SERVICE, AND SUBMIT CHARTING, COPY OF OPERATIVE REPORT, TOGETHER WITH A COPY OF THE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF), F-11035, TO PA UNIT ATTENTION DENTAL CONTSULTANT.
P958	NOTE THAT CODE D4341 HAS BEEN CHANGED. REFER TO THE DECISION NOTICE FOR AUTHORIZED QUANTITY.
P960	YOUR PA HAS BEEN APPROVED FOR 90 DAYS. THE 90 DAY APPROVAL DOES NOT IMPLY THE PA REQUEST MEETS PRIOR AUTHORIZATION CRITERIA. AFTER ADDITIONAL INFORMATION IS AVAILABLE IN INTERCHANGE, COLORADO MEDICAID WILL CREATE AN AMENDMENT REQUEST TO EXTEND THE PA FOR
P961	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P962	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
PA10	THE REQUESTED END DATE IS INVALID.
PA12	PLEASE FURNISH A WRITTEN DESCRIPTION OF THE CLIENTS DIAGNOSIS.

Denial Code	Long Description
PA13	PROVIDE DIAGNOSES WITH DATES OF ONSET.
PA14	IDENTIFY PROBLEMS TO BE TREATED.
PA15	THE AUDIOLOGISTS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1), F-11020, AND PRIOR AUTHORIZATION REQUEST/HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2), F-11021.
PA16	THE PHYSICIANS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION/PHYSICIAN OTOLOGICAL REPORT (PA/POR), F-11019.
PA17	SUBMIT BRIEF HISTORY WITH REFERRAL INFORMATION, LIVING SITUATION, FUNCTIONAL STATUS, AND OTHER PERTINENT INFORMATION. WHAT CHANGE OF STATUS RESULTED IN REFERRAL AT THIS TIME?
PA18	PLEASE FURNISH THE CLIENTS HEIGHT AND WEIGHT.
PA19	PLEASE SUBMIT CLINICAL INFORMATION SUFFICIENT TO VERIFY THE NEED FOR THE REQUESTED SERVICE(S).
PA20	PLEASE RESUBMIT WITH COMPLETE PERIODONTAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PA21	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL EDUCATIONAL PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA22	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL PROGRAM PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA23	REFER TO THE DURABLE MEDICAL EQUIPMENT INDEX FOR APPROPRIATE CODE AND DESCRIPTION. DO NOT USE AN "UNLISTED" CODE.
PA24	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUALIZED FAMILY SERVICE PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA25	INFORMATION ON THE REQUEST FORM IS ILLEGIBLE, AND THE REQUEST CANNOT BE PROCESSED.
PA26	RE-EVALUATE YOUR GOALS. EMPHASIS SHOULD BE ON FUNCTIONAL SELF-CARE. GOALS MUST BE RELATED TO FUNCTIONAL OUTCOME.
PA27	PLEASE CLARIFY THE NUMBER OF HOURS PER WEEK REQUESTED.
PA28	PLEASE CLARIFY THE NUMBER OF HOURS PER DAY REQUESTED.
PA29	PLEASE CLARIFY THE NUMBER OF VISITS PER DAY REQUESTED.
PA30	ATTACH SUPPORTIVE DOCUMENTATION; HOME EXERCISE PROGRAM AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA31	THE DIAGNOSIS CODE INDICATED ON THE REQUEST DOES NOT CORRESPOND TO THE DIAGNOSIS CODE DESCRIPTION.
PA32	PLEASE SUBMIT ADDITIONAL INFORMATION SUFFICIENT TO VERIFY APPROPRIATENESS AND NEED FOR TRANSPLANT.
PA33	PLEASE SUBMIT THE INITIAL AND PROGRESSIVE OBJECTIVE FINDINGS.
PA34	ATTACH SUPPORTIVE DOCUMENTATION, FACILITY PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA35	PLEASE SUBMIT THE CLIENTS ORIGINAL COMPLAINTS AND EXAMINATION FINDINGS.
PA36	ATTACH SUPPORTIVE DOCUMENTATION, IN-HOME AUTISM PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA37	PLEASE SUBMIT YOUR TREATMENT PLAN FOR THIS CLIENT.
PA38	ATTACH SUPPORTIVE DOCUMENTATION AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA39	INITIAL EVALUATIONS MUST BE PERFORMED BY AN OCCUPATIONAL THERAPIST REGISTERED (OTR), PER AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA) STANDARDS.
PA41	IDENTIFY THE PLACE OF SERVICE AND ITS EFFECT ON SUPPORTING THE DESIRED TREATMENT OUTCOME.
PA42	PLEASE INDICATE THE HOURS OF USE OF OXYGEN PER 24-HOUR PERIOD.
PA43	PROVIDE BASELINE DOCUMENTATION FOR THIS CLIENTS LIMITATIONS USING UNITS OF MEASUREMENT THAT ARE APPLIED CONSISTENTLY WHEN REPORTING STATUS.
PA44	IDENTIFY FUNCTIONAL LIMITATIONS AS THEY ARE RELATED TO IDENTIFIED CONDITIONS.
PA46	CORRELATE PLAN OF CARE TO REQUESTED PROCEDURE CODES.
PA47	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE FREQUENCY/DURATION REQUESTED.

Denial Code	Long Description
PA48	PLEASE PROVIDE THE NAME AND CREDENTIALS OF THE RENDERING PROVIDER.
PA50	COLORADO MEDICAID RECORDS INDICATE THE CLIENT OWNS A WHEELCHAIR. DOCUMENT THE REASON AND NEED FOR REPLACEMENT AND COST TO REPAIR CURRENT WHEELCHAIR.
PA51	PLEASE DISTINGUISH PRIMARY AND SUPPORTIVE MODALITIES.
PA52	PLEASE SUBMIT A PROGRESS REPORT.
PA53	MULTIPLE FAMILY CLIENTS TREATMENT BY THE SAME PROVIDER REQUIRES FURTHER INFORMATION DOCUMENTING COORDINATION OF TREATMENT PLAN.
PA54	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE MINUTES REQUESTED.
PA55	MEDICAL NECESSITY OF TREATMENT REQUIRES ADDITIONAL DOCUMENTATION.
PA56	GIVEN AGE, DIAGNOSES, CURRENT LEVEL OF FUNCTION, PAST RESPONSE TO TREATMENT, AND LIVING SITUATION, EXPAND ON POTENTIAL FOR SIGNIFICANT FUNCTIONAL PROGRESS WITHIN THE NEXT SIX MONTHS. EMPHASIZE WHY PROGRESS IS EXPECTED WITH SERVICES AT THIS TIME.
PA57	SUBMIT THE INITIAL FINDINGS. INCLUDE A COMPREHENSIVE EVALUATION.
PA58	SUBMIT PROGRESSIVE, OBJECTIVE FINDINGS. INCLUDE A PERTINENT RE-EVALUATION.
PA59	PLEASE SUPPLY INFORMATION REGARDING THE CLIENTS MEDICATION REQUIREMENTS, IF ANY.
PA60	PLEASE SPECIFY IF THE CLIENT IS IN AN EDUCATIONAL SETTING.
PA61	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA62	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
PA63	THE SKILLS OF A THERAPIST ARE PURPOSEFUL AND SKILLED INTERVENTIONS REQUIRED TO CONTINUALLY DESIGN, IMPLEMENT, REASSESS, MODIFY/GRADE, AND/OR DISCONTINUE A PLAN OF CARE IN A TIMELY MANNER, BASED ON THE COMPLEXITY OF THE CLIENTS MEDICAL CONDITION AND/OR CO
PA64	PLEASE SUBMIT A THERAPY PLAN OF CARE, INCLUDING A CURRENT, DATED EVALUATION.
PA65	A PLAN OF CARE SIGNED AND DATED BY THE PHYSICIAN IS REQUIRED.
PA66	THE SKILLS OF A THERAPIST ARE REQUIRED WHEN ONLY THE THERAPIST CAN SAFELY AND EFFECTIVELY DELIVER THE THERAPEUTIC PROCEDURES BECAUSE OF THEIR UNIQUE KNOWLEDGE, TRAINING, AND EXPERTISE. DESCRIBE THE REASON THAT SOMEONE OTHER THAN A THERAPIST CANNOT SAFELY
PA67	PLEASE SPECIFY IF THE CLIENTS WORK SITE DEMANDS GOOD BINAURAL HEARING.
PA68	DESCRIBE THE REASON, BASED ON THE CLIENTS COGNITIVE, PHYSICAL, COMMUNICATION, OR RESOURCE STATUS, THAT A HOME PROGRAM, EQUIPMENT, OR ENVIRONMENTAL ADAPTATIONS ALONE CANNOT MEET CLIENTS NEEDS.
PA69	PLEASE SPECIFY IF THE CLIENT HAS AN ACCOMPANYING DISABILITY THAT ADDS TO THE HEARING PROBLEM.
PA70	DISTINGUISH REQUESTED PROCEDURES AND GOALS FROM OTHER SERVICES THIS CLIENT RECEIVES. THEY MAY NOT BE DUPLICATIVE.
PA71	PLEASE INDICATE THE NUMBER OF DAYS REQUESTED.
PA73	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA74	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA75	PLEASE DOCUMENT CARRYOVER OF THE THERAPY PROGRAM TO NURSING.
PA76	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA79	PROVIDE EVIDENCE OF SIGNIFICANT FUNCTIONAL PROGRESS IN LAST SIX MONTHS.
PA84	THE GRANT DATE OF THIS REQUEST CANNOT BE PRIOR TO THE SIGNATURE DATE OF THE PRESCRIBING PHYSICIAN.
PA86	PROVIDE EVIDENCE OF SKILLS GAINED IN THERAPY CARRYING OVER TO OTHER SETTINGS WITHIN SIX MONTHS.
PA87	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE NUMBER OF SESSIONS REQUESTED.
PA88	THE REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL SCOPE OF PRACTICE.
PA89	PRIOR AUTHORIZATION IS NOT REQUIRED UNTIL LIMITATION OF SERVICE HAS BEEN REACHED.

Denial Code	Long Description
PA91	PLEASE SUBMIT REQUIRED X-RAYS.
PA92	PLEASE PROVIDE AN EXPLANATION FOR THE MATERIAL SUBMITTED WITH THE REQUEST.
PA95	PLEASE DESCRIBE HOW THE PROVISION OF THIS SERVICE WOULD PREVENT INSTITUTIONALIZATION OF THE CLIENT.
PA96	COULD THE EXISTING DENTURE(S) BE RELINED OR REBASED? IF NOT, PLEASE EXPLAIN WHY NOT.
PA97	REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL STANDARDS OF PRACTICE.
PA98	PLEASE INDICATE IF THE CLIENT IS CURRENTLY BEING TUBE FED.
PB02	PLEASE PROVIDE THE REQUIRED DATED SIGNATURES ON THE ATTACHMENTS.
PB03	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING THE LOSS/DESTRUCTION/THEFT OF THE HEARING AID.
PB04	DESCRIBE THE CLIENTS ABILITY TO STAND OR AMBULATE SUFFICIENTLY TO ACCOMPLISH SELF-CARE ACTIVITIES.
PB07	PLEASE SUBMIT AN ORTHODONTIC STUDY MODEL OR DIAGNOSTIC CASTS.
PB09	PLEASE PROVIDE A PHOTOGRAPH OF THE INVOLVED AREA(S).
PB10	PLEASE PROVIDE AN ESTIMATION (IN GRAMS) OF THE TOTAL AMOUNT OF TISSUE TO BE RESECTED.
PB11	PLEASE SUBMIT THE PLAN OF CARE FOR CO-TREATMENT.
PB12	FURNISH A DETAILED DESCRIPTION FOR THE PROCEDURE CODE REQUESTED.
PB13	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB15	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB18	PLEASE COMPLETE THE ATTACHED OUT-OF-STATE PROVIDER DATA SHEET, F-11001, AND RESUBMIT.
PB20	A SIGNED AND DATED PRESCRIPTION IS REQUIRED WITHIN THREE MONTHS OF RECEIPT BY COLORADO MEDICAID FOR INITIAL REQUESTS AND WITHIN 12 MONTHS OF RECEIPT BY COLORADO MEDICAID FOR SUBSEQUENT REQUESTS.
PB21	PLEASE COMPLETE THE APPROPRIATE PRIOR AUTHORIZATION ATTACHMENT. CONTACT PROVIDER SERVICES OR THE PRIOR AUTHORIZATION UNIT FOR ASSISTANCE.
PB23	PHYSICAL THERAPY ASSISTANT NOTES AND ALL FORMS SUBMITTED MUST BE COSIGNED BY A REGISTERED PHYSICAL THERAPIST.
PB31	ARE YOU REQUESTING A COMPLETE APPLIANCE, OR REPLACEMENT PARTS?
PB32	THE PROCEDURE CODE INDICATED ON THE REQUEST DOES NOT MATCH THE DESCRIPTION OF SERVICE; PLEASE CORRECT AND RESUBMIT.
PB35	THE SERVICE REQUESTED DOES NOT REQUIRE PRIOR AUTHORIZATION.
PB41	PLEASE FURNISH A CURRENT MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT, F-11090 (DATED WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID).
PB45	THE CERTIFICATION PERIOD ON THE PLAN OF CARE (POC) DOES NOT COVER THE REQUESTED GRANT/START DATE. PLEASE RESUBMIT YOUR REQUEST WITH A NEW POC.
PB49	A CERTIFIED OCCUPATIONAL THERAPY ASSISTANTS NOTES MUST BE COSIGNED BY AN OCCUPATIONAL THERAPIST REGISTERED.
PB51	ADDITIONAL INFORMATION IS REQUIRED ON PRIOR AUTHORIZATION TO ENABLE PRICING.
PB54	REQUESTED SERVICES DO NOT MATCH SERVICES ON THE PHYSICIANS ORDERS.
PB59	PLEASE PROVIDE AN INDIVIDUAL EDUCATIONAL PLAN (IEP), WHICH HAS BEEN SIGNED BY THE PROVIDER NO EARLIER THAN NINE MONTHS PRIOR TO RECEIPT AT COLORADO MEDICAID; OTHERWISE, DOCUMENT WHY NO IEP EXISTS.
PB65	PLEASE FURNISH THE ANTICIPATED TOTAL CHARGES FOR THIS REQUEST.
PB66	A PHOTOCOPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED; THE DATE MUST BE WITHIN SIX MONTHS OF RECEIPT BY COLORADO MEDICAID.
PB67	THE PRESCRIPTION DATE MUST INCLUDE MONTH, DAY, AND YEAR.
PB68	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID.
PB73	THE SERVICES IDENTIFIED ON THE PLAN OF CARE DO NOT APPEAR APPROPRIATE FOR THE PROCEDURE CODE(S) REQUESTED ON THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018.
PB74	THE CLIENT/PROVIDER DOES NOT HAVE RETROACTIVE ENROLLMENT.
PB75	THE REQUESTED START DATE IS MORE THAN 14 DAYS BEFORE OR 62 DAYS AFTER RECEIPT.
PB82	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.

Denial Code	Long Description
PB83	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A HOME HEALTH AIDE. PLEASE RESUBMIT AS A PERSONAL CARE WORKER OR PROVIDE ADDITIONAL DOCUMENTATION.
PB86	THE SERVICES REQUESTED ARE NOT BEING PROVIDED IN THE CLIENTS RESIDENCE. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL.
PB87	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A NURSE. PLEASE RESUBMIT AS A HOME HEALTH AIDE OR PROVIDE ADDITIONAL DOCUMENTATION.
PB92	PLEASE FURNISH THE CLIENTS COMPLETE ADDRESS.
PB94	IF THE CLIENT IS A RESIDENT OF A NURSING HOME, SUPPLY THE COMPLETE NAME AND ADDRESS OF THE NURSING HOME.
PB99	THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018, MUST BE SIGNED AND DATED.
PC01	PLEASE SUPPLY THE RENDERING PROVIDERS PROVIDER NUMBER.
PC03	THE DRUG ENFORCEMENT ADMINISTRATION NUMBER IS MISSING OR INVALID.
PC06	PLEASE DESCRIBE YOUR PROGRAM; INCLUDE ENTRY DATE, TERMINATION DATE, HOURS PER WEEK, AND NUMBER OF WEEKS OF PRIMARY INTENSIVE SERVICE REQUESTED.
PC07	PLEASE DESCRIBE YOUR "AFTERCARE/FOLLOW-UP" PLANS FOR THIS CLIENT.
PC08	PLEASE SUPPLY DOCUMENTATION OF PREVIOUS SUBSTANCE ABUSE SERVICES WITH DATE(S) AND OUTCOME.
PC09	PLEASE DESCRIBE IN DETAIL THE TREATMENT OBJECTIVES/GOALS FOR THIS CLIENT.
PC10	PLEASE DESCRIBE THE FAMILY SITUATION/DYNAMICS. EXPLAIN HOW THE FAMILY WILL BE INCORPORATED INTO THE CLIENTS PLAN OF CARE.
PC12	PLEASE EXPLAIN IF YOUR SERVICE ENCOURAGES THE CLIENT TO ATTEND SELF-HELP GROUPS.
PC13	PLEASE SUPPLY A SPECIFIC SCHEDULE OF ACTIVITIES, INCLUDING DAY, TIME OF DAY, LENGTH OF SESSION, AND SERVICE TO BE RENDERED DURING THAT TIME.
PC15	PLEASE FURNISH DIAGNOSTIC RATIONALE.
PC17	PLEASE DOCUMENT IF THE CLIENT EVER RECEIVED SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT.
PC19	PLEASE FURNISH MORE EXTENSIVE AND IN-DEPTH HISTORICAL AND PSYCHOSOCIAL DATA.
PC20	PLEASE SUPPLY THE DATE THE CLIENT BECAME TOTALLY ENDENTULOUS.
PC23	PLEASE SUBMIT A PHYSICIANS STATEMENT REGARDING THE MEDICAL NECESSITY OF DENTURES FOR THIS CLIENT. THE PHYSICIANS STATEMENT MUST DOCUMENT THE MEDICAL NEED FOR DENTURES.
PC24	THE SERVICE REQUESTED WAS PREVIOUSLY AUTHORIZED. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT INDICATING THIS FACT IS REQUIRED.
PC25	PLEASE SUPPLY SUFFICIENT MITIGATING CIRCUMSTANCES TO WARRANT THE CONSTRUCTION OF NEW DENTURES(S).
PC26	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
PC28	PLEASE SUBMIT A PHYSICIANS STATEMENT INDICATING DENTURES ARE NECESSARY FOR THIS NURSING HOME CLIENT.
PC29	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING LOSS OR DESTRUCTION OF DENTURE(S). INCLUDE SIGNED STATEMENT FROM CLIENT OR FACILITY DIRECTOR REGARDING HOW, WHEN AND WHERE LOST.
PC30	PLEASE PROVIDE COMPLETE INTRAORAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PC31	PLEASE DESCRIBE ANY RELATED DEFORMITIES OF THE FEET.
PC34	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD WITH REQUESTED DME ITEM(S) AND DOCUMENT IF THE CLIENT CAN USE SAFELY AND INDEPENDENTLY.
PC35	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD AND DESCRIBE THE RESULTS AND EFFECTIVENESS OF THE SERVICE REQUESTED.
PC39	PLEASE INDICATE LITER FLOW PER MINUTE, HOURS OF USE PER 24 HOUR PERIOD, AND THE EXPECTED DURATION OF NEED.
PC40	THE ITEM DOES NOT REQUIRE PRIOR AUTHORIZATION UNTIL THE LIFE EXPECTANCY HAS BEEN REACHED.
PC41	PLEASE SUPPLY INFORMATION INDICATING THE NECESSITY OF POSITIONING THE CLIENT'S BODY IN MULTIPLE POSITIONS.

Denial Code	Long Description
PC42	PLEASE INDICATE IF THE BED HEIGHT MUST BE CHANGED TO ALLOW FOR SAFE TRANSFER OR ADEQUATE BED CARE.
PC43	SUPPLY A PHYSICIANS STATEMENT INDICATING TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR UNIT HAS REDUCED PAIN, IMPROVED/INCREASED THE CLIENTS ACTIVITY LEVEL, AND/OR REDUCED CLIENTS USE OF PAIN MEDICATION.
PC44	A CURRENT AUTHORIZATION FOR THIS SERVICE IS ON FILE FOR ANOTHER PROVIDER. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT OF THAT FACT IS REQUIRED BY THE CLIENT OF FIRST PROVIDER.
PC59	DOCUMENT DECLINE OR PROGRESS IN SPECIFIC, MEASURABLE, OBJECTIVE TERMS.
PC60	DOCUMENT IF CLIENT HAS DEMONSTRATED A GOOD APPOINTMENT COMPLIANCE RECORD.
PC61	THE PHYSICIANS SIGNATURE DATE MUST NOT EXCEED 90 DAYS FROM THE DATE OF RECEIPT BY COLORADO MEDICAID.
PC62	REQUESTS FOR A CONTINUATION OF THERAPY SHOULD NOT BE SUBMITTED MORE THAN FOUR WEEKS PRIOR TO THE EXPIRATION DATE OF THE CURRENT AUTHORIZATION.
PC63	PLEASE FURNISH THE STYLE AND MANUFACTURER OF THE FRAME.
PC64	PLEASE FURNISH THE CLIENTS LENS FORMULA.
PC66	ALL REQUESTS FOR TINTS REQUIRE DOCUMENTATION OF THE VISUAL OR MEDICAL CONDITION RELATED TO PHOTOPHOBIA.
PC67	PLEASE DOCUMENT THE REASON AND JUSTIFICATION FOR REPLACEMENT BEYOND THE FIRST LENS/FRAME.
PC68	DOCUMENT IF ALL REMAINING MAXILLARY AND/OR MANDIBULAR TEETH ARE DECAY-FREE, PROPERLY RESTORED, AND PERIODONTICALLY SOUND.
PC72	SUPPLY MORE DETAIL REGARDING PROGRESS (ATTACHMENT OF GOALS, ETC.). CORRELATE PROGRESS TO PREVIOUS GOALS AND IDENTIFIED LIMITATIONS.
PC77	PLEASE SUBMIT A PLAN OF CARE DESCRIBING THE SERVICES THAT WOULD BE PROVIDED.
PC78	PLEASE DOCUMENT SPECIFIC, MEASURABLE GOALS.
PC82	THE PRIOR AUTHORIZATION (PA) SYSTEM CAN PROCESS ONLY 26 DETAILS PER PA REQUEST. PLEASE RESUBMIT YOUR REQUEST WITH NO MORE THAN 26 DETAILS.
PC83	PLEASE SUPPLY A PHYSICIANS PRESCRIPTION DATED WITHIN ONE MONTH OF REQUESTED SUBSTANCE ABUSE DAY TREATMENT.
PC84	PLEASE PROVIDE INFORMATION INDICATING THIS CLIENT IS APPROPRIATELY DETOXIFIED FROM ALCOHOL AND/OR OTHER DRUGS.
PC85	PLEASE PROVIDE INFORMATION TO INDICATE THE CLIENTS ABILITY TO ABSTAIN FROM ALCOHOL OR DRUGS WHILE IN THE SUBSTANCE ABUSE DAY TREATMENT PROGRAM.
PC86	PLEASE INDICATE IF THIS CLIENT IS WILLING TO PARTICIPATE IN AFTERCARE OR CONTINUING CARE SERVICES.
PC87	PROVIDE MORE INFORMATION ON TREATMENT HISTORY; INCLUDE SERVICE PROVIDED, DATES, AND OUTCOME. PROVIDE DETAIL OF PREVIOUS TREATMENT.
PC88	PLEASE PROVIDE MORE RATIONALE FOR THE APPROPRIATENESS AND MEDICAL NECESSITY OF SUBSTANCE ABUSE DAY TREATMENT.
PC89	PROVIDE A TREATMENT PLAN THAT CONTAINS MEASURABLE GOALS AND OBJECTIVES CORRESPONDING TO THE IDENTIFIED DEFICIT.
PC91	PLEASE PROVIDE MORE INFORMATION ON FAMILY INVOLVEMENT TREATMENT.
PC92	PLEASE PROVIDE MORE HISTORY AND EXPLANATION ABOUT THE ISSUE OF ABSTINENCE FOR THIS CLIENT.
PC94	PLEASE PROVIDE THE ANTICIPATED BEGINNING DATE AND/OR THE ESTIMATED SUBSTANCE ABUSE DAY TREATMENT DISCHARGE DATE.
PC95	PLEASE SUPPLY JUSTIFICATION FOR BEGINNING CLIENT IN SERVICE PRIOR TO AUTHORIZATION BEING OBTAINED.
PC96	THE INITIAL THREE HOURS OF SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IN A CALENDAR YEAR DO NOT REQUIRE PRIOR AUTHORIZATION.
PC97	REIMBURSEMENT FOR INITIAL SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IS LIMITED TO THREE HOURS IN A CALENDAR YEAR AND DOES NOT REQUIRE PRIOR AUTHORIZATION.
PC98	THIS DRUG IS CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE BILL USING THE APPROPRIATE NATIONAL DRUG CODE (NDC) OR SUBMIT A COMPLETED DRUG ADDITION REQUEST FORM IF THE NDC IS NOT LISTED IN THE DRUG INDEX.

Denial Code	Long Description
PC99	THIS DRUG IS NOT CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL, CURRENT ADMINISTRATIVE RULE, OR COLORADO DRUG INDEX FOR COVERAGE LIMITATIONS.
PD01	DOCUMENT THAT CLIENT HAS ACHIEVED GOOD ORAL HYGIENE, PERIODONTAL CASE TYPE 1 OR 2, AND IS MOTIVATED TO MAINTAIN SAME.
PD03	PLEASE PROVIDE AN ARTERIAL BLOOD GAS READING OR PULSE OXIMETRY RESULTS DONE ON ROOM AIR SIGNED AND DATED BY A MEDICAL DOCTOR. THIS SHOULD BE DONE WITHIN 60 DAYS OF REQUESTED SERVICE.
PD04	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 30 DAYS OF RECEIPT BY COLORADO MEDICAID.
PD07	SUBMIT A PHOTOCOPY OF A VALID PRESCRIPTION, ISSUED WITHIN THE PAST YEAR, OR COMPLETE SECTION B OF THE PRIOR AUTHORIZATION/DRUG ATTACHMENT (PA/DGA), F-11049.
PD10	BRAND MEDICALLY NECESSARY MUST BE IN THE PRESCRIBERS OWN HANDWRITING AND WRITTEN DIRECTLY ON THE PRESCRIPTION OR A SEPARATE ORDER ATTACHED TO THE ORIGINAL PRESCRIPTION.
PD12	COMPLETE DENTURES, PARTIAL DENTURES, DENTURE RELINES, AND FIXED PROSTHODONTIC SERVICES ARE NOT COVERED SERVICES FOR ADULTS FOR DATES OF SERVICE ON AND AFTER OCTOBER 1, 1995.
PD22	PLEASE COMPLETE ALL REQUIRED ELEMENTS ON THE PERSONAL CARE SCREENING TOOL (PCST), F-11133.
PD24	THIS PRIOR AUTHORIZATION REQUEST IS UNABLE TO BE PROCESSED. PLEASE RESUBMIT WITH ADDITIONAL REQUIRED FORMS, INCLUDING THE ENTIRE PERSONAL CARE SCREENING TOOL (PCST), F-11133; PERSONAL CARE ADDENDUM, F-11136; AND SUPPORTING DOCUMENTATION, AS DIRECTED.
PD25	THERE IS A PERSONAL CARE SCREENING TOOL (PCST), F-11133, COMPLETED BY ANOTHER AGENCY. CONTACT THE AGENCY TO TRANSFER SCREEN.
PD26	THERE IS A LIMITED TERM CARE FUNCTIONAL SCREEN (LTC-FS) COMPLETED BY ANOTHER AGENCY. THE PERSONAL CARE SCREENING TOOL (PCST), F-11133, INFORMATION IS IN CONFLICT WITH LTC-FS.
PD27	ONLY ONE LEVEL OF FUNCTION MAY BE SELECTED FOR ALL ELEMENTS EXCEPT TOILETING. COLORADO MEDICAID IS UNABLE TO PROCESS THE PRIOR AUTHORIZATION REQUEST.
PD28	NO UNITS MAY BE REQUESTED USING THIS PRIOR AUTHORIZATION PROCESS. PLEASE SUBMIT WITH THE APPROPRIATE ATTACHMENTS FOR REQUESTING SPECIFIC PERSONAL CARE WORKER UNITS.
PD29	CLIENT IS NOT ELIGIBLE FOR THE REQUESTED SERVICE(S) AS OF THE REQUESTED START DATE.
PD30	NO TRAVEL TIME MAY BE AUTHORIZED WHEN NO PERSONAL CARE WORKER SERVICE IS AUTHORIZED.
PD32	PROVIDER NOT CERTIFIED TO RENDER THE SERVICE(S) REQUESTED.
PD34	BASED ON THE DOCUMENTATION SUBMITTED, THIS REQUEST CAN NOT BE PRIOR AUTHORIZED. REFER TO THE PA MESSAGES FROM THE CONSULTANT FOR COMPLETE EXPLANATION.
PD98	PLEASE DOCUMENT HOW AND WHEN EACH PREVIOUSLY AUTHORIZED PRO RE NATA VISIT WAS USED.

Child Health Plan Plus (CHP+)

Denial Code	Long Description
0201	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
0233	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0235	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0237	CLIENT IDENTIFICATION NUMBER DOES NOT MATCH CLIENTS FIRST NAME.
0238	THE CLIENT IDENTIFICATION NUMBER DOES NOT MATCH THE CLIENTS LAST NAME.
0242	SECONDARY DIAGNOSIS CODE IS INVALID.
0248	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0249	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0251	PROCEDURE CODE MODIFIER IN FIRST POSITION IS INVALID.
0252	THE PROCEDURE CODE MODIFIER IN SECOND POSITION IS INVALID FOR REQUESTED START DATE OR DATE OF RECEIPT.

Denial Code	Long Description
0253	THE PROCEDURE CODE MODIFIER IN THIRD POSITION IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
0258	THE PRIMARY DIAGNOSIS CODE IS REQUIRED.
0272	THE PRIMARY DIAGNSOSIS CODE IS INVALID.
0400	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0853	HCPCS - ANNUAL UPDATE
0885	NEVER EVENTS MODIFIERS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
0886	NEVER EVENTS DIAGNOSIS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
1000	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
1002	RENDERING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1003	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1007	RENDERING PROVIDER ID IS NOT ON FILE.
1047	THE RENDERING PROVIDERS CERTIFICATION HAS BEEN CANCELLED.
1048	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1801	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
1804	A CERTIFIED SUBSTANCE ABUSE DAY TREATMENT PROVIDER MUST SUBMIT A SUBSTANCE ABUSE DAY TREATMENT PROCEDURE CODE.
1806	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
1808	THE BILLING PROVIDER DOES NOT HAVE THE REQUIRED CERTIFICATION ADDENDUM ON FILE.
1900	THE BILLING PROVIDERS TAXONOMY CODE IS INVALID.
1901	THE RENDERING PROVIDERS TAXONOMY CODE IS INVALID.
1927	A NATIONAL PROVIDER IDENTIFIER IS REQUIRED FOR THE BILLING PROVIDER.
1934	A NATIONAL PROVIDER INDENTIFIER IS REQUIRED FOR THE RENDERING PROVIDER.
1936	THE BILLING PROVIDER NUMBER IS INVALID.
1937	THE RENDERING PROVIDER NUMBER IS INVALID.
1960	INTERNAL PROCESSING IS REQUIRED.
1963	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.
1964	THE BILLING PROVIDER INDICATED IS NOT ALLOWABLE AS A BILLING PROVIDER.
1965	RENDERING PROVIDER NUMBER IS MISSING/INVALID FOR THIS PROCEDURE PROVIDER.
1974	PRESCRIBING/REFERRING/ORDERING PROVIDER INDICATED IS NOT CERTIFIED AS A PRESCRIBING/REFERRING/ORDERING PROVIDER.
1975	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
1976	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
2001	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2003	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2017	THE CLIENT IS ENROLLED IN A MEDICAID OR OTHER MANAGED CARE PROGRAM.
2037	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2603	CLIENT LOCKED-IN TO A PROVIDER OR ENROLLED IN A HOSPICE. CONTACT CLIENTS HOSPICE FOR PAYMENT OF SERVICES OR RESUBMIT WITH DOCUMENTATION OF UNRELATED NATURE OF CARE.
3324	THE MODIFIER HAS BEEN DISCONTINUED BY THE CENTERS OF MEDICARE AND MEDICAID SERVICES OR THE AMERICAN MEDICAL ASSOCIATION FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
3337	THE PROCEDURE CODE HAS BEEN TERMINATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AMERICAN MEDICAL ASSOCIATION, OR AMERICAN DENTAL ASSOCIATION FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT. RESUBMIT WITH VALID A PROCEDURE CODE.
3339	THE PROCEDURE BILLED IS NOT PAYABLE ACCORDING TO DEFICIT REDUCTION ACT (DEFRA) GUIDELINES.
3351	THE PROCEDURE IS NOT COVERED FOR CLIENTS WITH A NURSING HOME AUTHORIZATION ON THE REQUESTED START DATE OR DATE OF RECEIPT.
3353	THE PROCEDURE IS NOT A COVERED SERVICE FOR HOME AND COMMUNITY-BASED WAIVER CLIENTS.
4021	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4027	THE DIAGNOSIS CODE IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
4031	THE PROCEDURE SUBMITTED IS NOT APPROPRIATE FOR CLIENTS GENDER.
4032	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.

Denial Code	Long Description
4034	THE PROCEDURE CODE HAS AN AGE RESTRICTION.
4036	THE PLACE OF SERVICE CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4040	THE PRIMARY DIAGNOSIS CODE IS NOT ON FILE.
4041	THE SECONDARY DIAGNOSIS IS NOT ON FILE.
4046	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4127	INTERNAL PROCESSING IS REQUIRED.
4131	INTERNAL PROCESSING IS REQUIRED.
4141	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4149	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4150	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4236	ETIOLOGY DIAGNOSIS CODE(S) (E-CODES) ARE INVALID AS THE PRIMARY DIAGNOSIS.
4244	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4245	THE FOURTH POSITION MODIFIER IS INVALID FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT.
4256	THE PROCEDURE CODE AND MODIFIER COMBINATION IS NOT PAYABLE FOR THE CLIENTS BENEFIT PLAN.
4257	THE MODIFIERS SUBMITTED ARE EITHER INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT OR THE MODIFIERS ARE MISSING.
4311	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4315	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4316	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4371	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4372	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4711	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR CLIENTS AGE.
4714	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS AGE.
4731	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS DIAGNOSIS.
4742	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4743	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4744	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4745	DIAGNOSIS AND/OR PROCEDURE AND/OR PLACE OF SERVICE (POS) CODE IS NOT COVERED FOR EXPRESS ENROLLMENT CLIENTS.
4746	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4801	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4802	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
4821	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
4871	PLEASE REFER TO PA MESSAGES FOR RETURN INFORMATION.
4963	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS GENDER.
4990	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
7500	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
7509	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
P001	THE BILLING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THE SERVICES.
P002	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P003	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P005	THE PRIOR AUTHORIZATION CAN NOT BE END DATED. THE PRIOR AUTHORIZATION STATUS IS NOT APPROVED OR APPROVED WITH REVISIONS.
P006	PLEASE FURNISH THE PROCEDURE CODE AND CORRESPONDING DESCRIPTION.
P008	THE BILLING PROVIDER NUMBER IS INVALID.
P009	THE BILLING PROVIDER NUMBER IS INVALID.
P010	THE REQUESTED END DATE IS INVALID.
P011	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.

Denial Code	Long Description
P012	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P013	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P014	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P015	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P016	THE REQUESTED START DATE IS MISSING OR INVALID.
P019	THE REQUESTED START DATE IS MISSING OR INVALID.
P020	THE RENDERING PROVIDER NUMBER IS INVALID.
P021	THE RENDERING PROVIDER NUMBER IS INVALID.
P022	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P023	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P024	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P026	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P027	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P030	FIRST MODIFIER IS INVALID.
P031	FIRST MODIFIER IS INVALID.
P032	SECOND MODIFIER IS INVALID.
P033	SECOND MODIFIER IS INVALID.
P034	THIRD MODIFIER IS INVALID.
P035	THIRD MODIFIER IS INVALID.
P036	FOURTH MODIFIER IS INVALID.
P037	FOURTH MODIFIER IS INVALID.
P038	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P039	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P040	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P041	CLIENTS FIRST NAME IS MISSING.
P042	CLIENTS LAST NAME IS MISSING.
P043	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P044	BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES REQUESTED.
P045	FIRST MODIFIER IS INVALID.
P046	SECOND MODIFIER IS INVALID.
P047	THIRD MODIFIER IS INVALID.
P048	FOURTH MODIFIER IS INVALID.
P052	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P053	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P054	RENDERING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES FOR THE BENEFIT PLAN.
P055	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P061	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P062	THE CLIENT ID AND/OR NAME INDICATED ON THE PA REQUEST IS INCORRECT. THE CLIENT ID AND/OR NAME HAS BEEN UPDATED. PLEASE VERIFY THE ID AND/OR NAME IS CORRECT.
P064	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
P067	THE FREQUENCY OF HOURS REQUESTED ARE NOT APPROPRIATE FOR THIS CLIENT AND HAVE BEEN MODIFIED ACCORDINGLY.
P079	BILLING PROVIDER IS ON PAYMENT SUSPENSION DUE TO CREDIBLE ALLEGATION OF FRAUD.
P120	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAS BEEN REDUCED.

Denial Code	Long Description
P121	THE SERVICE/ PROCEDURE REQUESTED IS NOT SUPPORTED BY SUBMITTED DOCUMENTATION.
P126	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
P128	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.
P138	SERVICE(S) DO NOT MEET COLORADO MEDICAID GUIDELINES.
P167	REQUESTED DOCUMENTATION HAS NOT BEEN SUBMITTED.
P178	THE SERVICE REQUESTED IS NOT MEDICALLY NECESSARY.
P179	THE MEDICAL NECESSITY FOR THIS SERVICE IS NOT SUPPORTED BY THE SUBMITTED DOCUMENTATION.
P233	THE DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE ADDITIONAL CARE.
P257	THIS CLIENTS FUNCTIONAL ASSESSMENT SCORES PLACE THIS CLIENT OUTSIDE ELIGIBILITY FOR DAY TREATMENT.
P274	OUR RECORDS INDICATE THIS CLIENT IS INVOLVED IN EFFECTIVE AND APPROPRIATE SERVICE ELSEWHERE.
P292	INTENSIVE REHABILITATION HOURS ARE NO LONGER APPROPRIATE AS INDICATED BY HISTORY, DIAGNOSIS, AND/ OR FUNCTIONAL ASSESSMENT SCORES.
P328	THE SERVICES REQUESTED INCLUDE NON-COVERED SERVICES, AND HOURS ARE REDUCED ACCORDINGLY.
P339	THE CLIENTS PAST HISTORY INDICATES REDUCED TREATMENT HOURS ARE WARRANTED.
P342	THE REQUEST DOES NOT MEET GENERALLY ACCEPTED CONDITIONS REQUIRING FLUORIDE TREATMENTS.
P346	SERVICES EXCEED COLORADO MEDICAID LIMITATION AND DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE MEDICAL NECESSITY OF THE SERVICE.
P349	THE SERVICE REQUESTED WAS PERFORMED LESS THAN FIVE YEARS AGO.
P353	THE EXISTING APPLIANCE HAS NOT BEEN WORN FOR THREE YEARS.
P367	THE CLIENT HAS BEEN TOTALLY WITHOUT TEETH AND AN APPLIANCE FOR FIVE YEARS.
P392	THE CLIENT IS MISSING AN ANTERIOR TOOTH AND/OR HAS TWO OR MORE POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P405	THE SERVICE(S) REQUESTED COULD ADEQUATELY BE PERFORMED IN THE DENTAL OFFICE.
P406	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE OF GOOD PERIODONTAL HEALTH (AMERICAN ACADEMY OF PERIODONTOLOGY PERIODONTAL CLASSIFICATION OF TYPE I OR II).
P407	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE VISIBLE ON RADIOGRAPHS THAT AT LEAST 50 PERCENT OF THE CLINICAL CROWN IS INTACT.
P409	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING SIX OR MORE TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED, INCLUDING THIRD MOLARS.
P410	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING ONE OR MORE ANTERIOR TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED.
P411	DOCUMENTATION DOES NOT SUPPORT THE NEED FOR PERIODONTIC SERVICES. POCKETS ARE LESS THAN 4MM AND/OR GREATER THAN 6MM FOR CLIENT AND/OR THE CLIENT IS UNDER THE AGE OF 13.
P412	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA.
P413	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA. THIS PA HAS BEEN GRANTED AS APPROVED NOT APPROVED WITH REVISIONS. THE DURATION REQUESTED MAY HAVE BEEN REDUCED TO REFLECT COVERAGE LIMITATIONS, PRESCRIBER ORDERS, CONFLICTI
P417	THE SERVICE(S) REQUESTED COULD BE ADEQUATELY PERFORMED WITH LOCAL ANESTHESIA.
P437	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO POOR ORAL HYGIENE.
P444	THIS LINE ITEM IS A DUPLICATE OF ANOTHER LINE ITEM ON THIS PRIOR AUTHORIZATION (PA) REQUEST. PLEASE CORRECT.
P446	THIS IS A DUPLICATE OF AN EXISTING PRIOR AUTHORIZATION (PA) REQUEST. YOU MAY CONTACT PROVIDER SERVICES IF YOU REQUIRE ASSISTANCE. DUPLICATE PA REQUEST
P448	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO DECAY HISTORY.
P449	QUESTIONABLE LONG TERM PROGNOSIS DUE TO GUM AND BONE DISEASE.
P456	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO APPARENT ROOT INFECTION.
P457	OUR RECORDS INDICATE THIS CLIENT HAS EXCEEDED ESTABLISHED PROGRAM LIMITATIONS. COLORADO MEDICAID WILL NOT AUTHORIZE NEW DENTURES.
P458	DOCUMENTATION PROVIDED INDICATES A LESS ELABORATE PROCEDURE SHOULD BE CONSIDERED.
P502	RENTAL ONLY ALLOWED; MEDICAL NEED FOR PURCHASE HAS NOT BEEN DOCUMENTED.
P503	PURCHASE ONLY ALLOWED; MEDICAL NEED FOR RENTAL HAS NOT BEEN DOCUMENTED.

Denial Code	Long Description
P504	OCCUPATIONAL THERAPY GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P505	THE SERVICE REQUESTED IS INCLUDED IN THE NURSING HOME RATE STRUCTURE.
P511	THIS NATIONAL DRUG CODE IS ONLY BILLABLE AS PART OF A COMPOUND DRUG.
P515	THE PRESENCE OF A HANDICAPPING MALOCCLUSION OR HANDICAPPING DENTOFACIAL DEFORMITY IS NOT SUPPORTED BY THE DOCUMENTATION SUBMITTED.
P521	THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVERED BY COLORADO MEDICAID.
P522	GASTRO-INTESTINAL SURGERY FOR THE PURPOSE OF WEIGHT CONTROL IS COVERED ONLY AS A LIFE THREATENING PROCEDURE.
P523	THE TREATMENT REQUEST IS NOT CONSISTENT WITH THE CLIENT'S DIAGNOSIS.
P524	PSYCHOTHERAPY PROVIDED IN THE CLIENTS HOME IS NOT A COVERED BENEFIT OF COLORADO MEDICAID .
P525	THE INFORMATION PROVIDED IS NOT CONSISTENT WITH THE INTENSITY OF SERVICES REQUESTED.
P526	INTENSIVE MULTIPLE MODALITY TREATMENT IS NOT CONSISTENT WITH THE INFORMATION PROVIDED.
P527	MULTIPLE PROVIDERS OF TREATMENT ARE NOT INDICATED FOR THIS CLIENT.
P528	THE DURATION OF TREATMENT SESSIONS EXCEED CURRENT COLORADO MEDICAID GUIDELINES.
P534	DOCUMENTATION OF POOR PHYSICAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P535	OTHER PHYSICAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P536	THE PHYSICAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P537	USE OF PHYSICAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P538	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF A PHYSICAL THERAPIST.
P539	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS AND LIVING ARRANGEMENT.
P540	GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P541	THE PROCEDURE(S) REQUESTED ARE NOT MEDICAL IN NATURE.
P542	DOCUMENTATION OF POOR OCCUPATIONAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P543	DOCUMENTATION OF POOR SPEECH THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P544	OTHER OCCUPATIONAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P546	THE OCCUPATIONAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P547	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF PHYSICAL THERAPY.
P548	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P549	ACTIVITIES TO PROMOTE DIVERSION OR GENERAL MOTIVATION ARE NONCOVERED COLORADO MEDICAID SERVICES.
P550	REVISIONS OF THE REQUEST IS NECESSITATED BY THE CLIENTS MINIMAL PROGRESS.
P551	RESTORATIVE NURSING INVOLVEMENT COULD BE INCREASED.
P552	CLIENTS DEMONSTRATED RESPONSE TO CURRENT THERAPY DOES NOT WARRANT THE INTENSE FREQUENCY REQUESTED.
P553	MAINTENANCE IS TWO TIMES PER WEEK OR LESS.
P554	THE SPEECH THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P555	USE OF OCCUPATIONAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P556	USE OF SPEECH THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P557	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF AN OCCUPATIONAL THERAPIST.
P558	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.

Denial Code	Long Description
P559	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P560	THE MATERIALS/ SERVICES REQUESTED ARE PRINCIPALLY COSMETIC IN NATURE.
P561	THE LENS FORMULA DOES NOT JUSTIFY REPLACEMENT.
P562	THE CHANGE IN THE LENS FORMULA DOES NOT WARRANT MULTIPLE REPLACEMENTS.
P563	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P564	LENSES ONLY ARE APPROVED; PLEASE DISPENSE A CONTRACTED FRAME. THE NON-CONTRACTED FRAME IS NOT MEDICALLY JUSTIFIED.
P565	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P566	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P567	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF OCCUPATIONAL THERAPY.
P568	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF SPEECH THERAPY.
P569	LEVEL, INTENSITY, OR EXTENT OF SERVICE(S) REQUESTED HAS BEEN MODIFIED CONSISTENT WITH MEDICAL NEED AS DEFINED IN THE PLAN OF CARE.
P570	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P571	THE SERVICE ASKED FOR IS NOT COVERED BY COLORADO MEDICAID AS THESE TASKS CAN BE DONE BY NURSES OR ACTIVITY STAFF.
P572	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P573	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.
P574	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P575	MEDICAL NEED FOR EQUIPMENT/ SUPPLY REQUESTED IS NOT SUPPORTED BY DOCUMENTATION SUBMITTED.
P576	OTHER SPEECH THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P577	DOCUMENTATION SUBMITTED IDENTIFIES THAT THE CLIENT HAS FEWER THAN TWO POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P582	LESS EXPENSIVE ALTERNATIVE SERVICES ARE AVAILABLE FOR THIS CLIENT.
P634	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P711	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING PERIODONTAL SCALING AND ROOT PLANNING.
P712	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING GINGIVECTOMY.
P754	AN APPROVED SUBSTANCE ABUSE DAY TREATMENT PROGRAM CANNOT EXCEED A SIX WEEK PERIOD.
P761	THE CLIENT DOES NOT APPEAR TO BE ABLE OR WILLING TO ABSTAIN FROM ALCOHOL/DRUG USAGE WHILE IN TREATMENT. THEREFORE, SUBSTANCE ABUSE DAY TREATMENT SERVICES ARE NOT APPROVED.
P764	THIS CLIENT HAS COMPLETED INTENSIVE SUBSTANCE ABUSE TREATMENT WITHIN THE PAST 12 MONTHS. THE DOCUMENTATION PROVIDED IS NOT ADEQUATE TO JUSTIFY ADDITIONAL INTENSIVE TREATMENT AT THIS TIME.
P785	A LESS THAN SIX-WEEK HEALING PERIOD HAS BEEN SPECIFIED FOR THIS PRIOR AUTHORIZATION. THEREFORE IT IS NOT NECESSARY TO WAIT THE FULL SIX WEEKS AFTER EXTRACTIONS BEFORE TAKING DENTURE IMPRESSIONS.
P818	SIX-WEEK HEALING TIME IS REQUIRED BETWEEN EDENTULATION AND FINAL IMPRESSIONS. PAYMENT FOR DENTURES WILL BE DENIED OR RECOUPED IF HEALING PERIOD IS NOT OBSERVED.
P849	COLORADO MEDICAID HAS DETERMINED THERE WERE (ARE) SEVERAL HOME HEALTH AGENCIES WILLING TO PROVIDE MEDICALLY NECESSARY SKILLED NURSING SERVICES TO THIS CLIENT.
P864	THE DOCUMENTATION YOU HAVE SUBMITTED DOES NOT MEET THE REQUIREMENTS OF COLORADO MEDICAID.
P873	THE MEDICAL NECESSITY FOR THE HOURS REQUESTED IS NOT SUPPORTED BY THE INFORMATION SUBMITTED.
P874	THE DOCUMENTATION SUBMITTED INDICATES THE TASKS SPECIFIED CAN BE COMPLETED DURING THE VISITS APPROVED.

Denial Code	Long Description
P878	THE DOCUMENTATION SUBMITTED DOES NOT INDICATE THAT MEDICALLY ORIENTED TASKS ARE MEDICALLY NECESSARY; THEREFORE PERSONAL CARE SERVICES HAVE BEEN APPROVED.
P880	THE QUANTITY OF SERVICES AUTHORIZED FOR THIS CLIENTS PERSONAL CARE HAS BEEN AMENDED BASED ON INFORMATION RECEIVED FROM ONE OR MORE OF THESE SOURCES: THE CLIENT, THEIR PHYSICIAN, AND/OR THE IN-HOME VISIT BY STAFF OF THE OIG (OFFICE OF INSPECTOR GENERAL).
P885	THE USE OF THIS DRUG FOR THE INTENDED PURPOSE IS NOT COVERED BY COLORADO MEDICAID, CONSISTENT WITH COLORADO ADMINISTRATIVE CODE AND FEDERAL LAW.
P924	THE MEDICAL RECORDS SUBMITTED WITH THE CURRENT REQUEST CONFLICT OR DISAGREE WITH OUR MEDICAL RECORDS ON THIS CLIENT.
P950	INDEPENDENT NURSES, PLEASE NOTE PAYABLE SERVICES MAY NOT EXCEED 12 HOURS/DAY OR 60 HOURS/WEEK.
P951	SERVICES CAN ONLY BE AUTHORIZED THROUGH ONE YEAR FROM THE PRESCRIPTION DATE.
P952	LEAD INSPECTION IS A COVERED COLORADO MEDICAID SERVICE WHEN THE CHILD HAS BEEN SHOWN TO HAVE LEAD POISONING (E.G., CHILD HAS A BLOOD LEAD LEVEL > 19 UG/DL OR TWO CONSECUTIVE BLOOD LEAD LEVELS OF 15-19 UG/DL DONE AT LEAST 90 DAYS APART). THE INSPECTION MUS
P953	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P954	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P956	THE REQUEST CAN ONLY BE BACKDATED A MAXIMUM OF 14 DAYS FROM FIRST DATE RECEIVED BY COLORADO MEDICAID.
P957	COMPLETE PERIODONTAL CHARTING AT TIME OF SERVICE, AND SUBMIT CHARTING, COPY OF OPERATIVE REPORT, TOGETHER WITH A COPY OF THE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF), F-11035, TO PA UNIT ATTENTION DENTAL CONTSULTANT.
P958	NOTE THAT CODE D4341 HAS BEEN CHANGED. REFER TO THE DECISION NOTICE FOR AUTHORIZED QUANTITY.
P960	YOUR PA HAS BEEN APPROVED FOR 90 DAYS. THE 90 DAY APPROVAL DOES NOT IMPLY THE PA REQUEST MEETS PRIOR AUTHORIZATION CRITERIA. AFTER ADDITIONAL INFORMATION IS AVAILABLE IN INTERCHANGE, COLORADO MEDICAID WILL CREATE AN AMENDMENT REQUEST TO EXTEND THE PA FOR
P961	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P962	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
PA10	THE REQUESTED END DATE IS INVALID.
PA12	PLEASE FURNISH A WRITTEN DESCRIPTION OF THE CLIENTS DIAGNOSIS.
PA13	PROVIDE DIAGNOSES WITH DATES OF ONSET.
PA14	IDENTIFY PROBLEMS TO BE TREATED.
PA15	THE AUDIOLOGISTS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1), F-11020, AND PRIOR AUTHORIZATION REQUEST/HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2), F-11021.
PA16	THE PHYSICIANS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION/PHYSICIAN OTOLOGICAL REPORT (PA/POR), F-11019.
PA17	SUBMIT BRIEF HISTORY WITH REFERRAL INFORMATION, LIVING SITUATION, FUNCTIONAL STATUS, AND OTHER PERTINENT INFORMATION. WHAT CHANGE OF STATUS RESULTED IN REFERRAL AT THIS TIME?
PA18	PLEASE FURNISH THE CLIENTS HEIGHT AND WEIGHT.
PA19	PLEASE SUBMIT CLINICAL INFORMATION SUFFICIENT TO VERIFY THE NEED FOR THE REQUESTED SERVICE(S).
PA20	PLEASE RESUBMIT WITH COMPLETE PERIODONTAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PA21	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL EDUCATIONAL PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA22	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL PROGRAM PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.

Denial Code	Long Description
PA23	REFER TO THE DURABLE MEDICAL EQUIPMENT INDEX FOR APPROPRIATE CODE AND DESCRIPTION. DO NOT USE AN "UNLISTED" CODE.
PA24	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUALIZED FAMILY SERVICE PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA25	INFORMATION ON THE REQUEST FORM IS ILLEGIBLE, AND THE REQUEST CANNOT BE PROCESSED.
PA26	RE-EVALUATE YOUR GOALS. EMPHASIS SHOULD BE ON FUNCTIONAL SELF-CARE. GOALS MUST BE RELATED TO FUNCTIONAL OUTCOME.
PA27	PLEASE CLARIFY THE NUMBER OF HOURS PER WEEK REQUESTED.
PA28	PLEASE CLARIFY THE NUMBER OF HOURS PER DAY REQUESTED.
PA29	PLEASE CLARIFY THE NUMBER OF VISITS PER DAY REQUESTED.
PA30	ATTACH SUPPORTIVE DOCUMENTATION; HOME EXERCISE PROGRAM AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA31	THE DIAGNOSIS CODE INDICATED ON THE REQUEST DOES NOT CORRESPOND TO THE DIAGNOSIS CODE DESCRIPTION.
PA32	PLEASE SUBMIT ADDITIONAL INFORMATION SUFFICIENT TO VERIFY APPROPRIATENESS AND NEED FOR TRANSPLANT.
PA33	PLEASE SUBMIT THE INITIAL AND PROGRESSIVE OBJECTIVE FINDINGS.
PA34	ATTACH SUPPORTIVE DOCUMENTATION, FACILITY PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA35	PLEASE SUBMIT THE CLIENTS ORIGINAL COMPLAINTS AND EXAMINATION FINDINGS.
PA36	ATTACH SUPPORTIVE DOCUMENTATION, IN-HOME AUTISM PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA37	PLEASE SUBMIT YOUR TREATMENT PLAN FOR THIS CLIENT.
PA38	ATTACH SUPPORTIVE DOCUMENTATION AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA39	INITIAL EVALUATIONS MUST BE PERFORMED BY AN OCCUPATIONAL THERAPIST REGISTERED (OTR), PER AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA) STANDARDS.
PA41	IDENTIFY THE PLACE OF SERVICE AND ITS EFFECT ON SUPPORTING THE DESIRED TREATMENT OUTCOME.
PA42	PLEASE INDICATE THE HOURS OF USE OF OXYGEN PER 24-HOUR PERIOD.
PA43	PROVIDE BASELINE DOCUMENTATION FOR THIS CLIENTS LIMITATIONS USING UNITS OF MEASUREMENT THAT ARE APPLIED CONSISTENTLY WHEN REPORTING STATUS.
PA44	IDENTIFY FUNCTIONAL LIMITATIONS AS THEY ARE RELATED TO IDENTIFIED CONDITIONS.
PA46	CORRELATE PLAN OF CARE TO REQUESTED PROCEDURE CODES.
PA47	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE FREQUENCY/DURATION REQUESTED.
PA48	PLEASE PROVIDE THE NAME AND CREDENTIALS OF THE RENDERING PROVIDER.
PA50	COLORADO MEDICAID RECORDS INDICATE THE CLIENT OWNS A WHEELCHAIR. DOCUMENT THE REASON AND NEED FOR REPLACEMENT AND COST TO REPAIR CURRENT WHEELCHAIR.
PA51	PLEASE DISTINGUISH PRIMARY AND SUPPORTIVE MODALITIES.
PA52	PLEASE SUBMIT A PROGRESS REPORT.
PA53	MULTIPLE FAMILY CLIENTS TREATMENT BY THE SAME PROVIDER REQUIRES FURTHER INFORMATION DOCUMENTING COORDINATION OF TREATMENT PLAN.
PA54	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE MINUTES REQUESTED.
PA55	MEDICAL NECESSITY OF TREATMENT REQUIRES ADDITIONAL DOCUMENTATION.
PA56	GIVEN AGE, DIAGNOSES, CURRENT LEVEL OF FUNCTION, PAST RESPONSE TO TREATMENT, AND LIVING SITUATION, EXPAND ON POTENTIAL FOR SIGNIFICANT FUNCTIONAL PROGRESS WITHIN THE NEXT SIX MONTHS. EMPHASIZE WHY PROGRESS IS EXPECTED WITH SERVICES AT THIS TIME.
PA57	SUBMIT THE INITIAL FINDINGS. INCLUDE A COMPREHENSIVE EVALUATION.
PA58	SUBMIT PROGRESSIVE, OBJECTIVE FINDINGS. INCLUDE A PERTINENT RE-EVALUATION.
PA59	PLEASE SUPPLY INFORMATION REGARDING THE CLIENTS MEDICATION REQUIREMENTS, IF ANY.
PA60	PLEASE SPECIFY IF THE CLIENT IS IN AN EDUCATIONAL SETTING.
PA61	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).

Denial Code	Long Description
PA62	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
PA63	THE SKILLS OF A THERAPIST ARE PURPOSEFUL AND SKILLED INTERVENTIONS REQUIRED TO CONTINUALLY DESIGN, IMPLEMENT, REASSESS, MODIFY/GRADE, AND/OR DISCONTINUE A PLAN OF CARE IN A TIMELY MANNER, BASED ON THE COMPLEXITY OF THE CLIENTS MEDICAL CONDITION AND/OR CO
PA64	PLEASE SUBMIT A THERAPY PLAN OF CARE, INCLUDING A CURRENT, DATED EVALUATION.
PA65	A PLAN OF CARE SIGNED AND DATED BY THE PHYSICIAN IS REQUIRED.
PA66	THE SKILLS OF A THERAPIST ARE REQUIRED WHEN ONLY THE THERAPIST CAN SAFELY AND EFFECTIVELY DELIVER THE THERAPEUTIC PROCEDURES BECAUSE OF THEIR UNIQUE KNOWLEDGE, TRAINING, AND EXPERTISE. DESCRIBE THE REASON THAT SOMEONE OTHER THAN A THERAPIST CANNOT SAFELY
PA67	PLEASE SPECIFY IF THE CLIENTS WORK SITE DEMANDS GOOD BINAURAL HEARING.
PA68	DESCRIBE THE REASON, BASED ON THE CLIENTS COGNITIVE, PHYSICAL, COMMUNICATION, OR RESOURCE STATUS, THAT A HOME PROGRAM, EQUIPMENT, OR ENVIRONMENTAL ADAPTATIONS ALONE CANNOT MEET CLIENTS NEEDS.
PA69	PLEASE SPECIFY IF THE CLIENT HAS AN ACCOMPANYING DISABILITY THAT ADDS TO THE HEARING PROBLEM.
PA70	DISTINGUISH REQUESTED PROCEDURES AND GOALS FROM OTHER SERVICES THIS CLIENT RECEIVES. THEY MAY NOT BE DUPLICATIVE.
PA71	PLEASE INDICATE THE NUMBER OF DAYS REQUESTED.
PA73	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA74	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA75	PLEASE DOCUMENT CARRYOVER OF THE THERAPY PROGRAM TO NURSING.
PA76	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA79	PROVIDE EVIDENCE OF SIGNIFICANT FUNCTIONAL PROGRESS IN LAST SIX MONTHS.
PA84	THE GRANT DATE OF THIS REQUEST CANNOT BE PRIOR TO THE SIGNATURE DATE OF THE PRESCRIBING PHYSICIAN.
PA86	PROVIDE EVIDENCE OF SKILLS GAINED IN THERAPY CARRYING OVER TO OTHER SETTINGS WITHIN SIX MONTHS.
PA87	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE NUMBER OF SESSIONS REQUESTED.
PA88	THE REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL SCOPE OF PRACTICE.
PA89	PRIOR AUTHORIZATION IS NOT REQUIRED UNTIL LIMITATION OF SERVICE HAS BEEN REACHED.
PA91	PLEASE SUBMIT REQUIRED X-RAYS.
PA92	PLEASE PROVIDE AN EXPLANATION FOR THE MATERIAL SUBMITTED WITH THE REQUEST.
PA95	PLEASE DESCRIBE HOW THE PROVISION OF THIS SERVICE WOULD PREVENT INSTITUTIONALIZATION OF THE CLIENT.
PA96	COULD THE EXISTING DENTURE(S) BE RELINED OR REBASED? IF NOT, PLEASE EXPLAIN WHY NOT.
PA97	REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL STANDARDS OF PRACTICE.
PA98	PLEASE INDICATE IF THE CLIENT IS CURRENTLY BEING TUBE FED.
PB02	PLEASE PROVIDE THE REQUIRED DATED SIGNATURES ON THE ATTACHMENTS.
PB03	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING THE LOSS/DESTRUCTION/THEFT OF THE HEARING AID.
PB04	DESCRIBE THE CLIENTS ABILITY TO STAND OR AMBULATE SUFFICIENTLY TO ACCOMPLISH SELF-CARE ACTIVITIES.
PB07	PLEASE SUBMIT AN ORTHODONTIC STUDY MODEL OR DIAGNOSTIC CASTS.
PB09	PLEASE PROVIDE A PHOTOGRAPH OF THE INVOLVED AREA(S).
PB10	PLEASE PROVIDE AN ESTIMATION (IN GRAMS) OF THE TOTAL AMOUNT OF TISSUE TO BE RESECTED.
PB11	PLEASE SUBMIT THE PLAN OF CARE FOR CO-TREATMENT.
PB12	FURNISH A DETAILED DESCRIPTION FOR THE PROCEDURE CODE REQUESTED.
PB13	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB15	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.

Denial Code	Long Description
PB18	PLEASE COMPLETE THE ATTACHED OUT-OF-STATE PROVIDER DATA SHEET, F-11001, AND RESUBMIT.
PB20	A SIGNED AND DATED PRESCRIPTION IS REQUIRED WITHIN THREE MONTHS OF RECEIPT BY COLORADO MEDICAID FOR INITIAL REQUESTS AND WITHIN 12 MONTHS OF RECEIPT BY COLORADO MEDICAID FOR SUBSEQUENT REQUESTS.
PB21	PLEASE COMPLETE THE APPROPRIATE PRIOR AUTHORIZATION ATTACHMENT. CONTACT PROVIDER SERVICES OR THE PRIOR AUTHORIZATION UNIT FOR ASSISTANCE.
PB23	PHYSICAL THERAPY ASSISTANT NOTES AND ALL FORMS SUBMITTED MUST BE COSIGNED BY A REGISTERED PHYSICAL THERAPIST.
PB31	ARE YOU REQUESTING A COMPLETE APPLIANCE, OR REPLACEMENT PARTS?
PB32	THE PROCEDURE CODE INDICATED ON THE REQUEST DOES NOT MATCH THE DESCRIPTION OF SERVICE; PLEASE CORRECT AND RESUBMIT.
PB35	THE SERVICE REQUESTED DOES NOT REQUIRE PRIOR AUTHORIZATION.
PB41	PLEASE FURNISH A CURRENT MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT, F-11090 (DATED WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID).
PB45	THE CERTIFICATION PERIOD ON THE PLAN OF CARE (POC) DOES NOT COVER THE REQUESTED GRANT/START DATE. PLEASE RESUBMIT YOUR REQUEST WITH A NEW POC.
PB49	A CERTIFIED OCCUPATIONAL THERAPY ASSISTANTS NOTES MUST BE COSIGNED BY AN OCCUPATIONAL THERAPIST REGISTERED.
PB51	ADDITIONAL INFORMATION IS REQUIRED ON PRIOR AUTHORIZATION TO ENABLE PRICING.
PB54	REQUESTED SERVICES DO NOT MATCH SERVICES ON THE PHYSICIANS ORDERS.
PB59	PLEASE PROVIDE AN INDIVIDUAL EDUCATIONAL PLAN (IEP), WHICH HAS BEEN SIGNED BY THE PROVIDER NO EARLIER THAN NINE MONTHS PRIOR TO RECEIPT AT COLORADO MEDICAID; OTHERWISE, DOCUMENT WHY NO IEP EXISTS.
PB65	PLEASE FURNISH THE ANTICIPATED TOTAL CHARGES FOR THIS REQUEST.
PB66	A PHOTOCOPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED; THE DATE MUST BE WITHIN SIX MONTHS OF RECEIPT BY COLORADO MEDICAID.
PB67	THE PRESCRIPTION DATE MUST INCLUDE MONTH, DAY, AND YEAR.
PB68	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID.
PB73	THE SERVICES IDENTIFIED ON THE PLAN OF CARE DO NOT APPEAR APPROPRIATE FOR THE PROCEDURE CODE(S) REQUESTED ON THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018.
PB74	THE CLIENT/PROVIDER DOES NOT HAVE RETROACTIVE ENROLLMENT.
PB75	THE REQUESTED START DATE IS MORE THAN 14 DAYS BEFORE OR 62 DAYS AFTER RECEIPT.
PB82	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
PB83	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A HOME HEALTH AIDE. PLEASE RESUBMIT AS A PERSONAL CARE WORKER OR PROVIDE ADDITIONAL DOCUMENTATION.
PB86	THE SERVICES REQUESTED ARE NOT BEING PROVIDED IN THE CLIENTS RESIDENCE. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL.
PB87	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A NURSE. PLEASE RESUBMIT AS A HOME HEALTH AIDE OR PROVIDE ADDITIONAL DOCUMENTATION.
PB92	PLEASE FURNISH THE CLIENTS COMPLETE ADDRESS.
PB94	IF THE CLIENT IS A RESIDENT OF A NURSING HOME, SUPPLY THE COMPLETE NAME AND ADDRESS OF THE NURSING HOME.
PB99	THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018, MUST BE SIGNED AND DATED.
PC01	PLEASE SUPPLY THE RENDERING PROVIDERS PROVIDER NUMBER.
PC03	THE DRUG ENFORCEMENT ADMINISTRATION NUMBER IS MISSING OR INVALID.
PC06	PLEASE DESCRIBE YOUR PROGRAM; INCLUDE ENTRY DATE, TERMINATION DATE, HOURS PER WEEK, AND NUMBER OF WEEKS OF PRIMARY INTENSIVE SERVICE REQUESTED.
PC07	PLEASE DESCRIBE YOUR "AFTERCARE/FOLLOW-UP" PLANS FOR THIS CLIENT.
PC08	PLEASE SUPPLY DOCUMENTATION OF PREVIOUS SUBSTANCE ABUSE SERVICES WITH DATE(S) AND OUTCOME.
PC09	PLEASE DESCRIBE IN DETAIL THE TREATMENT OBJECTIVES/GOALS FOR THIS CLIENT.

Denial Code	Long Description
PC10	PLEASE DESCRIBE THE FAMILY SITUATION/DYNAMICS. EXPLAIN HOW THE FAMILY WILL BE INCORPORATED INTO THE CLIENTS PLAN OF CARE.
PC12	PLEASE EXPLAIN IF YOUR SERVICE ENCOURAGES THE CLIENT TO ATTEND SELF-HELP GROUPS.
PC13	PLEASE SUPPLY A SPECIFIC SCHEDULE OF ACTIVITIES, INCLUDING DAY, TIME OF DAY, LENGTH OF SESSION, AND SERVICE TO BE RENDERED DURING THAT TIME.
PC15	PLEASE FURNISH DIAGNOSTIC RATIONALE.
PC17	PLEASE DOCUMENT IF THE CLIENT EVER RECEIVED SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT.
PC19	PLEASE FURNISH MORE EXTENSIVE AND IN-DEPTH HISTORICAL AND PSYCHOSOCIAL DATA.
PC20	PLEASE SUPPLY THE DATE THE CLIENT BECAME TOTALLY ENDENTULOUS.
PC23	PLEASE SUBMIT A PHYSICIANS STATEMENT REGARDING THE MEDICAL NECESSITY OF DENTURES FOR THIS CLIENT. THE PHYSICIANS STATEMENT MUST DOCUMENT THE MEDICAL NEED FOR DENTURES.
PC24	THE SERVICE REQUESTED WAS PREVIOUSLY AUTHORIZED. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT INDICATING THIS FACT IS REQUIRED.
PC25	PLEASE SUPPLY SUFFICIENT MITIGATING CIRCUMSTANCES TO WARRANT THE CONSTRUCTION OF NEW DENTURES(S).
PC26	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
PC28	PLEASE SUBMIT A PHYSICIANS STATEMENT INDICATING DENTURES ARE NECESSARY FOR THIS NURSING HOME CLIENT.
PC29	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING LOSS OR DESTRUCTION OF DENTURE(S). INCLUDE SIGNED STATEMENT FROM CLIENT OR FACILITY DIRECTOR REGARDING HOW, WHEN AND WHERE LOST.
PC30	PLEASE PROVIDE COMPLETE INTRAORAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PC31	PLEASE DESCRIBE ANY RELATED DEFORMITIES OF THE FEET.
PC34	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD WITH REQUESTED DME ITEM(S) AND DOCUMENT IF THE CLIENT CAN USE SAFELY AND INDEPENDENTLY.
PC35	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD AND DESCRIBE THE RESULTS AND EFFECTIVENESS OF THE SERVICE REQUESTED.
PC39	PLEASE INDICATE LITER FLOW PER MINUTE, HOURS OF USE PER 24 HOUR PERIOD, AND THE EXPECTED DURATION OF NEED.
PC40	THE ITEM DOES NOT REQUIRE PRIOR AUTHORIZATION UNTIL THE LIFE EXPECTANCY HAS BEEN REACHED.
PC41	PLEASE SUPPLY INFORMATION INDICATING THE NECESSITY OF POSITIONING THE CLIENT'S BODY IN MULTIPLE POSITIONS.
PC42	PLEASE INDICATE IF THE BED HEIGHT MUST BE CHANGED TO ALLOW FOR SAFE TRANSFER OR ADEQUATE BED CARE.
PC43	SUPPLY A PHYSICIANS STATEMENT INDICATING TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR UNIT HAS REDUCED PAIN, IMPROVED/INCREASED THE CLIENTS ACTIVITY LEVEL, AND/OR REDUCED CLIENTS USE OF PAIN MEDICATION.
PC44	A CURRENT AUTHORIZATION FOR THIS SERVICE IS ON FILE FOR ANOTHER PROVIDER. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT OF THAT FACT IS REQUIRED BY THE CLIENT OF FIRST PROVIDER.
PC59	DOCUMENT DECLINE OR PROGRESS IN SPECIFIC, MEASURABLE, OBJECTIVE TERMS.
PC60	DOCUMENT IF CLIENT HAS DEMONSTRATED A GOOD APPOINTMENT COMPLIANCE RECORD.
PC61	THE PHYSICIANS SIGNATURE DATE MUST NOT EXCEED 90 DAYS FROM THE DATE OF RECEIPT BY COLORADO MEDICAID.
PC62	REQUESTS FOR A CONTINUATION OF THERAPY SHOULD NOT BE SUBMITTED MORE THAN FOUR WEEKS PRIOR TO THE EXPIRATION DATE OF THE CURRENT AUTHORIZATION.
PC63	PLEASE FURNISH THE STYLE AND MANUFACTURER OF THE FRAME.
PC64	PLEASE FURNISH THE CLIENTS LENS FORMULA.
PC66	ALL REQUESTS FOR TINTS REQUIRE DOCUMENTATION OF THE VISUAL OR MEDICAL CONDITION RELATED TO PHOTOPHOBIA.
PC67	PLEASE DOCUMENT THE REASON AND JUSTIFICATION FOR REPLACEMENT BEYOND THE FIRST LENS/FRAME.
PC68	DOCUMENT IF ALL REMAINING MAXILLARY AND/OR MANDIBULAR TEETH ARE DECAY-FREE, PROPERLY RESTORED, AND PERIODONTICALLY SOUND.

Denial Code	Long Description
PC72	SUPPLY MORE DETAIL REGARDING PROGRESS (ATTACHMENT OF GOALS, ETC.). CORRELATE PROGRESS TO PREVIOUS GOALS AND IDENTIFIED LIMITATIONS.
PC77	PLEASE SUBMIT A PLAN OF CARE DESCRIBING THE SERVICES THAT WOULD BE PROVIDED.
PC78	PLEASE DOCUMENT SPECIFIC, MEASURABLE GOALS.
PC82	THE PRIOR AUTHORIZATION (PA) SYSTEM CAN PROCESS ONLY 26 DETAILS PER PA REQUEST. PLEASE RESUBMIT YOUR REQUEST WITH NO MORE THAN 26 DETAILS.
PC83	PLEASE SUPPLY A PHYSICIANS PRESCRIPTION DATED WITHIN ONE MONTH OF REQUESTED SUBSTANCE ABUSE DAY TREATMENT.
PC84	PLEASE PROVIDE INFORMATION INDICATING THIS CLIENT IS APPROPRIATELY DETOXIFIED FROM ALCOHOL AND/OR OTHER DRUGS.
PC85	PLEASE PROVIDE INFORMATION TO INDICATE THE CLIENTS ABILITY TO ABSTAIN FROM ALCOHOL OR DRUGS WHILE IN THE SUBSTANCE ABUSE DAY TREATMENT PROGRAM.
PC86	PLEASE INDICATE IF THIS CLIENT IS WILLING TO PARTICIPATE IN AFTERCARE OR CONTINUING CARE SERVICES.
PC87	PROVIDE MORE INFORMATION ON TREATMENT HISTORY; INCLUDE SERVICE PROVIDED, DATES, AND OUTCOME. PROVIDE DETAIL OF PREVIOUS TREATMENT.
PC88	PLEASE PROVIDE MORE RATIONALE FOR THE APPROPRIATENESS AND MEDICAL NECESSITY OF SUBSTANCE ABUSE DAY TREATMENT.
PC89	PROVIDE A TREATMENT PLAN THAT CONTAINS MEASURABLE GOALS AND OBJECTIVES CORRESPONDING TO THE IDENTIFIED DEFICIT.
PC91	PLEASE PROVIDE MORE INFORMATION ON FAMILY INVOLVEMENT TREATMENT.
PC92	PLEASE PROVIDE MORE HISTORY AND EXPLANATION ABOUT THE ISSUE OF ABSTINENCE FOR THIS CLIENT.
PC94	PLEASE PROVIDE THE ANTICIPATED BEGINNING DATE AND/OR THE ESTIMATED SUBSTANCE ABUSE DAY TREATMENT DISCHARGE DATE.
PC95	PLEASE SUPPLY JUSTIFICATION FOR BEGINNING CLIENT IN SERVICE PRIOR TO AUTHORIZATION BEING OBTAINED.
PC96	THE INITIAL THREE HOURS OF SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IN A CALENDAR YEAR DO NOT REQUIRE PRIOR AUTHORIZATION.
PC97	REIMBURSEMENT FOR INITIAL SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IS LIMITED TO THREE HOURS IN A CALENDAR YEAR AND DOES NOT REQUIRE PRIOR AUTHORIZATION.
PC98	THIS DRUG IS CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE BILL USING THE APPROPRIATE NATIONAL DRUG CODE (NDC) OR SUBMIT A COMPLETED DRUG ADDITION REQUEST FORM IF THE NDC IS NOT LISTED IN THE DRUG INDEX.
PC99	THIS DRUG IS NOT CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL, CURRENT ADMINISTRATIVE RULE, OR COLORADO DRUG INDEX FOR COVERAGE LIMITATIONS.
PD01	DOCUMENT THAT CLIENT HAS ACHIEVED GOOD ORAL HYGIENE, PERIODONTAL CASE TYPE 1 OR 2, AND IS MOTIVATED TO MAINTAIN SAME.
PD03	PLEASE PROVIDE AN ARTERIAL BLOOD GAS READING OR PULSE OXIMETRY RESULTS DONE ON ROOM AIR SIGNED AND DATED BY A MEDICAL DOCTOR. THIS SHOULD BE DONE WITHIN 60 DAYS OF REQUESTED SERVICE.
PD04	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 30 DAYS OF RECEIPT BY COLORADO MEDICAID.
PD07	SUBMIT A PHOTOCOPY OF A VALID PRESCRIPTION, ISSUED WITHIN THE PAST YEAR, OR COMPLETE SECTION B OF THE PRIOR AUTHORIZATION/DRUG ATTACHMENT (PA/DGA), F-11049.
PD10	BRAND MEDICALLY NECESSARY MUST BE IN THE PRESCRIBERS OWN HANDWRITING AND WRITTEN DIRECTLY ON THE PRESCRIPTION OR A SEPARATE ORDER ATTACHED TO THE ORIGINAL PRESCRIPTION.
PD12	COMPLETE DENTURES, PARTIAL DENTURES, DENTURE RELINES, AND FIXED PROSTHODONTIC SERVICES ARE NOT COVERED SERVICES FOR ADULTS FOR DATES OF SERVICE ON AND AFTER OCTOBER 1, 1995.
PD22	PLEASE COMPLETE ALL REQUIRED ELEMENTS ON THE PERSONAL CARE SCREENING TOOL (PCST), F-11133.
PD24	THIS PRIOR AUTHORIZATION REQUEST IS UNABLE TO BE PROCESSED. PLEASE RESUBMIT WITH ADDITIONAL REQUIRED FORMS, INCLUDING THE ENTIRE PERSONAL CARE SCREENING TOOL (PCST), F-11133; PERSONAL CARE ADDENDUM, F-11136; AND SUPPORTING DOCUMENTATION, AS DIRECTED.

Denial Code	Long Description
PD25	THERE IS A PERSONAL CARE SCREENING TOOL (PCST), F-11133, COMPLETED BY ANOTHER AGENCY. CONTACT THE AGENCY TO TRANSFER SCREEN.
PD26	THERE IS A LIMITED TERM CARE FUNCTIONAL SCREEN (LTC-FS) COMPLETED BY ANOTHER AGENCY. THE PERSONAL CARE SCREENING TOOL (PCST), F-11133, INFORMATION IS IN CONFLICT WITH LTC-FS.
PD27	ONLY ONE LEVEL OF FUNCTION MAY BE SELECTED FOR ALL ELEMENTS EXCEPT TOILETING. COLORADO MEDICAID IS UNABLE TO PROCESS THE PRIOR AUTHORIZATION REQUEST.
PD28	NO UNITS MAY BE REQUESTED USING THIS PRIOR AUTHORIZATION PROCESS. PLEASE SUBMIT WITH THE APPROPRIATE ATTACHMENTS FOR REQUESTING SPECIFIC PERSONAL CARE WORKER UNITS.
PD29	CLIENT IS NOT ELIGIBLE FOR THE REQUESTED SERVICE(S) AS OF THE REQUESTED START DATE.
PD30	NO TRAVEL TIME MAY BE AUTHORIZED WHEN NO PERSONAL CARE WORKER SERVICE IS AUTHORIZED.
PD32	PROVIDER NOT CERTIFIED TO RENDER THE SERVICE(S) REQUESTED.
PD34	BASED ON THE DOCUMENTATION SUBMITTED, THIS REQUEST CAN NOT BE PRIOR AUTHORIZED. REFER TO THE PA MESSAGES FROM THE CONSULTANT FOR COMPLETE EXPLANATION.
PD98	PLEASE DOCUMENT HOW AND WHEN EACH PREVIOUSLY AUTHORIZED PRO RE NATA VISIT WAS USED.

Complex Rehabilitation Technology (CRT)

Denial Code	Long Description
0201	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
0233	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0235	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0237	CLIENT IDENTIFICATION NUMBER DOES NOT MATCH CLIENTS FIRST NAME.
0238	THE CLIENT IDENTIFICATION NUMBER DOES NOT MATCH THE CLIENTS LAST NAME.
0242	SECONDARY DIAGNOSIS CODE IS INVALID.
0248	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0249	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0251	PROCEDURE CODE MODIFIER IN FIRST POSITION IS INVALID.
0252	THE PROCEDURE CODE MODIFIER IN SECOND POSITION IS INVALID FOR REQUESTED START DATE OR DATE OF RECEIPT.
0253	THE PROCEDURE CODE MODIFIER IN THIRD POSITION IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
0258	THE PRIMARY DIAGNOSIS CODE IS REQUIRED.
0272	THE PRIMARY DIAGNSOSIS CODE IS INVALID.
0400	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0853	HCPCS - ANNUAL UPDATE
0885	NEVER EVENTS MODIFIERS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
0886	NEVER EVENTS DIAGNOSIS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
1000	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
1002	RENDERING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1003	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1007	RENDERING PROVIDER ID IS NOT ON FILE.
1047	THE RENDERING PROVIDERS CERTIFICATION HAS BEEN CANCELLED.
1048	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1801	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
1804	A CERTIFIED SUBSTANCE ABUSE DAY TREATMENT PROVIDER MUST SUBMIT A SUBSTANCE ABUSE DAY TREATMENT PROCEDURE CODE.
1806	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
1808	THE BILLING PROVIDER DOES NOT HAVE THE REQUIRED CERTIFICATION ADDENDUM ON FILE.

Denial Code	Long Description
1900	THE BILLING PROVIDERS TAXONOMY CODE IS INVALID.
1901	THE RENDERING PROVIDERS TAXONOMY CODE IS INVALID.
1927	A NATIONAL PROVIDER IDENTIFIER IS REQUIRED FOR THE BILLING PROVIDER.
1934	A NATIONAL PROVIDER INDENTIFIER IS REQUIRED FOR THE RENDERING PROVIDER.
1936	THE BILLING PROVIDER NUMBER IS INVALID.
1937	THE RENDERING PROVIDER NUMBER IS INVALID.
1960	INTERNAL PROCESSING IS REQUIRED.
1963	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.
1964	THE BILLING PROVIDER INDICATED IS NOT ALLOWABLE AS A BILLING PROVIDER.
1965	RENDERING PROVIDER NUMBER IS MISSING/INVALID FOR THIS PROCEDURE PROVIDER.
1974	PRESCRIBING/REFERRING/ORDERING PROVIDER INDICATED IS NOT CERTIFIED AS A PRESCRIBING/REFERRING/ORDERING PROVIDER.
1975	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
1976	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
2001	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2003	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2017	THE CLIENT IS ENROLLED IN A MEDICAID OR OTHER MANAGED CARE PROGRAM.
2037	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2603	CLIENT LOCKED-IN TO A PROVIDER OR ENROLLED IN A HOSPICE. CONTACT CLIENTS HOSPICE FOR PAYMENT OF SERVICES OR RESUBMIT WITH DOCUMENTATION OF UNRELATED NATURE OF CARE.
3324	THE MODIFIER HAS BEEN DISCONTINUED BY THE CENTERS OF MEDICARE AND MEDICAID SERVICES OR THE AMERICAN MEDICAL ASSOCIATION FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
3337	THE PROCEDURE CODE HAS BEEN TERMINATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AMERICAN MEDICAL ASSOCIATION, OR AMERICAN DENTAL ASSOCIATION FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT. RESUBMIT WITH VALID A PROCEDURE CODE.
3339	THE PROCEDURE BILLED IS NOT PAYABLE ACCORDING TO DEFICIT REDUCTION ACT (DEFRA) GUIDELINES.
3351	THE PROCEDURE IS NOT COVERED FOR CLIENTS WITH A NURSING HOME AUTHORIZATION ON THE REQUESTED START DATE OR DATE OF RECEIPT.
3353	THE PROCEDURE IS NOT A COVERED SERVICE FOR HOME AND COMMUNITY-BASED WAIVER CLIENTS.
4021	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4027	THE DIAGNOSIS CODE IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
4031	THE PROCEDURE SUBMITTED IS NOT APPROPRIATE FOR CLIENTS GENDER.
4032	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4034	THE PROCEDURE CODE HAS AN AGE RESTRICTION.
4036	THE PLACE OF SERVICE CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4040	THE PRIMARY DIAGNOSIS CODE IS NOT ON FILE.
4041	THE SECONDARY DIAGNOSIS IS NOT ON FILE.
4046	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4127	INTERNAL PROCESSING IS REQUIRED.
4131	INTERNAL PROCESSING IS REQUIRED.
4141	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4149	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4150	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4236	ETIOLOGY DIAGNOSIS CODE(S) (E-CODES) ARE INVALID AS THE PRIMARY DIAGNOSIS.
4244	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4245	THE FOURTH POSITION MODIFIER IS INVALID FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT.
4256	THE PROCEDURE CODE AND MODIFIER COMBINATION IS NOT PAYABLE FOR THE CLIENTS BENEFIT PLAN.
4257	THE MODIFIERS SUBMITTED ARE EITHER INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT OR THE MODIFIERS ARE MISSING.
4311	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4315	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4316	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.

Denial Code	Long Description
4371	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4372	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4711	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR CLIENTS AGE.
4714	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS AGE.
4731	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS DIAGNOSIS.
4742	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4743	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4744	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4745	DIAGNOSIS AND/OR PROCEDURE AND/OR PLACE OF SERVICE (POS) CODE IS NOT COVERED FOR EXPRESS ENROLLMENT CLIENTS.
4746	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4801	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4802	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
4821	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
4871	PLEASE REFER TO PA MESSAGES FOR RETURN INFORMATION.
4963	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS GENDER.
4990	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
7500	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
7509	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
P001	THE BILLING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THE SERVICES.
P002	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P003	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P005	THE PRIOR AUTHORIZATION CAN NOT BE END DATED. THE PRIOR AUTHORIZATION STATUS IS NOT APPROVED OR APPROVED WITH REVISIONS.
P006	PLEASE FURNISH THE PROCEDURE CODE AND CORRESPONDING DESCRIPTION.
P008	THE BILLING PROVIDER NUMBER IS INVALID.
P009	THE BILLING PROVIDER NUMBER IS INVALID.
P010	THE REQUESTED END DATE IS INVALID.
P011	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P012	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P013	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P014	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P015	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P016	THE REQUESTED START DATE IS MISSING OR INVALID.
P019	THE REQUESTED START DATE IS MISSING OR INVALID.
P020	THE RENDERING PROVIDER NUMBER IS INVALID.
P021	THE RENDERING PROVIDER NUMBER IS INVALID.
P022	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P023	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P024	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P026	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P027	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P030	FIRST MODIFIER IS INVALID.
P031	FIRST MODIFIER IS INVALID.
P032	SECOND MODIFIER IS INVALID.
P033	SECOND MODIFIER IS INVALID.

Denial Code	Long Description
P034	THIRD MODIFIER IS INVALID.
P035	THIRD MODIFIER IS INVALID.
P036	FOURTH MODIFIER IS INVALID.
P037	FOURTH MODIFIER IS INVALID.
P038	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P039	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P040	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P041	CLIENTS FIRST NAME IS MISSING.
P042	CLIENTS LAST NAME IS MISSING.
P043	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P044	BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES REQUESTED.
P045	FIRST MODIFIER IS INVALID.
P046	SECOND MODIFIER IS INVALID.
P047	THIRD MODIFIER IS INVALID.
P048	FOURTH MODIFIER IS INVALID.
P052	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P053	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P054	RENDERING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES FOR THE BENEFIT PLAN.
P055	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P061	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P062	THE CLIENT ID AND/OR NAME INDICATED ON THE PA REQUEST IS INCORRECT. THE CLIENT ID AND/OR NAME HAS BEEN UPDATED. PLEASE VERIFY THE ID AND/OR NAME IS CORRECT.
P064	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
P067	THE FREQUENCY OF HOURS REQUESTED ARE NOT APPROPRIATE FOR THIS CLIENT AND HAVE BEEN MODIFIED ACCORDINGLY.
P079	BILLING PROVIDER IS ON PAYMENT SUSPENSION DUE TO CREDIBLE ALLEGATION OF FRAUD.
P120	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAS BEEN REDUCED.
P121	THE SERVICE/ PROCEDURE REQUESTED IS NOT SUPPORTED BY SUBMITTED DOCUMENTATION.
P126	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
P128	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.
P138	SERVICE(S) DO NOT MEET COLORADO MEDICAID GUIDELINES.
P167	REQUESTED DOCUMENTATION HAS NOT BEEN SUBMITTED.
P178	THE SERVICE REQUESTED IS NOT MEDICALLY NECESSARY.
P179	THE MEDICAL NECESSITY FOR THIS SERVICE IS NOT SUPPORTED BY THE SUBMITTED DOCUMENTATION.
P233	THE DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE ADDITIONAL CARE.
P257	THIS CLIENTS FUNCTIONAL ASSESSMENT SCORES PLACE THIS CLIENT OUTSIDE ELIGIBILITY FOR DAY TREATMENT.
P274	OUR RECORDS INDICATE THIS CLIENT IS INVOLVED IN EFFECTIVE AND APPROPRIATE SERVICE ELSEWHERE.
P292	INTENSIVE REHABILITATION HOURS ARE NO LONGER APPROPRIATE AS INDICATED BY HISTORY, DIAGNOSIS, AND/ OR FUNCTIONAL ASSESSMENT SCORES.
P328	THE SERVICES REQUESTED INCLUDE NON-COVERED SERVICES, AND HOURS ARE REDUCED ACCORDINGLY.
P339	THE CLIENTS PAST HISTORY INDICATES REDUCED TREATMENT HOURS ARE WARRANTED.
P342	THE REQUEST DOES NOT MEET GENERALLY ACCEPTED CONDITIONS REQUIRING FLUORIDE TREATMENTS.
P346	SERVICES EXCEED COLORADO MEDICAID LIMITATION AND DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE MEDICAL NECESSITY OF THE SERVICE.
P349	THE SERVICE REQUESTED WAS PERFORMED LESS THAN FIVE YEARS AGO.
P353	THE EXISTING APPLIANCE HAS NOT BEEN WORN FOR THREE YEARS.

Denial Code	Long Description
P367	THE CLIENT HAS BEEN TOTALLY WITHOUT TEETH AND AN APPLIANCE FOR FIVE YEARS.
P392	THE CLIENT IS MISSING AN ANTERIOR TOOTH AND/OR HAS TWO OR MORE POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P405	THE SERVICE(S) REQUESTED COULD ADEQUATELY BE PERFORMED IN THE DENTAL OFFICE.
P406	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE OF GOOD PERIODONTAL HEALTH (AMERICAN ACADEMY OF PERIODONTOLOGY PERIODONTAL CLASSIFICATION OF TYPE I OR II).
P407	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE VISIBLE ON RADIOGRAPHS THAT AT LEAST 50 PERCENT OF THE CLINICAL CROWN IS INTACT.
P409	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING SIX OR MORE TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED, INCLUDING THIRD MOLARS.
P410	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING ONE OR MORE ANTERIOR TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED.
P411	DOCUMENTATION DOES NOT SUPPORT THE NEED FOR PERIODONTIC SERVICES. POCKETS ARE LESS THAN 4MM AND/OR GREATER THAN 6MM FOR CLIENT AND/OR THE CLIENT IS UNDER THE AGE OF 13.
P412	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA.
P413	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA. THIS PA HAS BEEN GRANTED AS APPROVED NOT APPROVED WITH REVISIONS. THE DURATION REQUESTED MAY HAVE BEEN REDUCED TO REFLECT COVERAGE LIMITATIONS, PRESCRIBER ORDERS, CONFLICTI
P417	THE SERVICE(S) REQUESTED COULD BE ADEQUATELY PERFORMED WITH LOCAL ANESTHESIA.
P437	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO POOR ORAL HYGIENE.
P444	THIS LINE ITEM IS A DUPLICATE OF ANOTHER LINE ITEM ON THIS PRIOR AUTHORIZATION (PA) REQUEST. PLEASE CORRECT.
P446	THIS IS A DUPLICATE OF AN EXISTING PRIOR AUTHORIZATION (PA) REQUEST. YOU MAY CONTACT PROVIDER SERVICES IF YOU REQUIRE ASSISTANCE. DUPLICATE PA REQUEST
P448	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO DECAY HISTORY.
P449	QUESTIONABLE LONG TERM PROGNOSIS DUE TO GUM AND BONE DISEASE.
P456	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO APPARENT ROOT INFECTION.
P457	OUR RECORDS INDICATE THIS CLIENT HAS EXCEEDED ESTABLISHED PROGRAM LIMITATIONS. COLORADO MEDICAID WILL NOT AUTHORIZE NEW DENTURES.
P458	DOCUMENTATION PROVIDED INDICATES A LESS ELABORATE PROCEDURE SHOULD BE CONSIDERED.
P502	RENTAL ONLY ALLOWED; MEDICAL NEED FOR PURCHASE HAS NOT BEEN DOCUMENTED.
P503	PURCHASE ONLY ALLOWED; MEDICAL NEED FOR RENTAL HAS NOT BEEN DOCUMENTED.
P504	OCCUPATIONAL THERAPY GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P505	THE SERVICE REQUESTED IS INCLUDED IN THE NURSING HOME RATE STRUCTURE.
P511	THIS NATIONAL DRUG CODE IS ONLY BILLABLE AS PART OF A COMPOUND DRUG.
P515	THE PRESENCE OF A HANDICAPPING MALOCCLUSION OR HANDICAPPING DENTOFACIAL DEFORMITY IS NOT SUPPORTED BY THE DOCUMENTATION SUBMITTED.
P521	THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVERED BY COLORADO MEDICAID.
P522	GASTRO-INTESTINAL SURGERY FOR THE PURPOSE OF WEIGHT CONTROL IS COVERED ONLY AS A LIFE THREATENING PROCEDURE.
P523	THE TREATMENT REQUEST IS NOT CONSISTENT WITH THE CLIENT'S DIAGNOSIS.
P524	PSYCHOTHERAPY PROVIDED IN THE CLIENTS HOME IS NOT A COVERED BENEFIT OF COLORADO MEDICAID .
P525	THE INFORMATION PROVIDED IS NOT CONSISTENT WITH THE INTENSITY OF SERVICES REQUESTED.
P526	INTENSIVE MULTIPLE MODALITY TREATMENT IS NOT CONSISTENT WITH THE INFORMATION PROVIDED.
P527	MULTIPLE PROVIDERS OF TREATMENT ARE NOT INDICATED FOR THIS CLIENT.
P528	THE DURATION OF TREATMENT SESSIONS EXCEED CURRENT COLORADO MEDICAID GUIDELINES.
P534	DOCUMENTATION OF POOR PHYSICAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P535	OTHER PHYSICAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P536	THE PHYSICAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.

Denial Code	Long Description
P537	USE OF PHYSICAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P538	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF A PHYSICAL THERAPIST.
P539	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS AND LIVING ARRANGEMENT.
P540	GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P541	THE PROCEDURE(S) REQUESTED ARE NOT MEDICAL IN NATURE.
P542	DOCUMENTATION OF POOR OCCUPATIONAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P543	DOCUMENTATION OF POOR SPEECH THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P544	OTHER OCCUPATIONAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P546	THE OCCUPATIONAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P547	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF PHYSICAL THERAPY.
P548	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P549	ACTIVITIES TO PROMOTE DIVERSION OR GENERAL MOTIVATION ARE NONCOVERED COLORADO MEDICAID SERVICES.
P550	REVISIONS OF THE REQUEST IS NECESSITATED BY THE CLIENTS MINIMAL PROGRESS.
P551	RESTORATIVE NURSING INVOLVEMENT COULD BE INCREASED.
P552	CLIENTS DEMONSTRATED RESPONSE TO CURRENT THERAPY DOES NOT WARRANT THE INTENSE FREQUENCY REQUESTED.
P553	MAINTENANCE IS TWO TIMES PER WEEK OR LESS.
P554	THE SPEECH THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P555	USE OF OCCUPATIONAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P556	USE OF SPEECH THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P557	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF AN OCCUPATIONAL THERAPIST.
P558	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
P559	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P560	THE MATERIALS/ SERVICES REQUESTED ARE PRINCIPALLY COSMETIC IN NATURE.
P561	THE LENS FORMULA DOES NOT JUSTIFY REPLACEMENT.
P562	THE CHANGE IN THE LENS FORMULA DOES NOT WARRANT MULTIPLE REPLACEMENTS.
P563	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P564	LENSES ONLY ARE APPROVED; PLEASE DISPENSE A CONTRACTED FRAME. THE NON-CONTRACTED FRAME IS NOT MEDICALLY JUSTIFIED.
P565	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P566	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P567	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF OCCUPATIONAL THERAPY.
P568	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF SPEECH THERAPY.
P569	LEVEL, INTENSITY, OR EXTENT OF SERVICE(S) REQUESTED HAS BEEN MODIFIED CONSISTENT WITH MEDICAL NEED AS DEFINED IN THE PLAN OF CARE.
P570	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P571	THE SERVICE ASKED FOR IS NOT COVERED BY COLORADO MEDICAID AS THESE TASKS CAN BE DONE BY NURSES OR ACTIVITY STAFF.
P572	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.

Denial Code	Long Description
P573	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.
P574	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P575	MEDICAL NEED FOR EQUIPMENT/ SUPPLY REQUESTED IS NOT SUPPORTED BY DOCUMENTATION SUBMITTED.
P576	OTHER SPEECH THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P577	DOCUMENTATION SUBMITTED IDENTIFIES THAT THE CLIENT HAS FEWER THAN TWO POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P582	LESS EXPENSIVE ALTERNATIVE SERVICES ARE AVAILABLE FOR THIS CLIENT.
P634	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P711	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING PERIODONTAL SCALING AND ROOT PLANNING.
P712	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING GINGIVECTOMY.
P754	AN APPROVED SUBSTANCE ABUSE DAY TREATMENT PROGRAM CANNOT EXCEED A SIX WEEK PERIOD.
P761	THE CLIENT DOES NOT APPEAR TO BE ABLE OR WILLING TO ABSTAIN FROM ALCOHOL/DRUG USAGE WHILE IN TREATMENT. THEREFORE, SUBSTANCE ABUSE DAY TREATMENT SERVICES ARE NOT APPROVED.
P764	THIS CLIENT HAS COMPLETED INTENSIVE SUBSTANCE ABUSE TREATMENT WITHIN THE PAST 12 MONTHS. THE DOCUMENTATION PROVIDED IS NOT ADEQUATE TO JUSTIFY ADDITIONAL INTENSIVE TREATMENT AT THIS TIME.
P785	A LESS THAN SIX-WEEK HEALING PERIOD HAS BEEN SPECIFIED FOR THIS PRIOR AUTHORIZATION. THEREFORE IT IS NOT NECESSARY TO WAIT THE FULL SIX WEEKS AFTER EXTRACTIONS BEFORE TAKING DENTURE IMPRESSIONS.
P818	SIX-WEEK HEALING TIME IS REQUIRED BETWEEN EDENTULATION AND FINAL IMPRESSIONS. PAYMENT FOR DENTURES WILL BE DENIED OR RECOUPED IF HEALING PERIOD IS NOT OBSERVED.
P849	COLORADO MEDICAID HAS DETERMINED THERE WERE (ARE) SEVERAL HOME HEALTH AGENCIES WILLING TO PROVIDE MEDICALLY NECESSARY SKILLED NURSING SERVICES TO THIS CLIENT.
P864	THE DOCUMENTATION YOU HAVE SUBMITTED DOES NOT MEET THE REQUIREMENTS OF COLORADO MEDICAID.
P873	THE MEDICAL NECESSITY FOR THE HOURS REQUESTED IS NOT SUPPORTED BY THE INFORMATION SUBMITTED.
P874	THE DOCUMENTATION SUBMITTED INDICATES THE TASKS SPECIFIED CAN BE COMPLETED DURING THE VISITS APPROVED.
P878	THE DOCUMENTATION SUBMITTED DOES NOT INDICATE THAT MEDICALLY ORIENTED TASKS ARE MEDICALLY NECESSARY; THEREFORE PERSONAL CARE SERVICES HAVE BEEN APPROVED.
P880	THE QUANTITY OF SERVICES AUTHORIZED FOR THIS CLIENTS PERSONAL CARE HAS BEEN AMENDED BASED ON INFORMATION RECEIVED FROM ONE OR MORE OF THESE SOURCES: THE CLIENT, THEIR PHYSICIAN, AND/OR THE IN-HOME VISIT BY STAFF OF THE OIG (OFFICE OF INSPECTOR GENERAL).
P885	THE USE OF THIS DRUG FOR THE INTENDED PURPOSE IS NOT COVERED BY COLORADO MEDICAID, CONSISTENT WITH COLORADO ADMINISTRATIVE CODE AND FEDERAL LAW.
P924	THE MEDICAL RECORDS SUBMITTED WITH THE CURRENT REQUEST CONFLICT OR DISAGREE WITH OUR MEDICAL RECORDS ON THIS CLIENT.
P950	INDEPENDENT NURSES, PLEASE NOTE PAYABLE SERVICES MAY NOT EXCEED 12 HOURS/DAY OR 60 HOURS/WEEK.
P951	SERVICES CAN ONLY BE AUTHORIZED THROUGH ONE YEAR FROM THE PRESCRIPTION DATE.
P952	LEAD INSPECTION IS A COVERED COLORADO MEDICAID SERVICE WHEN THE CHILD HAS BEEN SHOWN TO HAVE LEAD POISONING (E.G., CHILD HAS A BLOOD LEAD LEVEL > 19 UG/DL OR TWO CONSECUTIVE BLOOD LEAD LEVELS OF 15-19 UG/DL DONE AT LEAST 90 DAYS APART). THE INSPECTION MUS
P953	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P954	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P956	THE REQUEST CAN ONLY BE BACKDATED A MAXIMUM OF 14 DAYS FROM FIRST DATE RECEIVED BY COLORADO MEDICAID.

Denial Code	Long Description
P957	COMPLETE PERIODONTAL CHARTING AT TIME OF SERVICE, AND SUBMIT CHARTING, COPY OF OPERATIVE REPORT, TOGETHER WITH A COPY OF THE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF), F-11035, TO PA UNIT ATTENTION DENTAL CONTSULTANT.
P958	NOTE THAT CODE D4341 HAS BEEN CHANGED. REFER TO THE DECISION NOTICE FOR AUTHORIZED QUANTITY.
P960	YOUR PA HAS BEEN APPROVED FOR 90 DAYS. THE 90 DAY APPROVAL DOES NOT IMPLY THE PA REQUEST MEETS PRIOR AUTHORIZATION CRITERIA. AFTER ADDITIONAL INFORMATION IS AVAILABLE IN INTERCHANGE, COLORADO MEDICAID WILL CREATE AN AMENDMENT REQUEST TO EXTEND THE PA FOR
P961	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P962	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
PA10	THE REQUESTED END DATE IS INVALID.
PA12	PLEASE FURNISH A WRITTEN DESCRIPTION OF THE CLIENTS DIAGNOSIS.
PA13	PROVIDE DIAGNOSES WITH DATES OF ONSET.
PA14	IDENTIFY PROBLEMS TO BE TREATED.
PA15	THE AUDIOLOGISTS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1), F-11020, AND PRIOR AUTHORIZATION REQUEST/HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2), F-11021.
PA16	THE PHYSICIANS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION/PHYSICIAN OTOLOGICAL REPORT (PA/POR), F-11019.
PA17	SUBMIT BRIEF HISTORY WITH REFERRAL INFORMATION, LIVING SITUATION, FUNCTIONAL STATUS, AND OTHER PERTINENT INFORMATION. WHAT CHANGE OF STATUS RESULTED IN REFERRAL AT THIS TIME?
PA18	PLEASE FURNISH THE CLIENTS HEIGHT AND WEIGHT.
PA19	PLEASE SUBMIT CLINICAL INFORMATION SUFFICIENT TO VERIFY THE NEED FOR THE REQUESTED SERVICE(S).
PA20	PLEASE RESUBMIT WITH COMPLETE PERIODONTAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PA21	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL EDUCATIONAL PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA22	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL PROGRAM PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA23	REFER TO THE DURABLE MEDICAL EQUIPMENT INDEX FOR APPROPRIATE CODE AND DESCRIPTION. DO NOT USE AN "UNLISTED" CODE.
PA24	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUALIZED FAMILY SERVICE PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA25	INFORMATION ON THE REQUEST FORM IS ILLEGIBLE, AND THE REQUEST CANNOT BE PROCESSED.
PA26	RE-EVALUATE YOUR GOALS. EMPHASIS SHOULD BE ON FUNCTIONAL SELF-CARE. GOALS MUST BE RELATED TO FUNCTIONAL OUTCOME.
PA27	PLEASE CLARIFY THE NUMBER OF HOURS PER WEEK REQUESTED.
PA28	PLEASE CLARIFY THE NUMBER OF HOURS PER DAY REQUESTED.
PA29	PLEASE CLARIFY THE NUMBER OF VISITS PER DAY REQUESTED.
PA30	ATTACH SUPPORTIVE DOCUMENTATION; HOME EXERCISE PROGRAM AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA31	THE DIAGNOSIS CODE INDICATED ON THE REQUEST DOES NOT CORRESPOND TO THE DIAGNOSIS CODE DESCRIPTION.
PA32	PLEASE SUBMIT ADDITIONAL INFORMATION SUFFICIENT TO VERIFY APPROPRIATENESS AND NEED FOR TRANSPLANT.
PA33	PLEASE SUBMIT THE INITIAL AND PROGRESSIVE OBJECTIVE FINDINGS.
PA34	ATTACH SUPPORTIVE DOCUMENTATION, FACILITY PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA35	PLEASE SUBMIT THE CLIENTS ORIGINAL COMPLAINTS AND EXAMINATION FINDINGS.

Denial Code	Long Description
PA36	ATTACH SUPPORTIVE DOCUMENTATION, IN-HOME AUTISM PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA37	PLEASE SUBMIT YOUR TREATMENT PLAN FOR THIS CLIENT.
PA38	ATTACH SUPPORTIVE DOCUMENTATION AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA39	INITIAL EVALUATIONS MUST BE PERFORMED BY AN OCCUPATIONAL THERAPIST REGISTERED (OTR), PER AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA) STANDARDS.
PA41	IDENTIFY THE PLACE OF SERVICE AND ITS EFFECT ON SUPPORTING THE DESIRED TREATMENT OUTCOME.
PA42	PLEASE INDICATE THE HOURS OF USE OF OXYGEN PER 24-HOUR PERIOD.
PA43	PROVIDE BASELINE DOCUMENTATION FOR THIS CLIENTS LIMITATIONS USING UNITS OF MEASUREMENT THAT ARE APPLIED CONSISTENTLY WHEN REPORTING STATUS.
PA44	IDENTIFY FUNCTIONAL LIMITATIONS AS THEY ARE RELATED TO IDENTIFIED CONDITIONS.
PA46	CORRELATE PLAN OF CARE TO REQUESTED PROCEDURE CODES.
PA47	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE FREQUENCY/DURATION REQUESTED.
PA48	PLEASE PROVIDE THE NAME AND CREDENTIALS OF THE RENDERING PROVIDER.
PA50	COLORADO MEDICAID RECORDS INDICATE THE CLIENT OWNS A WHEELCHAIR. DOCUMENT THE REASON AND NEED FOR REPLACEMENT AND COST TO REPAIR CURRENT WHEELCHAIR.
PA51	PLEASE DISTINGUISH PRIMARY AND SUPPORTIVE MODALITIES.
PA52	PLEASE SUBMIT A PROGRESS REPORT.
PA53	MULTIPLE FAMILY CLIENTS TREATMENT BY THE SAME PROVIDER REQUIRES FURTHER INFORMATION DOCUMENTING COORDINATION OF TREATMENT PLAN.
PA54	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE MINUTES REQUESTED.
PA55	MEDICAL NECESSITY OF TREATMENT REQUIRES ADDITIONAL DOCUMENTATION.
PA56	GIVEN AGE, DIAGNOSES, CURRENT LEVEL OF FUNCTION, PAST RESPONSE TO TREATMENT, AND LIVING SITUATION, EXPAND ON POTENTIAL FOR SIGNIFICANT FUNCTIONAL PROGRESS WITHIN THE NEXT SIX MONTHS. EMPHASIZE WHY PROGRESS IS EXPECTED WITH SERVICES AT THIS TIME.
PA57	SUBMIT THE INITIAL FINDINGS. INCLUDE A COMPREHENSIVE EVALUATION.
PA58	SUBMIT PROGRESSIVE, OBJECTIVE FINDINGS. INCLUDE A PERTINENT RE-EVALUATION.
PA59	PLEASE SUPPLY INFORMATION REGARDING THE CLIENTS MEDICATION REQUIREMENTS, IF ANY.
PA60	PLEASE SPECIFY IF THE CLIENT IS IN AN EDUCATIONAL SETTING.
PA61	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA62	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
PA63	THE SKILLS OF A THERAPIST ARE PURPOSEFUL AND SKILLED INTERVENTIONS REQUIRED TO CONTINUALLY DESIGN, IMPLEMENT, REASSESS, MODIFY/GRADE, AND/OR DISCONTINUE A PLAN OF CARE IN A TIMELY MANNER, BASED ON THE COMPLEXITY OF THE CLIENTS MEDICAL CONDITION AND/OR CO
PA64	PLEASE SUBMIT A THERAPY PLAN OF CARE, INCLUDING A CURRENT, DATED EVALUATION.
PA65	A PLAN OF CARE SIGNED AND DATED BY THE PHYSICIAN IS REQUIRED.
PA66	THE SKILLS OF A THERAPIST ARE REQUIRED WHEN ONLY THE THERAPIST CAN SAFELY AND EFFECTIVELY DELIVER THE THERAPEUTIC PROCEDURES BECAUSE OF THEIR UNIQUE KNOWLEDGE, TRAINING, AND EXPERTISE. DESCRIBE THE REASON THAT SOMEONE OTHER THAN A THERAPIST CANNOT SAFELY
PA67	PLEASE SPECIFY IF THE CLIENTS WORK SITE DEMANDS GOOD BINAURAL HEARING.
PA68	DESCRIBE THE REASON, BASED ON THE CLIENTS COGNITIVE, PHYSICAL, COMMUNICATION, OR RESOURCE STATUS, THAT A HOME PROGRAM, EQUIPMENT, OR ENVIRONMENTAL ADAPTATIONS ALONE CANNOT MEET CLIENTS NEEDS.
PA69	PLEASE SPECIFY IF THE CLIENT HAS AN ACCOMPANYING DISABILITY THAT ADDS TO THE HEARING PROBLEM.
PA70	DISTINGUISH REQUESTED PROCEDURES AND GOALS FROM OTHER SERVICES THIS CLIENT RECEIVES. THEY MAY NOT BE DUPLICATIVE.
PA71	PLEASE INDICATE THE NUMBER OF DAYS REQUESTED.

Denial Code	Long Description
PA73	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA74	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA75	PLEASE DOCUMENT CARRYOVER OF THE THERAPY PROGRAM TO NURSING.
PA76	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA79	PROVIDE EVIDENCE OF SIGNIFICANT FUNCTIONAL PROGRESS IN LAST SIX MONTHS.
PA84	THE GRANT DATE OF THIS REQUEST CANNOT BE PRIOR TO THE SIGNATURE DATE OF THE PRESCRIBING PHYSICIAN.
PA86	PROVIDE EVIDENCE OF SKILLS GAINED IN THERAPY CARRYING OVER TO OTHER SETTINGS WITHIN SIX MONTHS.
PA87	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE NUMBER OF SESSIONS REQUESTED.
PA88	THE REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL SCOPE OF PRACTICE.
PA89	PRIOR AUTHORIZATION IS NOT REQUIRED UNTIL LIMITATION OF SERVICE HAS BEEN REACHED.
PA91	PLEASE SUBMIT REQUIRED X-RAYS.
PA92	PLEASE PROVIDE AN EXPLANATION FOR THE MATERIAL SUBMITTED WITH THE REQUEST.
PA95	PLEASE DESCRIBE HOW THE PROVISION OF THIS SERVICE WOULD PREVENT INSTITUTIONALIZATION OF THE CLIENT.
PA96	COULD THE EXISTING DENTURE(S) BE RELINED OR REBASED? IF NOT, PLEASE EXPLAIN WHY NOT.
PA97	REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL STANDARDS OF PRACTICE.
PA98	PLEASE INDICATE IF THE CLIENT IS CURRENTLY BEING TUBE FED.
PB02	PLEASE PROVIDE THE REQUIRED DATED SIGNATURES ON THE ATTACHMENTS.
PB03	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING THE LOSS/DESTRUCTION/THEFT OF THE HEARING AID.
PB04	DESCRIBE THE CLIENTS ABILITY TO STAND OR AMBULATE SUFFICIENTLY TO ACCOMPLISH SELF-CARE ACTIVITIES.
PB07	PLEASE SUBMIT AN ORTHODONTIC STUDY MODEL OR DIAGNOSTIC CASTS.
PB09	PLEASE PROVIDE A PHOTOGRAPH OF THE INVOLVED AREA(S).
PB10	PLEASE PROVIDE AN ESTIMATION (IN GRAMS) OF THE TOTAL AMOUNT OF TISSUE TO BE RESECTED.
PB11	PLEASE SUBMIT THE PLAN OF CARE FOR CO-TREATMENT.
PB12	FURNISH A DETAILED DESCRIPTION FOR THE PROCEDURE CODE REQUESTED.
PB13	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB15	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB18	PLEASE COMPLETE THE ATTACHED OUT-OF-STATE PROVIDER DATA SHEET, F-11001, AND RESUBMIT.
PB20	A SIGNED AND DATED PRESCRIPTION IS REQUIRED WITHIN THREE MONTHS OF RECEIPT BY COLORADO MEDICAID FOR INITIAL REQUESTS AND WITHIN 12 MONTHS OF RECEIPT BY COLORADO MEDICAID FOR SUBSEQUENT REQUESTS.
PB21	PLEASE COMPLETE THE APPROPRIATE PRIOR AUTHORIZATION ATTACHMENT. CONTACT PROVIDER SERVICES OR THE PRIOR AUTHORIZATION UNIT FOR ASSISTANCE.
PB23	PHYSICAL THERAPY ASSISTANT NOTES AND ALL FORMS SUBMITTED MUST BE COSIGNED BY A REGISTERED PHYSICAL THERAPIST.
PB31	ARE YOU REQUESTING A COMPLETE APPLIANCE, OR REPLACEMENT PARTS?
PB32	THE PROCEDURE CODE INDICATED ON THE REQUEST DOES NOT MATCH THE DESCRIPTION OF SERVICE; PLEASE CORRECT AND RESUBMIT.
PB35	THE SERVICE REQUESTED DOES NOT REQUIRE PRIOR AUTHORIZATION.
PB41	PLEASE FURNISH A CURRENT MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT, F-11090 (DATED WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID).
PB45	THE CERTIFICATION PERIOD ON THE PLAN OF CARE (POC) DOES NOT COVER THE REQUESTED GRANT/START DATE. PLEASE RESUBMIT YOUR REQUEST WITH A NEW POC.
PB49	A CERTIFIED OCCUPATIONAL THERAPY ASSISTANTS NOTES MUST BE COSIGNED BY AN OCCUPATIONAL THERAPIST REGISTERED.
PB51	ADDITIONAL INFORMATION IS REQUIRED ON PRIOR AUTHORIZATION TO ENABLE PRICING.

Denial Code	Long Description
PB54	REQUESTED SERVICES DO NOT MATCH SERVICES ON THE PHYSICIANS ORDERS.
PB59	PLEASE PROVIDE AN INDIVIDUAL EDUCATIONAL PLAN (IEP), WHICH HAS BEEN SIGNED BY THE PROVIDER NO EARLIER THAN NINE MONTHS PRIOR TO RECEIPT AT COLORADO MEDICAID; OTHERWISE, DOCUMENT WHY NO IEP EXISTS.
PB65	PLEASE FURNISH THE ANTICIPATED TOTAL CHARGES FOR THIS REQUEST.
PB66	A PHOTOCOPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED; THE DATE MUST BE WITHIN SIX MONTHS OF RECEIPT BY COLORADO MEDICAID.
PB67	THE PRESCRIPTION DATE MUST INCLUDE MONTH, DAY, AND YEAR.
PB68	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID.
PB73	THE SERVICES IDENTIFIED ON THE PLAN OF CARE DO NOT APPEAR APPROPRIATE FOR THE PROCEDURE CODE(S) REQUESTED ON THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018.
PB74	THE CLIENT/PROVIDER DOES NOT HAVE RETROACTIVE ENROLLMENT.
PB75	THE REQUESTED START DATE IS MORE THAN 14 DAYS BEFORE OR 62 DAYS AFTER RECEIPT.
PB82	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
PB83	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A HOME HEALTH AIDE. PLEASE RESUBMIT AS A PERSONAL CARE WORKER OR PROVIDE ADDITIONAL DOCUMENTATION.
PB86	THE SERVICES REQUESTED ARE NOT BEING PROVIDED IN THE CLIENTS RESIDENCE. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL.
PB87	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A NURSE. PLEASE RESUBMIT AS A HOME HEALTH AIDE OR PROVIDE ADDITIONAL DOCUMENTATION.
PB92	PLEASE FURNISH THE CLIENTS COMPLETE ADDRESS.
PB94	IF THE CLIENT IS A RESIDENT OF A NURSING HOME, SUPPLY THE COMPLETE NAME AND ADDRESS OF THE NURSING HOME.
PB99	THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018, MUST BE SIGNED AND DATED.
PC01	PLEASE SUPPLY THE RENDERING PROVIDERS PROVIDER NUMBER.
PC03	THE DRUG ENFORCEMENT ADMINISTRATION NUMBER IS MISSING OR INVALID.
PC06	PLEASE DESCRIBE YOUR PROGRAM; INCLUDE ENTRY DATE, TERMINATION DATE, HOURS PER WEEK, AND NUMBER OF WEEKS OF PRIMARY INTENSIVE SERVICE REQUESTED.
PC07	PLEASE DESCRIBE YOUR "AFTERCARE/FOLLOW-UP" PLANS FOR THIS CLIENT.
PC08	PLEASE SUPPLY DOCUMENTATION OF PREVIOUS SUBSTANCE ABUSE SERVICES WITH DATE(S) AND OUTCOME.
PC09	PLEASE DESCRIBE IN DETAIL THE TREATMENT OBJECTIVES/GOALS FOR THIS CLIENT.
PC10	PLEASE DESCRIBE THE FAMILY SITUATION/DYNAMICS. EXPLAIN HOW THE FAMILY WILL BE INCORPORATED INTO THE CLIENTS PLAN OF CARE.
PC12	PLEASE EXPLAIN IF YOUR SERVICE ENCOURAGES THE CLIENT TO ATTEND SELF-HELP GROUPS.
PC13	PLEASE SUPPLY A SPECIFIC SCHEDULE OF ACTIVITIES, INCLUDING DAY, TIME OF DAY, LENGTH OF SESSION, AND SERVICE TO BE RENDERED DURING THAT TIME.
PC15	PLEASE FURNISH DIAGNOSTIC RATIONALE.
PC17	PLEASE DOCUMENT IF THE CLIENT EVER RECEIVED SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT.
PC19	PLEASE FURNISH MORE EXTENSIVE AND IN-DEPTH HISTORICAL AND PSYCHOSOCIAL DATA.
PC20	PLEASE SUPPLY THE DATE THE CLIENT BECAME TOTALLY ENDENTULOUS.
PC23	PLEASE SUBMIT A PHYSICIANS STATEMENT REGARDING THE MEDICAL NECESSITY OF DENTURES FOR THIS CLIENT. THE PHYSICIANS STATEMENT MUST DOCUMENT THE MEDICAL NEED FOR DENTURES.
PC24	THE SERVICE REQUESTED WAS PREVIOUSLY AUTHORIZED. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT INDICATING THIS FACT IS REQUIRED.
PC25	PLEASE SUPPLY SUFFICIENT MITIGATING CIRCUMSTANCES TO WARRANT THE CONSTRUCTION OF NEW DENTURES(S).
PC26	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
PC28	PLEASE SUBMIT A PHYSICIANS STATEMENT INDICATING DENTURES ARE NECESSARY FOR THIS NURSING HOME CLIENT.

Denial Code	Long Description
PC29	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING LOSS OR DESTRUCTION OF DENTURE(S). INCLUDE SIGNED STATEMENT FROM CLIENT OR FACILITY DIRECTOR REGARDING HOW, WHEN AND WHERE LOST.
PC30	PLEASE PROVIDE COMPLETE INTRAORAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PC31	PLEASE DESCRIBE ANY RELATED DEFORMITIES OF THE FEET.
PC34	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD WITH REQUESTED DME ITEM(S) AND DOCUMENT IF THE CLIENT CAN USE SAFELY AND INDEPENDENTLY.
PC35	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD AND DESCRIBE THE RESULTS AND EFFECTIVENESS OF THE SERVICE REQUESTED.
PC39	PLEASE INDICATE LITER FLOW PER MINUTE, HOURS OF USE PER 24 HOUR PERIOD, AND THE EXPECTED DURATION OF NEED.
PC40	THE ITEM DOES NOT REQUIRE PRIOR AUTHORIZATION UNTIL THE LIFE EXPECTANCY HAS BEEN REACHED.
PC41	PLEASE SUPPLY INFORMATION INDICATING THE NECESSITY OF POSITIONING THE CLIENT'S BODY IN MULTIPLE POSITIONS.
PC42	PLEASE INDICATE IF THE BED HEIGHT MUST BE CHANGED TO ALLOW FOR SAFE TRANSFER OR ADEQUATE BED CARE.
PC43	SUPPLY A PHYSICIANS STATEMENT INDICATING TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR UNIT HAS REDUCED PAIN, IMPROVED/INCREASED THE CLIENTS ACTIVITY LEVEL, AND/OR REDUCED CLIENTS USE OF PAIN MEDICATION.
PC44	A CURRENT AUTHORIZATION FOR THIS SERVICE IS ON FILE FOR ANOTHER PROVIDER. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT OF THAT FACT IS REQUIRED BY THE CLIENT OF FIRST PROVIDER.
PC59	DOCUMENT DECLINE OR PROGRESS IN SPECIFIC, MEASURABLE, OBJECTIVE TERMS.
PC60	DOCUMENT IF CLIENT HAS DEMONSTRATED A GOOD APPOINTMENT COMPLIANCE RECORD.
PC61	THE PHYSICIANS SIGNATURE DATE MUST NOT EXCEED 90 DAYS FROM THE DATE OF RECEIPT BY COLORADO MEDICAID.
PC62	REQUESTS FOR A CONTINUATION OF THERAPY SHOULD NOT BE SUBMITTED MORE THAN FOUR WEEKS PRIOR TO THE EXPIRATION DATE OF THE CURRENT AUTHORIZATION.
PC63	PLEASE FURNISH THE STYLE AND MANUFACTURER OF THE FRAME.
PC64	PLEASE FURNISH THE CLIENTS LENS FORMULA.
PC66	ALL REQUESTS FOR TINTS REQUIRE DOCUMENTATION OF THE VISUAL OR MEDICAL CONDITION RELATED TO PHOTOPHOBIA.
PC67	PLEASE DOCUMENT THE REASON AND JUSTIFICATION FOR REPLACEMENT BEYOND THE FIRST LENS/FRAME.
PC68	DOCUMENT IF ALL REMAINING MAXILLARY AND/OR MANDIBULAR TEETH ARE DECAY-FREE, PROPERLY RESTORED, AND PERIODONTICALLY SOUND.
PC72	SUPPLY MORE DETAIL REGARDING PROGRESS (ATTACHMENT OF GOALS, ETC.). CORRELATE PROGRESS TO PREVIOUS GOALS AND IDENTIFIED LIMITATIONS.
PC77	PLEASE SUBMIT A PLAN OF CARE DESCRIBING THE SERVICES THAT WOULD BE PROVIDED.
PC78	PLEASE DOCUMENT SPECIFIC, MEASURABLE GOALS.
PC82	THE PRIOR AUTHORIZATION (PA) SYSTEM CAN PROCESS ONLY 26 DETAILS PER PA REQUEST. PLEASE RESUBMIT YOUR REQUEST WITH NO MORE THAN 26 DETAILS.
PC83	PLEASE SUPPLY A PHYSICIANS PRESCRIPTION DATED WITHIN ONE MONTH OF REQUESTED SUBSTANCE ABUSE DAY TREATMENT.
PC84	PLEASE PROVIDE INFORMATION INDICATING THIS CLIENT IS APPROPRIATELY DETOXIFIED FROM ALCOHOL AND/OR OTHER DRUGS.
PC85	PLEASE PROVIDE INFORMATION TO INDICATE THE CLIENTS ABILITY TO ABSTAIN FROM ALCOHOL OR DRUGS WHILE IN THE SUBSTANCE ABUSE DAY TREATMENT PROGRAM.
PC86	PLEASE INDICATE IF THIS CLIENT IS WILLING TO PARTICIPATE IN AFTERCARE OR CONTINUING CARE SERVICES.
PC87	PROVIDE MORE INFORMATION ON TREATMENT HISTORY; INCLUDE SERVICE PROVIDED, DATES, AND OUTCOME. PROVIDE DETAIL OF PREVIOUS TREATMENT.
PC88	PLEASE PROVIDE MORE RATIONALE FOR THE APPROPRIATENESS AND MEDICAL NECESSITY OF SUBSTANCE ABUSE DAY TREATMENT.

Denial Code	Long Description
PC89	PROVIDE A TREATMENT PLAN THAT CONTAINS MEASURABLE GOALS AND OBJECTIVES CORRESPONDING TO THE IDENTIFIED DEFICIT.
PC91	PLEASE PROVIDE MORE INFORMATION ON FAMILY INVOLVEMENT TREATMENT.
PC92	PLEASE PROVIDE MORE HISTORY AND EXPLANATION ABOUT THE ISSUE OF ABSTINENCE FOR THIS CLIENT.
PC94	PLEASE PROVIDE THE ANTICIPATED BEGINNING DATE AND/OR THE ESTIMATED SUBSTANCE ABUSE DAY TREATMENT DISCHARGE DATE.
PC95	PLEASE SUPPLY JUSTIFICATION FOR BEGINNING CLIENT IN SERVICE PRIOR TO AUTHORIZATION BEING OBTAINED.
PC96	THE INITIAL THREE HOURS OF SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IN A CALENDAR YEAR DO NOT REQUIRE PRIOR AUTHORIZATION.
PC97	REIMBURSEMENT FOR INITIAL SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IS LIMITED TO THREE HOURS IN A CALENDAR YEAR AND DOES NOT REQUIRE PRIOR AUTHORIZATION.
PC98	THIS DRUG IS CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE BILL USING THE APPROPRIATE NATIONAL DRUG CODE (NDC) OR SUBMIT A COMPLETED DRUG ADDITION REQUEST FORM IF THE NDC IS NOT LISTED IN THE DRUG INDEX.
PC99	THIS DRUG IS NOT CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL, CURRENT ADMINISTRATIVE RULE, OR COLORADO DRUG INDEX FOR COVERAGE LIMITATIONS.
PD01	DOCUMENT THAT CLIENT HAS ACHIEVED GOOD ORAL HYGIENE, PERIODONTAL CASE TYPE 1 OR 2, AND IS MOTIVATED TO MAINTAIN SAME.
PD03	PLEASE PROVIDE AN ARTERIAL BLOOD GAS READING OR PULSE OXIMETRY RESULTS DONE ON ROOM AIR SIGNED AND DATED BY A MEDICAL DOCTOR. THIS SHOULD BE DONE WITHIN 60 DAYS OF REQUESTED SERVICE.
PD04	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 30 DAYS OF RECEIPT BY COLORADO MEDICAID.
PD07	SUBMIT A PHOTOCOPY OF A VALID PRESCRIPTION, ISSUED WITHIN THE PAST YEAR, OR COMPLETE SECTION B OF THE PRIOR AUTHORIZATION/DRUG ATTACHMENT (PA/DGA), F-11049.
PD10	BRAND MEDICALLY NECESSARY MUST BE IN THE PRESCRIBERS OWN HANDWRITING AND WRITTEN DIRECTLY ON THE PRESCRIPTION OR A SEPARATE ORDER ATTACHED TO THE ORIGINAL PRESCRIPTION.
PD12	COMPLETE DENTURES, PARTIAL DENTURES, DENTURE RELINES, AND FIXED PROSTHODONTIC SERVICES ARE NOT COVERED SERVICES FOR ADULTS FOR DATES OF SERVICE ON AND AFTER OCTOBER 1, 1995.
PD22	PLEASE COMPLETE ALL REQUIRED ELEMENTS ON THE PERSONAL CARE SCREENING TOOL (PCST), F-11133.
PD24	THIS PRIOR AUTHORIZATION REQUEST IS UNABLE TO BE PROCESSED. PLEASE RESUBMIT WITH ADDITIONAL REQUIRED FORMS, INCLUDING THE ENTIRE PERSONAL CARE SCREENING TOOL (PCST), F-11133; PERSONAL CARE ADDENDUM, F-11136; AND SUPPORTING DOCUMENTATION, AS DIRECTED.
PD25	THERE IS A PERSONAL CARE SCREENING TOOL (PCST), F-11133, COMPLETED BY ANOTHER AGENCY. CONTACT THE AGENCY TO TRANSFER SCREEN.
PD26	THERE IS A LIMITED TERM CARE FUNCTIONAL SCREEN (LTC-FS) COMPLETED BY ANOTHER AGENCY. THE PERSONAL CARE SCREENING TOOL (PCST), F-11133, INFORMATION IS IN CONFLICT WITH LTC-FS.
PD27	ONLY ONE LEVEL OF FUNCTION MAY BE SELECTED FOR ALL ELEMENTS EXCEPT TOILETING. COLORADO MEDICAID IS UNABLE TO PROCESS THE PRIOR AUTHORIZATION REQUEST.
PD28	NO UNITS MAY BE REQUESTED USING THIS PRIOR AUTHORIZATION PROCESS. PLEASE SUBMIT WITH THE APPROPRIATE ATTACHMENTS FOR REQUESTING SPECIFIC PERSONAL CARE WORKER UNITS.
PD29	CLIENT IS NOT ELIGIBLE FOR THE REQUESTED SERVICE(S) AS OF THE REQUESTED START DATE.
PD30	NO TRAVEL TIME MAY BE AUTHORIZED WHEN NO PERSONAL CARE WORKER SERVICE IS AUTHORIZED.
PD32	PROVIDER NOT CERTIFIED TO RENDER THE SERVICE(S) REQUESTED.
PD34	BASED ON THE DOCUMENTATION SUBMITTED, THIS REQUEST CAN NOT BE PRIOR AUTHORIZED. REFER TO THE PA MESSAGES FROM THE CONSULTANT FOR COMPLETE EXPLANATION.
PD98	PLEASE DOCUMENT HOW AND WHEN EACH PREVIOUSLY AUTHORIZED PRO RE NATA VISIT WAS USED.

Children With Autism (CWA)

Denial Code	Long Description
0201	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
0233	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0235	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0237	CLIENT IDENTIFICATION NUMBER DOES NOT MATCH CLIENTS FIRST NAME.
0238	THE CLIENT IDENTIFICATION NUMBER DOES NOT MATCH THE CLIENTS LAST NAME.
0242	SECONDARY DIAGNOSIS CODE IS INVALID.
0248	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0249	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0251	PROCEDURE CODE MODIFIER IN FIRST POSITION IS INVALID.
0252	THE PROCEDURE CODE MODIFIER IN SECOND POSITION IS INVALID FOR REQUESTED START DATE OR DATE OF RECEIPT.
0253	THE PROCEDURE CODE MODIFIER IN THIRD POSITION IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
0258	THE PRIMARY DIAGNOSIS CODE IS REQUIRED.
0272	THE PRIMARY DIAGNSOSIS CODE IS INVALID.
0400	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0853	HCPCS - ANNUAL UPDATE
0885	NEVER EVENTS MODIFIERS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
0886	NEVER EVENTS DIAGNOSIS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
1000	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
1002	RENDERING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1003	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1007	RENDERING PROVIDER ID IS NOT ON FILE.
1047	THE RENDERING PROVIDERS CERTIFICATION HAS BEEN CANCELLED.
1048	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1801	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
1804	A CERTIFIED SUBSTANCE ABUSE DAY TREATMENT PROVIDER MUST SUBMIT A SUBSTANCE ABUSE DAY TREATMENT PROCEDURE CODE.
1806	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
1808	THE BILLING PROVIDER DOES NOT HAVE THE REQUIRED CERTIFICATION ADDENDUM ON FILE.
1900	THE BILLING PROVIDERS TAXONOMY CODE IS INVALID.
1901	THE RENDERING PROVIDERS TAXONOMY CODE IS INVALID.
1927	A NATIONAL PROVIDER IDENTIFIER IS REQUIRED FOR THE BILLING PROVIDER.
1934	A NATIONAL PROVIDER INDENTIFIER IS REQUIRED FOR THE RENDERING PROVIDER.
1936	THE BILLING PROVIDER NUMBER IS INVALID.
1937	THE RENDERING PROVIDER NUMBER IS INVALID.
1960	INTERNAL PROCESSING IS REQUIRED.
1963	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.
1964	THE BILLING PROVIDER INDICATED IS NOT ALLOWABLE AS A BILLING PROVIDER.
1965	RENDERING PROVIDER NUMBER IS MISSING/INVALID FOR THIS PROCEDURE PROVIDER.
1974	PRESCRIBING/REFERRING/ORDERING PROVIDER INDICATED IS NOT CERTIFIED AS A PRESCRIBING/REFERRING/ORDERING PROVIDER.
1975	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
1976	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
2001	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2003	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2017	THE CLIENT IS ENROLLED IN A MEDICAID OR OTHER MANAGED CARE PROGRAM.

Denial Code	Long Description
2037	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2603	CLIENT LOCKED-IN TO A PROVIDER OR ENROLLED IN A HOSPICE. CONTACT CLIENTS HOSPICE FOR PAYMENT OF SERVICES OR RESUBMIT WITH DOCUMENTATION OF UNRELATED NATURE OF CARE.
3324	THE MODIFIER HAS BEEN DISCONTINUED BY THE CENTERS OF MEDICARE AND MEDICAID SERVICES OR THE AMERICAN MEDICAL ASSOCIATION FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
3337	THE PROCEDURE CODE HAS BEEN TERMINATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AMERICAN MEDICAL ASSOCIATION, OR AMERICAN DENTAL ASSOCIATION FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT. RESUBMIT WITH VALID A PROCEDURE CODE.
3339	THE PROCEDURE BILLED IS NOT PAYABLE ACCORDING TO DEFICIT REDUCTION ACT (DEFRA) GUIDELINES.
3351	THE PROCEDURE IS NOT COVERED FOR CLIENTS WITH A NURSING HOME AUTHORIZATION ON THE REQUESTED START DATE OR DATE OF RECEIPT.
3353	THE PROCEDURE IS NOT A COVERED SERVICE FOR HOME AND COMMUNITY-BASED WAIVER CLIENTS.
4021	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4027	THE DIAGNOSIS CODE IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
4031	THE PROCEDURE SUBMITTED IS NOT APPROPRIATE FOR CLIENTS GENDER.
4032	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4034	THE PROCEDURE CODE HAS AN AGE RESTRICTION.
4036	THE PLACE OF SERVICE CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4040	THE PRIMARY DIAGNOSIS CODE IS NOT ON FILE.
4041	THE SECONDARY DIAGNOSIS IS NOT ON FILE.
4046	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4127	INTERNAL PROCESSING IS REQUIRED.
4131	INTERNAL PROCESSING IS REQUIRED.
4141	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4149	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4150	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4236	ETIOLOGY DIAGNOSIS CODE(S) (E-CODES) ARE INVALID AS THE PRIMARY DIAGNOSIS.
4244	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4245	THE FOURTH POSITION MODIFIER IS INVALID FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT.
4256	THE PROCEDURE CODE AND MODIFIER COMBINATION IS NOT PAYABLE FOR THE CLIENTS BENEFIT PLAN.
4257	THE MODIFIERS SUBMITTED ARE EITHER INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT OR THE MODIFIERS ARE MISSING.
4311	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4315	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4316	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4371	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4372	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4711	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR CLIENTS AGE.
4714	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS AGE.
4731	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS DIAGNOSIS.
4742	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4743	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4744	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4745	DIAGNOSIS AND/OR PROCEDURE AND/OR PLACE OF SERVICE (POS) CODE IS NOT COVERED FOR EXPRESS ENROLLMENT CLIENTS.
4746	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4801	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4802	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
4821	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
4871	PLEASE REFER TO PA MESSAGES FOR RETURN INFORMATION.

Denial Code	Long Description
4963	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS GENDER.
4990	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
7500	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
7509	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
P001	THE BILLING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THE SERVICES.
P002	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P003	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P005	THE PRIOR AUTHORIZATION CAN NOT BE END DATED. THE PRIOR AUTHORIZATION STATUS IS NOT APPROVED OR APPROVED WITH REVISIONS.
P006	PLEASE FURNISH THE PROCEDURE CODE AND CORRESPONDING DESCRIPTION.
P008	THE BILLING PROVIDER NUMBER IS INVALID.
P009	THE BILLING PROVIDER NUMBER IS INVALID.
P010	THE REQUESTED END DATE IS INVALID.
P011	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P012	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P013	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P014	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P015	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P016	THE REQUESTED START DATE IS MISSING OR INVALID.
P019	THE REQUESTED START DATE IS MISSING OR INVALID.
P020	THE RENDERING PROVIDER NUMBER IS INVALID.
P021	THE RENDERING PROVIDER NUMBER IS INVALID.
P022	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P023	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P024	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P026	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P027	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P030	FIRST MODIFIER IS INVALID.
P031	FIRST MODIFIER IS INVALID.
P032	SECOND MODIFIER IS INVALID.
P033	SECOND MODIFIER IS INVALID.
P034	THIRD MODIFIER IS INVALID.
P035	THIRD MODIFIER IS INVALID.
P036	FOURTH MODIFIER IS INVALID.
P037	FOURTH MODIFIER IS INVALID.
P038	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P039	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P040	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P041	CLIENTS FIRST NAME IS MISSING.
P042	CLIENTS LAST NAME IS MISSING.
P043	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P044	BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES REQUESTED.
P045	FIRST MODIFIER IS INVALID.
P046	SECOND MODIFIER IS INVALID.
P047	THIRD MODIFIER IS INVALID.
P048	FOURTH MODIFIER IS INVALID.

Denial Code	Long Description
P052	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P053	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P054	RENDERING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES FOR THE BENEFIT PLAN.
P055	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P061	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P062	THE CLIENT ID AND/OR NAME INDICATED ON THE PA REQUEST IS INCORRECT. THE CLIENT ID AND/OR NAME HAS BEEN UPDATED. PLEASE VERIFY THE ID AND/OR NAME IS CORRECT.
P064	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
P067	THE FREQUENCY OF HOURS REQUESTED ARE NOT APPROPRIATE FOR THIS CLIENT AND HAVE BEEN MODIFIED ACCORDINGLY.
P079	BILLING PROVIDER IS ON PAYMENT SUSPENSION DUE TO CREDIBLE ALLEGATION OF FRAUD.
P120	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAS BEEN REDUCED.
P121	THE SERVICE/ PROCEDURE REQUESTED IS NOT SUPPORTED BY SUBMITTED DOCUMENTATION.
P126	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
P128	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.
P138	SERVICE(S) DO NOT MEET COLORADO MEDICAID GUIDELINES.
P167	REQUESTED DOCUMENTATION HAS NOT BEEN SUBMITTED.
P178	THE SERVICE REQUESTED IS NOT MEDICALLY NECESSARY.
P179	THE MEDICAL NECESSITY FOR THIS SERVICE IS NOT SUPPORTED BY THE SUBMITTED DOCUMENTATION.
P233	THE DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE ADDITIONAL CARE.
P257	THIS CLIENTS FUNCTIONAL ASSESSMENT SCORES PLACE THIS CLIENT OUTSIDE ELIGIBILITY FOR DAY TREATMENT.
P274	OUR RECORDS INDICATE THIS CLIENT IS INVOLVED IN EFFECTIVE AND APPROPRIATE SERVICE ELSEWHERE.
P292	INTENSIVE REHABILITATION HOURS ARE NO LONGER APPROPRIATE AS INDICATED BY HISTORY, DIAGNOSIS, AND/ OR FUNCTIONAL ASSESSMENT SCORES.
P328	THE SERVICES REQUESTED INCLUDE NON-COVERED SERVICES, AND HOURS ARE REDUCED ACCORDINGLY.
P339	THE CLIENTS PAST HISTORY INDICATES REDUCED TREATMENT HOURS ARE WARRANTED.
P342	THE REQUEST DOES NOT MEET GENERALLY ACCEPTED CONDITIONS REQUIRING FLUORIDE TREATMENTS.
P346	SERVICES EXCEED COLORADO MEDICAID LIMITATION AND DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE MEDICAL NECESSITY OF THE SERVICE.
P349	THE SERVICE REQUESTED WAS PERFORMED LESS THAN FIVE YEARS AGO.
P353	THE EXISTING APPLIANCE HAS NOT BEEN WORN FOR THREE YEARS.
P367	THE CLIENT HAS BEEN TOTALLY WITHOUT TEETH AND AN APPLIANCE FOR FIVE YEARS.
P392	THE CLIENT IS MISSING AN ANTERIOR TOOTH AND/OR HAS TWO OR MORE POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P405	THE SERVICE(S) REQUESTED COULD ADEQUATELY BE PERFORMED IN THE DENTAL OFFICE.
P406	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE OF GOOD PERIODONTAL HEALTH (AMERICAN ACADEMY OF PERIODONTOLOGY PERIODONTAL CLASSIFICATION OF TYPE I OR II).
P407	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE VISIBLE ON RADIOGRAPHS THAT AT LEAST 50 PERCENT OF THE CLINICAL CROWN IS INTACT.
P409	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING SIX OR MORE TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED, INCLUDING THIRD MOLARS.
P410	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING ONE OR MORE ANTERIOR TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED.
P411	DOCUMENTATION DOES NOT SUPPORT THE NEED FOR PERIODONTIC SERVICES. POCKETS ARE LESS THAN 4MM AND/OR GREATER THAN 6MM FOR CLIENT AND/OR THE CLIENT IS UNDER THE AGE OF 13.
P412	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA.

Denial Code	Long Description
P413	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA. THIS PA HAS BEEN GRANTED AS APPROVED NOT APPROVED WITH REVISIONS. THE DURATION REQUESTED MAY HAVE BEEN REDUCED TO REFLECT COVERAGE LIMITATIONS, PRESCRIBER ORDERS, CONFLICTI
P417	THE SERVICE(S) REQUESTED COULD BE ADEQUATELY PERFORMED WITH LOCAL ANESTHESIA.
P437	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO POOR ORAL HYGIENE.
P444	THIS LINE ITEM IS A DUPLICATE OF ANOTHER LINE ITEM ON THIS PRIOR AUTHORIZATION (PA) REQUEST. PLEASE CORRECT.
P446	THIS IS A DUPLICATE OF AN EXISTING PRIOR AUTHORIZATION (PA) REQUEST. YOU MAY CONTACT PROVIDER SERVICES IF YOU REQUIRE ASSISTANCE. DUPLICATE PA REQUEST
P448	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO DECAY HISTORY.
P449	QUESTIONABLE LONG TERM PROGNOSIS DUE TO GUM AND BONE DISEASE.
P456	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO APPARENT ROOT INFECTION.
P457	OUR RECORDS INDICATE THIS CLIENT HAS EXCEEDED ESTABLISHED PROGRAM LIMITATIONS. COLORADO MEDICAID WILL NOT AUTHORIZE NEW DENTURES.
P458	DOCUMENTATION PROVIDED INDICATES A LESS ELABORATE PROCEDURE SHOULD BE CONSIDERED.
P502	RENTAL ONLY ALLOWED; MEDICAL NEED FOR PURCHASE HAS NOT BEEN DOCUMENTED.
P503	PURCHASE ONLY ALLOWED; MEDICAL NEED FOR RENTAL HAS NOT BEEN DOCUMENTED.
P504	OCCUPATIONAL THERAPY GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P505	THE SERVICE REQUESTED IS INCLUDED IN THE NURSING HOME RATE STRUCTURE.
P511	THIS NATIONAL DRUG CODE IS ONLY BILLABLE AS PART OF A COMPOUND DRUG.
P515	THE PRESENCE OF A HANDICAPPING MALOCCLUSION OR HANDICAPPING DENTOFACIAL DEFORMITY IS NOT SUPPORTED BY THE DOCUMENTATION SUBMITTED.
P521	THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVERED BY COLORADO MEDICAID.
P522	GASTRO-INTESTINAL SURGERY FOR THE PURPOSE OF WEIGHT CONTROL IS COVERED ONLY AS A LIFE THREATENING PROCEDURE.
P523	THE TREATMENT REQUEST IS NOT CONSISTENT WITH THE CLIENT'S DIAGNOSIS.
P524	PSYCHOTHERAPY PROVIDED IN THE CLIENTS HOME IS NOT A COVERED BENEFIT OF COLORADO MEDICAID .
P525	THE INFORMATION PROVIDED IS NOT CONSISTENT WITH THE INTENSITY OF SERVICES REQUESTED.
P526	INTENSIVE MULTIPLE MODALITY TREATMENT IS NOT CONSISTENT WITH THE INFORMATION PROVIDED.
P527	MULTIPLE PROVIDERS OF TREATMENT ARE NOT INDICATED FOR THIS CLIENT.
P528	THE DURATION OF TREATMENT SESSIONS EXCEED CURRENT COLORADO MEDICAID GUIDELINES.
P534	DOCUMENTATION OF POOR PHYSICAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P535	OTHER PHYSICAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P536	THE PHYSICAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P537	USE OF PHYSICAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P538	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF A PHYSICAL THERAPIST.
P539	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS AND LIVING ARRANGEMENT.
P540	GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P541	THE PROCEDURE(S) REQUESTED ARE NOT MEDICAL IN NATURE.
P542	DOCUMENTATION OF POOR OCCUPATIONAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P543	DOCUMENTATION OF POOR SPEECH THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P544	OTHER OCCUPATIONAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P546	THE OCCUPATIONAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.

Denial Code	Long Description
P547	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF PHYSICAL THERAPY.
P548	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P549	ACTIVITIES TO PROMOTE DIVERSION OR GENERAL MOTIVATION ARE NONCOVERED COLORADO MEDICAID SERVICES.
P550	REVISIONS OF THE REQUEST IS NECESSITATED BY THE CLIENTS MINIMAL PROGRESS.
P551	RESTORATIVE NURSING INVOLVEMENT COULD BE INCREASED.
P552	CLIENTS DEMONSTRATED RESPONSE TO CURRENT THERAPY DOES NOT WARRANT THE INTENSE FREQUENCY REQUESTED.
P553	MAINTENANCE IS TWO TIMES PER WEEK OR LESS.
P554	THE SPEECH THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P555	USE OF OCCUPATIONAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P556	USE OF SPEECH THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P557	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF AN OCCUPATIONAL THERAPIST.
P558	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
P559	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P560	THE MATERIALS/ SERVICES REQUESTED ARE PRINCIPALLY COSMETIC IN NATURE.
P561	THE LENS FORMULA DOES NOT JUSTIFY REPLACEMENT.
P562	THE CHANGE IN THE LENS FORMULA DOES NOT WARRANT MULTIPLE REPLACEMENTS.
P563	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P564	LENSES ONLY ARE APPROVED; PLEASE DISPENSE A CONTRACTED FRAME. THE NON-CONTRACTED FRAME IS NOT MEDICALLY JUSTIFIED.
P565	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P566	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P567	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF OCCUPATIONAL THERAPY.
P568	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF SPEECH THERAPY.
P569	LEVEL, INTENSITY, OR EXTENT OF SERVICE(S) REQUESTED HAS BEEN MODIFIED CONSISTENT WITH MEDICAL NEED AS DEFINED IN THE PLAN OF CARE.
P570	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P571	THE SERVICE ASKED FOR IS NOT COVERED BY COLORADO MEDICAID AS THESE TASKS CAN BE DONE BY NURSES OR ACTIVITY STAFF.
P572	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P573	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.
P574	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P575	MEDICAL NEED FOR EQUIPMENT/ SUPPLY REQUESTED IS NOT SUPPORTED BY DOCUMENTATION SUBMITTED.
P576	OTHER SPEECH THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P577	DOCUMENTATION SUBMITTED IDENTIFIES THAT THE CLIENT HAS FEWER THAN TWO POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P582	LESS EXPENSIVE ALTERNATIVE SERVICES ARE AVAILABLE FOR THIS CLIENT.
P634	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P711	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING PERIODONTAL SCALING AND ROOT PLANNING.
P712	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING GINGIVECTOMY.
P754	AN APPROVED SUBSTANCE ABUSE DAY TREATMENT PROGRAM CANNOT EXCEED A SIX WEEK PERIOD.

Denial Code	Long Description
P761	THE CLIENT DOES NOT APPEAR TO BE ABLE OR WILLING TO ABSTAIN FROM ALCOHOL/DRUG USAGE WHILE IN TREATMENT. THEREFORE, SUBSTANCE ABUSE DAY TREATMENT SERVICES ARE NOT APPROVED.
P764	THIS CLIENT HAS COMPLETED INTENSIVE SUBSTANCE ABUSE TREATMENT WITHIN THE PAST 12 MONTHS. THE DOCUMENTATION PROVIDED IS NOT ADEQUATE TO JUSTIFY ADDITIONAL INTENSIVE TREATMENT AT THIS TIME.
P785	A LESS THAN SIX-WEEK HEALING PERIOD HAS BEEN SPECIFIED FOR THIS PRIOR AUTHORIZATION. THEREFORE IT IS NOT NECESSARY TO WAIT THE FULL SIX WEEKS AFTER EXTRACTIONS BEFORE TAKING DENTURE IMPRESSIONS.
P818	SIX-WEEK HEALING TIME IS REQUIRED BETWEEN EDENTULATION AND FINAL IMPRESSIONS. PAYMENT FOR DENTURES WILL BE DENIED OR RECOUPED IF HEALING PERIOD IS NOT OBSERVED.
P849	COLORADO MEDICAID HAS DETERMINED THERE WERE (ARE) SEVERAL HOME HEALTH AGENCIES WILLING TO PROVIDE MEDICALLY NECESSARY SKILLED NURSING SERVICES TO THIS CLIENT.
P864	THE DOCUMENTATION YOU HAVE SUBMITTED DOES NOT MEET THE REQUIREMENTS OF COLORADO MEDICAID.
P873	THE MEDICAL NECESSITY FOR THE HOURS REQUESTED IS NOT SUPPORTED BY THE INFORMATION SUBMITTED.
P874	THE DOCUMENTATION SUBMITTED INDICATES THE TASKS SPECIFIED CAN BE COMPLETED DURING THE VISITS APPROVED.
P878	THE DOCUMENTATION SUBMITTED DOES NOT INDICATE THAT MEDICALLY ORIENTED TASKS ARE MEDICALLY NECESSARY; THEREFORE PERSONAL CARE SERVICES HAVE BEEN APPROVED.
P880	THE QUANTITY OF SERVICES AUTHORIZED FOR THIS CLIENTS PERSONAL CARE HAS BEEN AMENDED BASED ON INFORMATION RECEIVED FROM ONE OR MORE OF THESE SOURCES: THE CLIENT, THEIR PHYSICIAN, AND/OR THE IN-HOME VISIT BY STAFF OF THE OIG (OFFICE OF INSPECTOR GENERAL).
P885	THE USE OF THIS DRUG FOR THE INTENDED PURPOSE IS NOT COVERED BY COLORADO MEDICAID, CONSISTENT WITH COLORADO ADMINISTRATIVE CODE AND FEDERAL LAW.
P924	THE MEDICAL RECORDS SUBMITTED WITH THE CURRENT REQUEST CONFLICT OR DISAGREE WITH OUR MEDICAL RECORDS ON THIS CLIENT.
P950	INDEPENDENT NURSES, PLEASE NOTE PAYABLE SERVICES MAY NOT EXCEED 12 HOURS/DAY OR 60 HOURS/WEEK.
P951	SERVICES CAN ONLY BE AUTHORIZED THROUGH ONE YEAR FROM THE PRESCRIPTION DATE.
P952	LEAD INSPECTION IS A COVERED COLORADO MEDICAID SERVICE WHEN THE CHILD HAS BEEN SHOWN TO HAVE LEAD POISONING (E.G., CHILD HAS A BLOOD LEAD LEVEL > 19 UG/DL OR TWO CONSECUTIVE BLOOD LEAD LEVELS OF 15-19 UG/DL DONE AT LEAST 90 DAYS APART). THE INSPECTION MUS
P953	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P954	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P956	THE REQUEST CAN ONLY BE BACKDATED A MAXIMUM OF 14 DAYS FROM FIRST DATE RECEIVED BY COLORADO MEDICAID.
P957	COMPLETE PERIODONTAL CHARTING AT TIME OF SERVICE, AND SUBMIT CHARTING, COPY OF OPERATIVE REPORT, TOGETHER WITH A COPY OF THE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF), F-11035, TO PA UNIT ATTENTION DENTAL CONTSULTANT.
P958	NOTE THAT CODE D4341 HAS BEEN CHANGED. REFER TO THE DECISION NOTICE FOR AUTHORIZED QUANTITY.
P960	YOUR PA HAS BEEN APPROVED FOR 90 DAYS. THE 90 DAY APPROVAL DOES NOT IMPLY THE PA REQUEST MEETS PRIOR AUTHORIZATION CRITERIA. AFTER ADDITIONAL INFORMATION IS AVAILABLE IN INTERCHANGE, COLORADO MEDICAID WILL CREATE AN AMENDMENT REQUEST TO EXTEND THE PA FOR
P961	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P962	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
PA10	THE REQUESTED END DATE IS INVALID.
PA12	PLEASE FURNISH A WRITTEN DESCRIPTION OF THE CLIENTS DIAGNOSIS.

Denial Code	Long Description
PA13	PROVIDE DIAGNOSES WITH DATES OF ONSET.
PA14	IDENTIFY PROBLEMS TO BE TREATED.
PA15	THE AUDIOLOGISTS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1), F-11020, AND PRIOR AUTHORIZATION REQUEST/HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2), F-11021.
PA16	THE PHYSICIANS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION/PHYSICIAN OTOLOGICAL REPORT (PA/POR), F-11019.
PA17	SUBMIT BRIEF HISTORY WITH REFERRAL INFORMATION, LIVING SITUATION, FUNCTIONAL STATUS, AND OTHER PERTINENT INFORMATION. WHAT CHANGE OF STATUS RESULTED IN REFERRAL AT THIS TIME?
PA18	PLEASE FURNISH THE CLIENTS HEIGHT AND WEIGHT.
PA19	PLEASE SUBMIT CLINICAL INFORMATION SUFFICIENT TO VERIFY THE NEED FOR THE REQUESTED SERVICE(S).
PA20	PLEASE RESUBMIT WITH COMPLETE PERIODONTAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PA21	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL EDUCATIONAL PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA22	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL PROGRAM PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA23	REFER TO THE DURABLE MEDICAL EQUIPMENT INDEX FOR APPROPRIATE CODE AND DESCRIPTION. DO NOT USE AN "UNLISTED" CODE.
PA24	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUALIZED FAMILY SERVICE PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA25	INFORMATION ON THE REQUEST FORM IS ILLEGIBLE, AND THE REQUEST CANNOT BE PROCESSED.
PA26	RE-EVALUATE YOUR GOALS. EMPHASIS SHOULD BE ON FUNCTIONAL SELF-CARE. GOALS MUST BE RELATED TO FUNCTIONAL OUTCOME.
PA27	PLEASE CLARIFY THE NUMBER OF HOURS PER WEEK REQUESTED.
PA28	PLEASE CLARIFY THE NUMBER OF HOURS PER DAY REQUESTED.
PA29	PLEASE CLARIFY THE NUMBER OF VISITS PER DAY REQUESTED.
PA30	ATTACH SUPPORTIVE DOCUMENTATION; HOME EXERCISE PROGRAM AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA31	THE DIAGNOSIS CODE INDICATED ON THE REQUEST DOES NOT CORRESPOND TO THE DIAGNOSIS CODE DESCRIPTION.
PA32	PLEASE SUBMIT ADDITIONAL INFORMATION SUFFICIENT TO VERIFY APPROPRIATENESS AND NEED FOR TRANSPLANT.
PA33	PLEASE SUBMIT THE INITIAL AND PROGRESSIVE OBJECTIVE FINDINGS.
PA34	ATTACH SUPPORTIVE DOCUMENTATION, FACILITY PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA35	PLEASE SUBMIT THE CLIENTS ORIGINAL COMPLAINTS AND EXAMINATION FINDINGS.
PA36	ATTACH SUPPORTIVE DOCUMENTATION, IN-HOME AUTISM PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA37	PLEASE SUBMIT YOUR TREATMENT PLAN FOR THIS CLIENT.
PA38	ATTACH SUPPORTIVE DOCUMENTATION AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA39	INITIAL EVALUATIONS MUST BE PERFORMED BY AN OCCUPATIONAL THERAPIST REGISTERED (OTR), PER AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA) STANDARDS.
PA41	IDENTIFY THE PLACE OF SERVICE AND ITS EFFECT ON SUPPORTING THE DESIRED TREATMENT OUTCOME.
PA42	PLEASE INDICATE THE HOURS OF USE OF OXYGEN PER 24-HOUR PERIOD.
PA43	PROVIDE BASELINE DOCUMENTATION FOR THIS CLIENTS LIMITATIONS USING UNITS OF MEASUREMENT THAT ARE APPLIED CONSISTENTLY WHEN REPORTING STATUS.
PA44	IDENTIFY FUNCTIONAL LIMITATIONS AS THEY ARE RELATED TO IDENTIFIED CONDITIONS.
PA46	CORRELATE PLAN OF CARE TO REQUESTED PROCEDURE CODES.
PA47	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE FREQUENCY/DURATION REQUESTED.

Denial Code	Long Description
PA48	PLEASE PROVIDE THE NAME AND CREDENTIALS OF THE RENDERING PROVIDER.
PA50	COLORADO MEDICAID RECORDS INDICATE THE CLIENT OWNS A WHEELCHAIR. DOCUMENT THE REASON AND NEED FOR REPLACEMENT AND COST TO REPAIR CURRENT WHEELCHAIR.
PA51	PLEASE DISTINGUISH PRIMARY AND SUPPORTIVE MODALITIES.
PA52	PLEASE SUBMIT A PROGRESS REPORT.
PA53	MULTIPLE FAMILY CLIENTS TREATMENT BY THE SAME PROVIDER REQUIRES FURTHER INFORMATION DOCUMENTING COORDINATION OF TREATMENT PLAN.
PA54	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE MINUTES REQUESTED.
PA55	MEDICAL NECESSITY OF TREATMENT REQUIRES ADDITIONAL DOCUMENTATION.
PA56	GIVEN AGE, DIAGNOSES, CURRENT LEVEL OF FUNCTION, PAST RESPONSE TO TREATMENT, AND LIVING SITUATION, EXPAND ON POTENTIAL FOR SIGNIFICANT FUNCTIONAL PROGRESS WITHIN THE NEXT SIX MONTHS. EMPHASIZE WHY PROGRESS IS EXPECTED WITH SERVICES AT THIS TIME.
PA57	SUBMIT THE INITIAL FINDINGS. INCLUDE A COMPREHENSIVE EVALUATION.
PA58	SUBMIT PROGRESSIVE, OBJECTIVE FINDINGS. INCLUDE A PERTINENT RE-EVALUATION.
PA59	PLEASE SUPPLY INFORMATION REGARDING THE CLIENTS MEDICATION REQUIREMENTS, IF ANY.
PA60	PLEASE SPECIFY IF THE CLIENT IS IN AN EDUCATIONAL SETTING.
PA61	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA62	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
PA63	THE SKILLS OF A THERAPIST ARE PURPOSEFUL AND SKILLED INTERVENTIONS REQUIRED TO CONTINUALLY DESIGN, IMPLEMENT, REASSESS, MODIFY/GRADE, AND/OR DISCONTINUE A PLAN OF CARE IN A TIMELY MANNER, BASED ON THE COMPLEXITY OF THE CLIENTS MEDICAL CONDITION AND/OR CO
PA64	PLEASE SUBMIT A THERAPY PLAN OF CARE, INCLUDING A CURRENT, DATED EVALUATION.
PA65	A PLAN OF CARE SIGNED AND DATED BY THE PHYSICIAN IS REQUIRED.
PA66	THE SKILLS OF A THERAPIST ARE REQUIRED WHEN ONLY THE THERAPIST CAN SAFELY AND EFFECTIVELY DELIVER THE THERAPEUTIC PROCEDURES BECAUSE OF THEIR UNIQUE KNOWLEDGE, TRAINING, AND EXPERTISE. DESCRIBE THE REASON THAT SOMEONE OTHER THAN A THERAPIST CANNOT SAFELY
PA67	PLEASE SPECIFY IF THE CLIENTS WORK SITE DEMANDS GOOD BINAURAL HEARING.
PA68	DESCRIBE THE REASON, BASED ON THE CLIENTS COGNITIVE, PHYSICAL, COMMUNICATION, OR RESOURCE STATUS, THAT A HOME PROGRAM, EQUIPMENT, OR ENVIRONMENTAL ADAPTATIONS ALONE CANNOT MEET CLIENTS NEEDS.
PA69	PLEASE SPECIFY IF THE CLIENT HAS AN ACCOMPANYING DISABILITY THAT ADDS TO THE HEARING PROBLEM.
PA70	DISTINGUISH REQUESTED PROCEDURES AND GOALS FROM OTHER SERVICES THIS CLIENT RECEIVES. THEY MAY NOT BE DUPLICATIVE.
PA71	PLEASE INDICATE THE NUMBER OF DAYS REQUESTED.
PA73	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA74	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA75	PLEASE DOCUMENT CARRYOVER OF THE THERAPY PROGRAM TO NURSING.
PA76	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA79	PROVIDE EVIDENCE OF SIGNIFICANT FUNCTIONAL PROGRESS IN LAST SIX MONTHS.
PA84	THE GRANT DATE OF THIS REQUEST CANNOT BE PRIOR TO THE SIGNATURE DATE OF THE PRESCRIBING PHYSICIAN.
PA86	PROVIDE EVIDENCE OF SKILLS GAINED IN THERAPY CARRYING OVER TO OTHER SETTINGS WITHIN SIX MONTHS.
PA87	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE NUMBER OF SESSIONS REQUESTED.
PA88	THE REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL SCOPE OF PRACTICE.
PA89	PRIOR AUTHORIZATION IS NOT REQUIRED UNTIL LIMITATION OF SERVICE HAS BEEN REACHED.

Denial Code	Long Description
PA91	PLEASE SUBMIT REQUIRED X-RAYS.
PA92	PLEASE PROVIDE AN EXPLANATION FOR THE MATERIAL SUBMITTED WITH THE REQUEST.
PA95	PLEASE DESCRIBE HOW THE PROVISION OF THIS SERVICE WOULD PREVENT INSTITUTIONALIZATION OF THE CLIENT.
PA96	COULD THE EXISTING DENTURE(S) BE RELINED OR REBASED? IF NOT, PLEASE EXPLAIN WHY NOT.
PA97	REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL STANDARDS OF PRACTICE.
PA98	PLEASE INDICATE IF THE CLIENT IS CURRENTLY BEING TUBE FED.
PB02	PLEASE PROVIDE THE REQUIRED DATED SIGNATURES ON THE ATTACHMENTS.
PB03	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING THE LOSS/DESTRUCTION/THEFT OF THE HEARING AID.
PB04	DESCRIBE THE CLIENTS ABILITY TO STAND OR AMBULATE SUFFICIENTLY TO ACCOMPLISH SELF-CARE ACTIVITIES.
PB07	PLEASE SUBMIT AN ORTHODONTIC STUDY MODEL OR DIAGNOSTIC CASTS.
PB09	PLEASE PROVIDE A PHOTOGRAPH OF THE INVOLVED AREA(S).
PB10	PLEASE PROVIDE AN ESTIMATION (IN GRAMS) OF THE TOTAL AMOUNT OF TISSUE TO BE RESECTED.
PB11	PLEASE SUBMIT THE PLAN OF CARE FOR CO-TREATMENT.
PB12	FURNISH A DETAILED DESCRIPTION FOR THE PROCEDURE CODE REQUESTED.
PB13	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB15	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB18	PLEASE COMPLETE THE ATTACHED OUT-OF-STATE PROVIDER DATA SHEET, F-11001, AND RESUBMIT.
PB20	A SIGNED AND DATED PRESCRIPTION IS REQUIRED WITHIN THREE MONTHS OF RECEIPT BY COLORADO MEDICAID FOR INITIAL REQUESTS AND WITHIN 12 MONTHS OF RECEIPT BY COLORADO MEDICAID FOR SUBSEQUENT REQUESTS.
PB21	PLEASE COMPLETE THE APPROPRIATE PRIOR AUTHORIZATION ATTACHMENT. CONTACT PROVIDER SERVICES OR THE PRIOR AUTHORIZATION UNIT FOR ASSISTANCE.
PB23	PHYSICAL THERAPY ASSISTANT NOTES AND ALL FORMS SUBMITTED MUST BE COSIGNED BY A REGISTERED PHYSICAL THERAPIST.
PB31	ARE YOU REQUESTING A COMPLETE APPLIANCE, OR REPLACEMENT PARTS?
PB32	THE PROCEDURE CODE INDICATED ON THE REQUEST DOES NOT MATCH THE DESCRIPTION OF SERVICE; PLEASE CORRECT AND RESUBMIT.
PB35	THE SERVICE REQUESTED DOES NOT REQUIRE PRIOR AUTHORIZATION.
PB41	PLEASE FURNISH A CURRENT MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT, F-11090 (DATED WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID).
PB45	THE CERTIFICATION PERIOD ON THE PLAN OF CARE (POC) DOES NOT COVER THE REQUESTED GRANT/START DATE. PLEASE RESUBMIT YOUR REQUEST WITH A NEW POC.
PB49	A CERTIFIED OCCUPATIONAL THERAPY ASSISTANTS NOTES MUST BE COSIGNED BY AN OCCUPATIONAL THERAPIST REGISTERED.
PB51	ADDITIONAL INFORMATION IS REQUIRED ON PRIOR AUTHORIZATION TO ENABLE PRICING.
PB54	REQUESTED SERVICES DO NOT MATCH SERVICES ON THE PHYSICIANS ORDERS.
PB59	PLEASE PROVIDE AN INDIVIDUAL EDUCATIONAL PLAN (IEP), WHICH HAS BEEN SIGNED BY THE PROVIDER NO EARLIER THAN NINE MONTHS PRIOR TO RECEIPT AT COLORADO MEDICAID; OTHERWISE, DOCUMENT WHY NO IEP EXISTS.
PB65	PLEASE FURNISH THE ANTICIPATED TOTAL CHARGES FOR THIS REQUEST.
PB66	A PHOTOCOPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED; THE DATE MUST BE WITHIN SIX MONTHS OF RECEIPT BY COLORADO MEDICAID.
PB67	THE PRESCRIPTION DATE MUST INCLUDE MONTH, DAY, AND YEAR.
PB68	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID.
PB73	THE SERVICES IDENTIFIED ON THE PLAN OF CARE DO NOT APPEAR APPROPRIATE FOR THE PROCEDURE CODE(S) REQUESTED ON THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018.
PB74	THE CLIENT/PROVIDER DOES NOT HAVE RETROACTIVE ENROLLMENT.
PB75	THE REQUESTED START DATE IS MORE THAN 14 DAYS BEFORE OR 62 DAYS AFTER RECEIPT.
PB82	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.

Denial Code	Long Description
PB83	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A HOME HEALTH AIDE. PLEASE RESUBMIT AS A PERSONAL CARE WORKER OR PROVIDE ADDITIONAL DOCUMENTATION.
PB86	THE SERVICES REQUESTED ARE NOT BEING PROVIDED IN THE CLIENTS RESIDENCE. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL.
PB87	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A NURSE. PLEASE RESUBMIT AS A HOME HEALTH AIDE OR PROVIDE ADDITIONAL DOCUMENTATION.
PB92	PLEASE FURNISH THE CLIENTS COMPLETE ADDRESS.
PB94	IF THE CLIENT IS A RESIDENT OF A NURSING HOME, SUPPLY THE COMPLETE NAME AND ADDRESS OF THE NURSING HOME.
PB99	THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018, MUST BE SIGNED AND DATED.
PC01	PLEASE SUPPLY THE RENDERING PROVIDERS PROVIDER NUMBER.
PC03	THE DRUG ENFORCEMENT ADMINISTRATION NUMBER IS MISSING OR INVALID.
PC06	PLEASE DESCRIBE YOUR PROGRAM; INCLUDE ENTRY DATE, TERMINATION DATE, HOURS PER WEEK, AND NUMBER OF WEEKS OF PRIMARY INTENSIVE SERVICE REQUESTED.
PC07	PLEASE DESCRIBE YOUR "AFTERCARE/FOLLOW-UP" PLANS FOR THIS CLIENT.
PC08	PLEASE SUPPLY DOCUMENTATION OF PREVIOUS SUBSTANCE ABUSE SERVICES WITH DATE(S) AND OUTCOME.
PC09	PLEASE DESCRIBE IN DETAIL THE TREATMENT OBJECTIVES/GOALS FOR THIS CLIENT.
PC10	PLEASE DESCRIBE THE FAMILY SITUATION/DYNAMICS. EXPLAIN HOW THE FAMILY WILL BE INCORPORATED INTO THE CLIENTS PLAN OF CARE.
PC12	PLEASE EXPLAIN IF YOUR SERVICE ENCOURAGES THE CLIENT TO ATTEND SELF-HELP GROUPS.
PC13	PLEASE SUPPLY A SPECIFIC SCHEDULE OF ACTIVITIES, INCLUDING DAY, TIME OF DAY, LENGTH OF SESSION, AND SERVICE TO BE RENDERED DURING THAT TIME.
PC15	PLEASE FURNISH DIAGNOSTIC RATIONALE.
PC17	PLEASE DOCUMENT IF THE CLIENT EVER RECEIVED SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT.
PC19	PLEASE FURNISH MORE EXTENSIVE AND IN-DEPTH HISTORICAL AND PSYCHOSOCIAL DATA.
PC20	PLEASE SUPPLY THE DATE THE CLIENT BECAME TOTALLY ENDENTULOUS.
PC23	PLEASE SUBMIT A PHYSICIANS STATEMENT REGARDING THE MEDICAL NECESSITY OF DENTURES FOR THIS CLIENT. THE PHYSICIANS STATEMENT MUST DOCUMENT THE MEDICAL NEED FOR DENTURES.
PC24	THE SERVICE REQUESTED WAS PREVIOUSLY AUTHORIZED. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT INDICATING THIS FACT IS REQUIRED.
PC25	PLEASE SUPPLY SUFFICIENT MITIGATING CIRCUMSTANCES TO WARRANT THE CONSTRUCTION OF NEW DENTURES(S).
PC26	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
PC28	PLEASE SUBMIT A PHYSICIANS STATEMENT INDICATING DENTURES ARE NECESSARY FOR THIS NURSING HOME CLIENT.
PC29	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING LOSS OR DESTRUCTION OF DENTURE(S). INCLUDE SIGNED STATEMENT FROM CLIENT OR FACILITY DIRECTOR REGARDING HOW, WHEN AND WHERE LOST.
PC30	PLEASE PROVIDE COMPLETE INTRAORAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PC31	PLEASE DESCRIBE ANY RELATED DEFORMITIES OF THE FEET.
PC34	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD WITH REQUESTED DME ITEM(S) AND DOCUMENT IF THE CLIENT CAN USE SAFELY AND INDEPENDENTLY.
PC35	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD AND DESCRIBE THE RESULTS AND EFFECTIVENESS OF THE SERVICE REQUESTED.
PC39	PLEASE INDICATE LITER FLOW PER MINUTE, HOURS OF USE PER 24 HOUR PERIOD, AND THE EXPECTED DURATION OF NEED.
PC40	THE ITEM DOES NOT REQUIRE PRIOR AUTHORIZATION UNTIL THE LIFE EXPECTANCY HAS BEEN REACHED.
PC41	PLEASE SUPPLY INFORMATION INDICATING THE NECESSITY OF POSITIONING THE CLIENT'S BODY IN MULTIPLE POSITIONS.

Denial Code	Long Description
PC42	PLEASE INDICATE IF THE BED HEIGHT MUST BE CHANGED TO ALLOW FOR SAFE TRANSFER OR ADEQUATE BED CARE.
PC43	SUPPLY A PHYSICIANS STATEMENT INDICATING TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR UNIT HAS REDUCED PAIN, IMPROVED/INCREASED THE CLIENTS ACTIVITY LEVEL, AND/OR REDUCED CLIENTS USE OF PAIN MEDICATION.
PC44	A CURRENT AUTHORIZATION FOR THIS SERVICE IS ON FILE FOR ANOTHER PROVIDER. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT OF THAT FACT IS REQUIRED BY THE CLIENT OF FIRST PROVIDER.
PC59	DOCUMENT DECLINE OR PROGRESS IN SPECIFIC, MEASURABLE, OBJECTIVE TERMS.
PC60	DOCUMENT IF CLIENT HAS DEMONSTRATED A GOOD APPOINTMENT COMPLIANCE RECORD.
PC61	THE PHYSICIANS SIGNATURE DATE MUST NOT EXCEED 90 DAYS FROM THE DATE OF RECEIPT BY COLORADO MEDICAID.
PC62	REQUESTS FOR A CONTINUATION OF THERAPY SHOULD NOT BE SUBMITTED MORE THAN FOUR WEEKS PRIOR TO THE EXPIRATION DATE OF THE CURRENT AUTHORIZATION.
PC63	PLEASE FURNISH THE STYLE AND MANUFACTURER OF THE FRAME.
PC64	PLEASE FURNISH THE CLIENTS LENS FORMULA.
PC66	ALL REQUESTS FOR TINTS REQUIRE DOCUMENTATION OF THE VISUAL OR MEDICAL CONDITION RELATED TO PHOTOPHOBIA.
PC67	PLEASE DOCUMENT THE REASON AND JUSTIFICATION FOR REPLACEMENT BEYOND THE FIRST LENS/FRAME.
PC68	DOCUMENT IF ALL REMAINING MAXILLARY AND/OR MANDIBULAR TEETH ARE DECAY-FREE, PROPERLY RESTORED, AND PERIODONTICALLY SOUND.
PC72	SUPPLY MORE DETAIL REGARDING PROGRESS (ATTACHMENT OF GOALS, ETC.). CORRELATE PROGRESS TO PREVIOUS GOALS AND IDENTIFIED LIMITATIONS.
PC77	PLEASE SUBMIT A PLAN OF CARE DESCRIBING THE SERVICES THAT WOULD BE PROVIDED.
PC78	PLEASE DOCUMENT SPECIFIC, MEASURABLE GOALS.
PC82	THE PRIOR AUTHORIZATION (PA) SYSTEM CAN PROCESS ONLY 26 DETAILS PER PA REQUEST. PLEASE RESUBMIT YOUR REQUEST WITH NO MORE THAN 26 DETAILS.
PC83	PLEASE SUPPLY A PHYSICIANS PRESCRIPTION DATED WITHIN ONE MONTH OF REQUESTED SUBSTANCE ABUSE DAY TREATMENT.
PC84	PLEASE PROVIDE INFORMATION INDICATING THIS CLIENT IS APPROPRIATELY DETOXIFIED FROM ALCOHOL AND/OR OTHER DRUGS.
PC85	PLEASE PROVIDE INFORMATION TO INDICATE THE CLIENTS ABILITY TO ABSTAIN FROM ALCOHOL OR DRUGS WHILE IN THE SUBSTANCE ABUSE DAY TREATMENT PROGRAM.
PC86	PLEASE INDICATE IF THIS CLIENT IS WILLING TO PARTICIPATE IN AFTERCARE OR CONTINUING CARE SERVICES.
PC87	PROVIDE MORE INFORMATION ON TREATMENT HISTORY; INCLUDE SERVICE PROVIDED, DATES, AND OUTCOME. PROVIDE DETAIL OF PREVIOUS TREATMENT.
PC88	PLEASE PROVIDE MORE RATIONALE FOR THE APPROPRIATENESS AND MEDICAL NECESSITY OF SUBSTANCE ABUSE DAY TREATMENT.
PC89	PROVIDE A TREATMENT PLAN THAT CONTAINS MEASURABLE GOALS AND OBJECTIVES CORRESPONDING TO THE IDENTIFIED DEFICIT.
PC91	PLEASE PROVIDE MORE INFORMATION ON FAMILY INVOLVEMENT TREATMENT.
PC92	PLEASE PROVIDE MORE HISTORY AND EXPLANATION ABOUT THE ISSUE OF ABSTINENCE FOR THIS CLIENT.
PC94	PLEASE PROVIDE THE ANTICIPATED BEGINNING DATE AND/OR THE ESTIMATED SUBSTANCE ABUSE DAY TREATMENT DISCHARGE DATE.
PC95	PLEASE SUPPLY JUSTIFICATION FOR BEGINNING CLIENT IN SERVICE PRIOR TO AUTHORIZATION BEING OBTAINED.
PC96	THE INITIAL THREE HOURS OF SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IN A CALENDAR YEAR DO NOT REQUIRE PRIOR AUTHORIZATION.
PC97	REIMBURSEMENT FOR INITIAL SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IS LIMITED TO THREE HOURS IN A CALENDAR YEAR AND DOES NOT REQUIRE PRIOR AUTHORIZATION.
PC98	THIS DRUG IS CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE BILL USING THE APPROPRIATE NATIONAL DRUG CODE (NDC) OR SUBMIT A COMPLETED DRUG ADDITION REQUEST FORM IF THE NDC IS NOT LISTED IN THE DRUG INDEX.

Denial Code	Long Description
PC99	THIS DRUG IS NOT CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL, CURRENT ADMINISTRATIVE RULE, OR COLORADO DRUG INDEX FOR COVERAGE LIMITATIONS.
PD01	DOCUMENT THAT CLIENT HAS ACHIEVED GOOD ORAL HYGIENE, PERIODONTAL CASE TYPE 1 OR 2, AND IS MOTIVATED TO MAINTAIN SAME.
PD03	PLEASE PROVIDE AN ARTERIAL BLOOD GAS READING OR PULSE OXIMETRY RESULTS DONE ON ROOM AIR SIGNED AND DATED BY A MEDICAL DOCTOR. THIS SHOULD BE DONE WITHIN 60 DAYS OF REQUESTED SERVICE.
PD04	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 30 DAYS OF RECEIPT BY COLORADO MEDICAID.
PD07	SUBMIT A PHOTOCOPY OF A VALID PRESCRIPTION, ISSUED WITHIN THE PAST YEAR, OR COMPLETE SECTION B OF THE PRIOR AUTHORIZATION/DRUG ATTACHMENT (PA/DGA), F-11049.
PD10	BRAND MEDICALLY NECESSARY MUST BE IN THE PRESCRIBERS OWN HANDWRITING AND WRITTEN DIRECTLY ON THE PRESCRIPTION OR A SEPARATE ORDER ATTACHED TO THE ORIGINAL PRESCRIPTION.
PD12	COMPLETE DENTURES, PARTIAL DENTURES, DENTURE RELINES, AND FIXED PROSTHODONTIC SERVICES ARE NOT COVERED SERVICES FOR ADULTS FOR DATES OF SERVICE ON AND AFTER OCTOBER 1, 1995.
PD22	PLEASE COMPLETE ALL REQUIRED ELEMENTS ON THE PERSONAL CARE SCREENING TOOL (PCST), F-11133.
PD24	THIS PRIOR AUTHORIZATION REQUEST IS UNABLE TO BE PROCESSED. PLEASE RESUBMIT WITH ADDITIONAL REQUIRED FORMS, INCLUDING THE ENTIRE PERSONAL CARE SCREENING TOOL (PCST), F-11133; PERSONAL CARE ADDENDUM, F-11136; AND SUPPORTING DOCUMENTATION, AS DIRECTED.
PD25	THERE IS A PERSONAL CARE SCREENING TOOL (PCST), F-11133, COMPLETED BY ANOTHER AGENCY. CONTACT THE AGENCY TO TRANSFER SCREEN.
PD26	THERE IS A LIMITED TERM CARE FUNCTIONAL SCREEN (LTC-FS) COMPLETED BY ANOTHER AGENCY. THE PERSONAL CARE SCREENING TOOL (PCST), F-11133, INFORMATION IS IN CONFLICT WITH LTC-FS.
PD27	ONLY ONE LEVEL OF FUNCTION MAY BE SELECTED FOR ALL ELEMENTS EXCEPT TOILETING. COLORADO MEDICAID IS UNABLE TO PROCESS THE PRIOR AUTHORIZATION REQUEST.
PD28	NO UNITS MAY BE REQUESTED USING THIS PRIOR AUTHORIZATION PROCESS. PLEASE SUBMIT WITH THE APPROPRIATE ATTACHMENTS FOR REQUESTING SPECIFIC PERSONAL CARE WORKER UNITS.
PD29	CLIENT IS NOT ELIGIBLE FOR THE REQUESTED SERVICE(S) AS OF THE REQUESTED START DATE.
PD30	NO TRAVEL TIME MAY BE AUTHORIZED WHEN NO PERSONAL CARE WORKER SERVICE IS AUTHORIZED.
PD32	PROVIDER NOT CERTIFIED TO RENDER THE SERVICE(S) REQUESTED.
PD34	BASED ON THE DOCUMENTATION SUBMITTED, THIS REQUEST CAN NOT BE PRIOR AUTHORIZED. REFER TO THE PA MESSAGES FROM THE CONSULTANT FOR COMPLETE EXPLANATION.
PD98	PLEASE DOCUMENT HOW AND WHEN EACH PREVIOUSLY AUTHORIZED PRO RE NATA VISIT WAS USED.

Children w/Life Limiting Illness (CLLI)

Denial Code	Long Description
0201	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
0233	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0235	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0237	CLIENT IDENTIFICATION NUMBER DOES NOT MATCH CLIENTS FIRST NAME.
0238	THE CLIENT IDENTIFICATION NUMBER DOES NOT MATCH THE CLIENTS LAST NAME.
0242	SECONDARY DIAGNOSIS CODE IS INVALID.
0248	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0249	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0251	PROCEDURE CODE MODIFIER IN FIRST POSITION IS INVALID.
0252	THE PROCEDURE CODE MODIFIER IN SECOND POSITION IS INVALID FOR REQUESTED START DATE OR DATE OF RECEIPT.

Denial Code	Long Description
0253	THE PROCEDURE CODE MODIFIER IN THIRD POSITION IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
0258	THE PRIMARY DIAGNOSIS CODE IS REQUIRED.
0272	THE PRIMARY DIAGNSOSIS CODE IS INVALID.
0400	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0853	HCPCS - ANNUAL UPDATE
0885	NEVER EVENTS MODIFIERS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
0886	NEVER EVENTS DIAGNOSIS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
1000	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
1002	RENDERING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1003	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1007	RENDERING PROVIDER ID IS NOT ON FILE.
1047	THE RENDERING PROVIDERS CERTIFICATION HAS BEEN CANCELLED.
1048	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1801	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
1804	A CERTIFIED SUBSTANCE ABUSE DAY TREATMENT PROVIDER MUST SUBMIT A SUBSTANCE ABUSE DAY TREATMENT PROCEDURE CODE.
1806	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
1808	THE BILLING PROVIDER DOES NOT HAVE THE REQUIRED CERTIFICATION ADDENDUM ON FILE.
1900	THE BILLING PROVIDERS TAXONOMY CODE IS INVALID.
1901	THE RENDERING PROVIDERS TAXONOMY CODE IS INVALID.
1927	A NATIONAL PROVIDER IDENTIFIER IS REQUIRED FOR THE BILLING PROVIDER.
1934	A NATIONAL PROVIDER INDENTIFIER IS REQUIRED FOR THE RENDERING PROVIDER.
1936	THE BILLING PROVIDER NUMBER IS INVALID.
1937	THE RENDERING PROVIDER NUMBER IS INVALID.
1960	INTERNAL PROCESSING IS REQUIRED.
1963	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.
1964	THE BILLING PROVIDER INDICATED IS NOT ALLOWABLE AS A BILLING PROVIDER.
1965	RENDERING PROVIDER NUMBER IS MISSING/INVALID FOR THIS PROCEDURE PROVIDER.
1974	PRESCRIBING/REFERRING/ORDERING PROVIDER INDICATED IS NOT CERTIFIED AS A PRESCRIBING/REFERRING/ORDERING PROVIDER.
1975	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
1976	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
2001	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2003	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2017	THE CLIENT IS ENROLLED IN A MEDICAID OR OTHER MANAGED CARE PROGRAM.
2037	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2603	CLIENT LOCKED-IN TO A PROVIDER OR ENROLLED IN A HOSPICE. CONTACT CLIENTS HOSPICE FOR PAYMENT OF SERVICES OR RESUBMIT WITH DOCUMENTATION OF UNRELATED NATURE OF CARE.
3324	THE MODIFIER HAS BEEN DISCONTINUED BY THE CENTERS OF MEDICARE AND MEDICAID SERVICES OR THE AMERICAN MEDICAL ASSOCIATION FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
3337	THE PROCEDURE CODE HAS BEEN TERMINATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AMERICAN MEDICAL ASSOCIATION, OR AMERICAN DENTAL ASSOCIATION FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT. RESUBMIT WITH VALID A PROCEDURE CODE.
3339	THE PROCEDURE BILLED IS NOT PAYABLE ACCORDING TO DEFICIT REDUCTION ACT (DEFRA) GUIDELINES.
3351	THE PROCEDURE IS NOT COVERED FOR CLIENTS WITH A NURSING HOME AUTHORIZATION ON THE REQUESTED START DATE OR DATE OF RECEIPT.
3353	THE PROCEDURE IS NOT A COVERED SERVICE FOR HOME AND COMMUNITY-BASED WAIVER CLIENTS.
4021	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4027	THE DIAGNOSIS CODE IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
4031	THE PROCEDURE SUBMITTED IS NOT APPROPRIATE FOR CLIENTS GENDER.
4032	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.

Denial Code	Long Description
4034	THE PROCEDURE CODE HAS AN AGE RESTRICTION.
4036	THE PLACE OF SERVICE CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4040	THE PRIMARY DIAGNOSIS CODE IS NOT ON FILE.
4041	THE SECONDARY DIAGNOSIS IS NOT ON FILE.
4046	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4127	INTERNAL PROCESSING IS REQUIRED.
4131	INTERNAL PROCESSING IS REQUIRED.
4141	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4149	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4150	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4236	ETIOLOGY DIAGNOSIS CODE(S) (E-CODES) ARE INVALID AS THE PRIMARY DIAGNOSIS.
4244	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4245	THE FOURTH POSITION MODIFIER IS INVALID FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT.
4256	THE PROCEDURE CODE AND MODIFIER COMBINATION IS NOT PAYABLE FOR THE CLIENTS BENEFIT PLAN.
4257	THE MODIFIERS SUBMITTED ARE EITHER INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT OR THE MODIFIERS ARE MISSING.
4311	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4315	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4316	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4371	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4372	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4711	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR CLIENTS AGE.
4714	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS AGE.
4731	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS DIAGNOSIS.
4742	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4743	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4744	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4745	DIAGNOSIS AND/OR PROCEDURE AND/OR PLACE OF SERVICE (POS) CODE IS NOT COVERED FOR EXPRESS ENROLLMENT CLIENTS.
4746	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4801	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4802	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
4821	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
4871	PLEASE REFER TO PA MESSAGES FOR RETURN INFORMATION.
4963	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS GENDER.
4990	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
7500	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
7509	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
P001	THE BILLING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THE SERVICES.
P002	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P003	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P005	THE PRIOR AUTHORIZATION CAN NOT BE END DATED. THE PRIOR AUTHORIZATION STATUS IS NOT APPROVED OR APPROVED WITH REVISIONS.
P006	PLEASE FURNISH THE PROCEDURE CODE AND CORRESPONDING DESCRIPTION.
P008	THE BILLING PROVIDER NUMBER IS INVALID.
P009	THE BILLING PROVIDER NUMBER IS INVALID.
P010	THE REQUESTED END DATE IS INVALID.
P011	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.

Denial Code	Long Description
P012	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P013	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P014	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P015	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P016	THE REQUESTED START DATE IS MISSING OR INVALID.
P019	THE REQUESTED START DATE IS MISSING OR INVALID.
P020	THE RENDERING PROVIDER NUMBER IS INVALID.
P021	THE RENDERING PROVIDER NUMBER IS INVALID.
P022	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P023	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P024	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P026	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P027	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P030	FIRST MODIFIER IS INVALID.
P031	FIRST MODIFIER IS INVALID.
P032	SECOND MODIFIER IS INVALID.
P033	SECOND MODIFIER IS INVALID.
P034	THIRD MODIFIER IS INVALID.
P035	THIRD MODIFIER IS INVALID.
P036	FOURTH MODIFIER IS INVALID.
P037	FOURTH MODIFIER IS INVALID.
P038	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P039	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P040	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P041	CLIENTS FIRST NAME IS MISSING.
P042	CLIENTS LAST NAME IS MISSING.
P043	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P044	BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES REQUESTED.
P045	FIRST MODIFIER IS INVALID.
P046	SECOND MODIFIER IS INVALID.
P047	THIRD MODIFIER IS INVALID.
P048	FOURTH MODIFIER IS INVALID.
P052	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P053	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P054	RENDERING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES FOR THE BENEFIT PLAN.
P055	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P061	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P062	THE CLIENT ID AND/OR NAME INDICATED ON THE PA REQUEST IS INCORRECT. THE CLIENT ID AND/OR NAME HAS BEEN UPDATED. PLEASE VERIFY THE ID AND/OR NAME IS CORRECT.
P064	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
P067	THE FREQUENCY OF HOURS REQUESTED ARE NOT APPROPRIATE FOR THIS CLIENT AND HAVE BEEN MODIFIED ACCORDINGLY.
P079	BILLING PROVIDER IS ON PAYMENT SUSPENSION DUE TO CREDIBLE ALLEGATION OF FRAUD.
P120	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAS BEEN REDUCED.

Denial Code	Long Description
P121	THE SERVICE/ PROCEDURE REQUESTED IS NOT SUPPORTED BY SUBMITTED DOCUMENTATION.
P126	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
P128	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.
P138	SERVICE(S) DO NOT MEET COLORADO MEDICAID GUIDELINES.
P167	REQUESTED DOCUMENTATION HAS NOT BEEN SUBMITTED.
P178	THE SERVICE REQUESTED IS NOT MEDICALLY NECESSARY.
P179	THE MEDICAL NECESSITY FOR THIS SERVICE IS NOT SUPPORTED BY THE SUBMITTED DOCUMENTATION.
P233	THE DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE ADDITIONAL CARE.
P257	THIS CLIENTS FUNCTIONAL ASSESSMENT SCORES PLACE THIS CLIENT OUTSIDE ELIGIBILITY FOR DAY TREATMENT.
P274	OUR RECORDS INDICATE THIS CLIENT IS INVOLVED IN EFFECTIVE AND APPROPRIATE SERVICE ELSEWHERE.
P292	INTENSIVE REHABILITATION HOURS ARE NO LONGER APPROPRIATE AS INDICATED BY HISTORY, DIAGNOSIS, AND/ OR FUNCTIONAL ASSESSMENT SCORES.
P328	THE SERVICES REQUESTED INCLUDE NON-COVERED SERVICES, AND HOURS ARE REDUCED ACCORDINGLY.
P339	THE CLIENTS PAST HISTORY INDICATES REDUCED TREATMENT HOURS ARE WARRANTED.
P342	THE REQUEST DOES NOT MEET GENERALLY ACCEPTED CONDITIONS REQUIRING FLUORIDE TREATMENTS.
P346	SERVICES EXCEED COLORADO MEDICAID LIMITATION AND DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE MEDICAL NECESSITY OF THE SERVICE.
P349	THE SERVICE REQUESTED WAS PERFORMED LESS THAN FIVE YEARS AGO.
P353	THE EXISTING APPLIANCE HAS NOT BEEN WORN FOR THREE YEARS.
P367	THE CLIENT HAS BEEN TOTALLY WITHOUT TEETH AND AN APPLIANCE FOR FIVE YEARS.
P392	THE CLIENT IS MISSING AN ANTERIOR TOOTH AND/OR HAS TWO OR MORE POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P405	THE SERVICE(S) REQUESTED COULD ADEQUATELY BE PERFORMED IN THE DENTAL OFFICE.
P406	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE OF GOOD PERIODONTAL HEALTH (AMERICAN ACADEMY OF PERIODONTOLOGY PERIODONTAL CLASSIFICATION OF TYPE I OR II).
P407	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE VISIBLE ON RADIOGRAPHS THAT AT LEAST 50 PERCENT OF THE CLINICAL CROWN IS INTACT.
P409	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING SIX OR MORE TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED, INCLUDING THIRD MOLARS.
P410	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING ONE OR MORE ANTERIOR TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED.
P411	DOCUMENTATION DOES NOT SUPPORT THE NEED FOR PERIODONTIC SERVICES. POCKETS ARE LESS THAN 4MM AND/OR GREATER THAN 6MM FOR CLIENT AND/OR THE CLIENT IS UNDER THE AGE OF 13.
P412	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA.
P413	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA. THIS PA HAS BEEN GRANTED AS APPROVED NOT APPROVED WITH REVISIONS. THE DURATION REQUESTED MAY HAVE BEEN REDUCED TO REFLECT COVERAGE LIMITATIONS, PRESCRIBER ORDERS, CONFLICTI
P417	THE SERVICE(S) REQUESTED COULD BE ADEQUATELY PERFORMED WITH LOCAL ANESTHESIA.
P437	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO POOR ORAL HYGIENE.
P444	THIS LINE ITEM IS A DUPLICATE OF ANOTHER LINE ITEM ON THIS PRIOR AUTHORIZATION (PA) REQUEST. PLEASE CORRECT.
P446	THIS IS A DUPLICATE OF AN EXISTING PRIOR AUTHORIZATION (PA) REQUEST. YOU MAY CONTACT PROVIDER SERVICES IF YOU REQUIRE ASSISTANCE. DUPLICATE PA REQUEST
P448	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO DECAY HISTORY.
P449	QUESTIONABLE LONG TERM PROGNOSIS DUE TO GUM AND BONE DISEASE.
P456	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO APPARENT ROOT INFECTION.
P457	OUR RECORDS INDICATE THIS CLIENT HAS EXCEEDED ESTABLISHED PROGRAM LIMITATIONS. COLORADO MEDICAID WILL NOT AUTHORIZE NEW DENTURES.
P458	DOCUMENTATION PROVIDED INDICATES A LESS ELABORATE PROCEDURE SHOULD BE CONSIDERED.
P502	RENTAL ONLY ALLOWED; MEDICAL NEED FOR PURCHASE HAS NOT BEEN DOCUMENTED.
P503	PURCHASE ONLY ALLOWED; MEDICAL NEED FOR RENTAL HAS NOT BEEN DOCUMENTED.

Denial Code	Long Description
P504	OCCUPATIONAL THERAPY GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P505	THE SERVICE REQUESTED IS INCLUDED IN THE NURSING HOME RATE STRUCTURE.
P511	THIS NATIONAL DRUG CODE IS ONLY BILLABLE AS PART OF A COMPOUND DRUG.
P515	THE PRESENCE OF A HANDICAPPING MALOCCLUSION OR HANDICAPPING DENTOFACIAL DEFORMITY IS NOT SUPPORTED BY THE DOCUMENTATION SUBMITTED.
P521	THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVERED BY COLORADO MEDICAID.
P522	GASTRO-INTESTINAL SURGERY FOR THE PURPOSE OF WEIGHT CONTROL IS COVERED ONLY AS A LIFE THREATENING PROCEDURE.
P523	THE TREATMENT REQUEST IS NOT CONSISTENT WITH THE CLIENT'S DIAGNOSIS.
P524	PSYCHOTHERAPY PROVIDED IN THE CLIENTS HOME IS NOT A COVERED BENEFIT OF COLORADO MEDICAID .
P525	THE INFORMATION PROVIDED IS NOT CONSISTENT WITH THE INTENSITY OF SERVICES REQUESTED.
P526	INTENSIVE MULTIPLE MODALITY TREATMENT IS NOT CONSISTENT WITH THE INFORMATION PROVIDED.
P527	MULTIPLE PROVIDERS OF TREATMENT ARE NOT INDICATED FOR THIS CLIENT.
P528	THE DURATION OF TREATMENT SESSIONS EXCEED CURRENT COLORADO MEDICAID GUIDELINES.
P534	DOCUMENTATION OF POOR PHYSICAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P535	OTHER PHYSICAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P536	THE PHYSICAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P537	USE OF PHYSICAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P538	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF A PHYSICAL THERAPIST.
P539	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS AND LIVING ARRANGEMENT.
P540	GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P541	THE PROCEDURE(S) REQUESTED ARE NOT MEDICAL IN NATURE.
P542	DOCUMENTATION OF POOR OCCUPATIONAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P543	DOCUMENTATION OF POOR SPEECH THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P544	OTHER OCCUPATIONAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P546	THE OCCUPATIONAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P547	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF PHYSICAL THERAPY.
P548	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P549	ACTIVITIES TO PROMOTE DIVERSION OR GENERAL MOTIVATION ARE NONCOVERED COLORADO MEDICAID SERVICES.
P550	REVISIONS OF THE REQUEST IS NECESSITATED BY THE CLIENTS MINIMAL PROGRESS.
P551	RESTORATIVE NURSING INVOLVEMENT COULD BE INCREASED.
P552	CLIENTS DEMONSTRATED RESPONSE TO CURRENT THERAPY DOES NOT WARRANT THE INTENSE FREQUENCY REQUESTED.
P553	MAINTENANCE IS TWO TIMES PER WEEK OR LESS.
P554	THE SPEECH THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P555	USE OF OCCUPATIONAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P556	USE OF SPEECH THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P557	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF AN OCCUPATIONAL THERAPIST.
P558	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.

Denial Code	Long Description
P559	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P560	THE MATERIALS/ SERVICES REQUESTED ARE PRINCIPALLY COSMETIC IN NATURE.
P561	THE LENS FORMULA DOES NOT JUSTIFY REPLACEMENT.
P562	THE CHANGE IN THE LENS FORMULA DOES NOT WARRANT MULTIPLE REPLACEMENTS.
P563	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P564	LENSES ONLY ARE APPROVED; PLEASE DISPENSE A CONTRACTED FRAME. THE NON-CONTRACTED FRAME IS NOT MEDICALLY JUSTIFIED.
P565	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P566	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P567	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF OCCUPATIONAL THERAPY.
P568	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF SPEECH THERAPY.
P569	LEVEL, INTENSITY, OR EXTENT OF SERVICE(S) REQUESTED HAS BEEN MODIFIED CONSISTENT WITH MEDICAL NEED AS DEFINED IN THE PLAN OF CARE.
P570	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P571	THE SERVICE ASKED FOR IS NOT COVERED BY COLORADO MEDICAID AS THESE TASKS CAN BE DONE BY NURSES OR ACTIVITY STAFF.
P572	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P573	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.
P574	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P575	MEDICAL NEED FOR EQUIPMENT/ SUPPLY REQUESTED IS NOT SUPPORTED BY DOCUMENTATION SUBMITTED.
P576	OTHER SPEECH THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P577	DOCUMENTATION SUBMITTED IDENTIFIES THAT THE CLIENT HAS FEWER THAN TWO POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P582	LESS EXPENSIVE ALTERNATIVE SERVICES ARE AVAILABLE FOR THIS CLIENT.
P634	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P711	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING PERIODONTAL SCALING AND ROOT PLANNING.
P712	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING GINGIVECTOMY.
P754	AN APPROVED SUBSTANCE ABUSE DAY TREATMENT PROGRAM CANNOT EXCEED A SIX WEEK PERIOD.
P761	THE CLIENT DOES NOT APPEAR TO BE ABLE OR WILLING TO ABSTAIN FROM ALCOHOL/DRUG USAGE WHILE IN TREATMENT. THEREFORE, SUBSTANCE ABUSE DAY TREATMENT SERVICES ARE NOT APPROVED.
P764	THIS CLIENT HAS COMPLETED INTENSIVE SUBSTANCE ABUSE TREATMENT WITHIN THE PAST 12 MONTHS. THE DOCUMENTATION PROVIDED IS NOT ADEQUATE TO JUSTIFY ADDITIONAL INTENSIVE TREATMENT AT THIS TIME.
P785	A LESS THAN SIX-WEEK HEALING PERIOD HAS BEEN SPECIFIED FOR THIS PRIOR AUTHORIZATION. THEREFORE IT IS NOT NECESSARY TO WAIT THE FULL SIX WEEKS AFTER EXTRACTIONS BEFORE TAKING DENTURE IMPRESSIONS.
P818	SIX-WEEK HEALING TIME IS REQUIRED BETWEEN EDENTULATION AND FINAL IMPRESSIONS. PAYMENT FOR DENTURES WILL BE DENIED OR RECOUPED IF HEALING PERIOD IS NOT OBSERVED.
P849	COLORADO MEDICAID HAS DETERMINED THERE WERE (ARE) SEVERAL HOME HEALTH AGENCIES WILLING TO PROVIDE MEDICALLY NECESSARY SKILLED NURSING SERVICES TO THIS CLIENT.
P864	THE DOCUMENTATION YOU HAVE SUBMITTED DOES NOT MEET THE REQUIREMENTS OF COLORADO MEDICAID.
P873	THE MEDICAL NECESSITY FOR THE HOURS REQUESTED IS NOT SUPPORTED BY THE INFORMATION SUBMITTED.
P874	THE DOCUMENTATION SUBMITTED INDICATES THE TASKS SPECIFIED CAN BE COMPLETED DURING THE VISITS APPROVED.

Denial Code	Long Description
P878	THE DOCUMENTATION SUBMITTED DOES NOT INDICATE THAT MEDICALLY ORIENTED TASKS ARE MEDICALLY NECESSARY; THEREFORE PERSONAL CARE SERVICES HAVE BEEN APPROVED.
P880	THE QUANTITY OF SERVICES AUTHORIZED FOR THIS CLIENTS PERSONAL CARE HAS BEEN AMENDED BASED ON INFORMATION RECEIVED FROM ONE OR MORE OF THESE SOURCES: THE CLIENT, THEIR PHYSICIAN, AND/OR THE IN-HOME VISIT BY STAFF OF THE OIG (OFFICE OF INSPECTOR GENERAL).
P885	THE USE OF THIS DRUG FOR THE INTENDED PURPOSE IS NOT COVERED BY COLORADO MEDICAID, CONSISTENT WITH COLORADO ADMINISTRATIVE CODE AND FEDERAL LAW.
P924	THE MEDICAL RECORDS SUBMITTED WITH THE CURRENT REQUEST CONFLICT OR DISAGREE WITH OUR MEDICAL RECORDS ON THIS CLIENT.
P950	INDEPENDENT NURSES, PLEASE NOTE PAYABLE SERVICES MAY NOT EXCEED 12 HOURS/DAY OR 60 HOURS/WEEK.
P951	SERVICES CAN ONLY BE AUTHORIZED THROUGH ONE YEAR FROM THE PRESCRIPTION DATE.
P952	LEAD INSPECTION IS A COVERED COLORADO MEDICAID SERVICE WHEN THE CHILD HAS BEEN SHOWN TO HAVE LEAD POISONING (E.G., CHILD HAS A BLOOD LEAD LEVEL > 19 UG/DL OR TWO CONSECUTIVE BLOOD LEAD LEVELS OF 15-19 UG/DL DONE AT LEAST 90 DAYS APART). THE INSPECTION MUS
P953	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P954	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P956	THE REQUEST CAN ONLY BE BACKDATED A MAXIMUM OF 14 DAYS FROM FIRST DATE RECEIVED BY COLORADO MEDICAID.
P957	COMPLETE PERIODONTAL CHARTING AT TIME OF SERVICE, AND SUBMIT CHARTING, COPY OF OPERATIVE REPORT, TOGETHER WITH A COPY OF THE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF), F-11035, TO PA UNIT ATTENTION DENTAL CONTSULTANT.
P958	NOTE THAT CODE D4341 HAS BEEN CHANGED. REFER TO THE DECISION NOTICE FOR AUTHORIZED QUANTITY.
P960	YOUR PA HAS BEEN APPROVED FOR 90 DAYS. THE 90 DAY APPROVAL DOES NOT IMPLY THE PA REQUEST MEETS PRIOR AUTHORIZATION CRITERIA. AFTER ADDITIONAL INFORMATION IS AVAILABLE IN INTERCHANGE, COLORADO MEDICAID WILL CREATE AN AMENDMENT REQUEST TO EXTEND THE PA FOR
P961	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P962	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
PA10	THE REQUESTED END DATE IS INVALID.
PA12	PLEASE FURNISH A WRITTEN DESCRIPTION OF THE CLIENTS DIAGNOSIS.
PA13	PROVIDE DIAGNOSES WITH DATES OF ONSET.
PA14	IDENTIFY PROBLEMS TO BE TREATED.
PA15	THE AUDIOLOGISTS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1), F-11020, AND PRIOR AUTHORIZATION REQUEST/HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2), F-11021.
PA16	THE PHYSICIANS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION/PHYSICIAN OTOLOGICAL REPORT (PA/POR), F-11019.
PA17	SUBMIT BRIEF HISTORY WITH REFERRAL INFORMATION, LIVING SITUATION, FUNCTIONAL STATUS, AND OTHER PERTINENT INFORMATION. WHAT CHANGE OF STATUS RESULTED IN REFERRAL AT THIS TIME?
PA18	PLEASE FURNISH THE CLIENTS HEIGHT AND WEIGHT.
PA19	PLEASE SUBMIT CLINICAL INFORMATION SUFFICIENT TO VERIFY THE NEED FOR THE REQUESTED SERVICE(S).
PA20	PLEASE RESUBMIT WITH COMPLETE PERIODONTAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PA21	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL EDUCATIONAL PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA22	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL PROGRAM PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.

Denial Code	Long Description
PA23	REFER TO THE DURABLE MEDICAL EQUIPMENT INDEX FOR APPROPRIATE CODE AND DESCRIPTION. DO NOT USE AN "UNLISTED" CODE.
PA24	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUALIZED FAMILY SERVICE PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA25	INFORMATION ON THE REQUEST FORM IS ILLEGIBLE, AND THE REQUEST CANNOT BE PROCESSED.
PA26	RE-EVALUATE YOUR GOALS. EMPHASIS SHOULD BE ON FUNCTIONAL SELF-CARE. GOALS MUST BE RELATED TO FUNCTIONAL OUTCOME.
PA27	PLEASE CLARIFY THE NUMBER OF HOURS PER WEEK REQUESTED.
PA28	PLEASE CLARIFY THE NUMBER OF HOURS PER DAY REQUESTED.
PA29	PLEASE CLARIFY THE NUMBER OF VISITS PER DAY REQUESTED.
PA30	ATTACH SUPPORTIVE DOCUMENTATION; HOME EXERCISE PROGRAM AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA31	THE DIAGNOSIS CODE INDICATED ON THE REQUEST DOES NOT CORRESPOND TO THE DIAGNOSIS CODE DESCRIPTION.
PA32	PLEASE SUBMIT ADDITIONAL INFORMATION SUFFICIENT TO VERIFY APPROPRIATENESS AND NEED FOR TRANSPLANT.
PA33	PLEASE SUBMIT THE INITIAL AND PROGRESSIVE OBJECTIVE FINDINGS.
PA34	ATTACH SUPPORTIVE DOCUMENTATION, FACILITY PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA35	PLEASE SUBMIT THE CLIENTS ORIGINAL COMPLAINTS AND EXAMINATION FINDINGS.
PA36	ATTACH SUPPORTIVE DOCUMENTATION, IN-HOME AUTISM PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA37	PLEASE SUBMIT YOUR TREATMENT PLAN FOR THIS CLIENT.
PA38	ATTACH SUPPORTIVE DOCUMENTATION AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA39	INITIAL EVALUATIONS MUST BE PERFORMED BY AN OCCUPATIONAL THERAPIST REGISTERED (OTR), PER AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA) STANDARDS.
PA41	IDENTIFY THE PLACE OF SERVICE AND ITS EFFECT ON SUPPORTING THE DESIRED TREATMENT OUTCOME.
PA42	PLEASE INDICATE THE HOURS OF USE OF OXYGEN PER 24-HOUR PERIOD.
PA43	PROVIDE BASELINE DOCUMENTATION FOR THIS CLIENTS LIMITATIONS USING UNITS OF MEASUREMENT THAT ARE APPLIED CONSISTENTLY WHEN REPORTING STATUS.
PA44	IDENTIFY FUNCTIONAL LIMITATIONS AS THEY ARE RELATED TO IDENTIFIED CONDITIONS.
PA46	CORRELATE PLAN OF CARE TO REQUESTED PROCEDURE CODES.
PA47	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE FREQUENCY/DURATION REQUESTED.
PA48	PLEASE PROVIDE THE NAME AND CREDENTIALS OF THE RENDERING PROVIDER.
PA50	COLORADO MEDICAID RECORDS INDICATE THE CLIENT OWNS A WHEELCHAIR. DOCUMENT THE REASON AND NEED FOR REPLACEMENT AND COST TO REPAIR CURRENT WHEELCHAIR.
PA51	PLEASE DISTINGUISH PRIMARY AND SUPPORTIVE MODALITIES.
PA52	PLEASE SUBMIT A PROGRESS REPORT.
PA53	MULTIPLE FAMILY CLIENTS TREATMENT BY THE SAME PROVIDER REQUIRES FURTHER INFORMATION DOCUMENTING COORDINATION OF TREATMENT PLAN.
PA54	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE MINUTES REQUESTED.
PA55	MEDICAL NECESSITY OF TREATMENT REQUIRES ADDITIONAL DOCUMENTATION.
PA56	GIVEN AGE, DIAGNOSES, CURRENT LEVEL OF FUNCTION, PAST RESPONSE TO TREATMENT, AND LIVING SITUATION, EXPAND ON POTENTIAL FOR SIGNIFICANT FUNCTIONAL PROGRESS WITHIN THE NEXT SIX MONTHS. EMPHASIZE WHY PROGRESS IS EXPECTED WITH SERVICES AT THIS TIME.
PA57	SUBMIT THE INITIAL FINDINGS. INCLUDE A COMPREHENSIVE EVALUATION.
PA58	SUBMIT PROGRESSIVE, OBJECTIVE FINDINGS. INCLUDE A PERTINENT RE-EVALUATION.
PA59	PLEASE SUPPLY INFORMATION REGARDING THE CLIENTS MEDICATION REQUIREMENTS, IF ANY.
PA60	PLEASE SPECIFY IF THE CLIENT IS IN AN EDUCATIONAL SETTING.
PA61	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).

Denial Code	Long Description
PA62	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
PA63	THE SKILLS OF A THERAPIST ARE PURPOSEFUL AND SKILLED INTERVENTIONS REQUIRED TO CONTINUALLY DESIGN, IMPLEMENT, REASSESS, MODIFY/GRADE, AND/OR DISCONTINUE A PLAN OF CARE IN A TIMELY MANNER, BASED ON THE COMPLEXITY OF THE CLIENTS MEDICAL CONDITION AND/OR CO
PA64	PLEASE SUBMIT A THERAPY PLAN OF CARE, INCLUDING A CURRENT, DATED EVALUATION.
PA65	A PLAN OF CARE SIGNED AND DATED BY THE PHYSICIAN IS REQUIRED.
PA66	THE SKILLS OF A THERAPIST ARE REQUIRED WHEN ONLY THE THERAPIST CAN SAFELY AND EFFECTIVELY DELIVER THE THERAPEUTIC PROCEDURES BECAUSE OF THEIR UNIQUE KNOWLEDGE, TRAINING, AND EXPERTISE. DESCRIBE THE REASON THAT SOMEONE OTHER THAN A THERAPIST CANNOT SAFELY
PA67	PLEASE SPECIFY IF THE CLIENTS WORK SITE DEMANDS GOOD BINAURAL HEARING.
PA68	DESCRIBE THE REASON, BASED ON THE CLIENTS COGNITIVE, PHYSICAL, COMMUNICATION, OR RESOURCE STATUS, THAT A HOME PROGRAM, EQUIPMENT, OR ENVIRONMENTAL ADAPTATIONS ALONE CANNOT MEET CLIENTS NEEDS.
PA69	PLEASE SPECIFY IF THE CLIENT HAS AN ACCOMPANYING DISABILITY THAT ADDS TO THE HEARING PROBLEM.
PA70	DISTINGUISH REQUESTED PROCEDURES AND GOALS FROM OTHER SERVICES THIS CLIENT RECEIVES. THEY MAY NOT BE DUPLICATIVE.
PA71	PLEASE INDICATE THE NUMBER OF DAYS REQUESTED.
PA73	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA74	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA75	PLEASE DOCUMENT CARRYOVER OF THE THERAPY PROGRAM TO NURSING.
PA76	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA79	PROVIDE EVIDENCE OF SIGNIFICANT FUNCTIONAL PROGRESS IN LAST SIX MONTHS.
PA84	THE GRANT DATE OF THIS REQUEST CANNOT BE PRIOR TO THE SIGNATURE DATE OF THE PRESCRIBING PHYSICIAN.
PA86	PROVIDE EVIDENCE OF SKILLS GAINED IN THERAPY CARRYING OVER TO OTHER SETTINGS WITHIN SIX MONTHS.
PA87	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE NUMBER OF SESSIONS REQUESTED.
PA88	THE REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL SCOPE OF PRACTICE.
PA89	PRIOR AUTHORIZATION IS NOT REQUIRED UNTIL LIMITATION OF SERVICE HAS BEEN REACHED.
PA91	PLEASE SUBMIT REQUIRED X-RAYS.
PA92	PLEASE PROVIDE AN EXPLANATION FOR THE MATERIAL SUBMITTED WITH THE REQUEST.
PA95	PLEASE DESCRIBE HOW THE PROVISION OF THIS SERVICE WOULD PREVENT INSTITUTIONALIZATION OF THE CLIENT.
PA96	COULD THE EXISTING DENTURE(S) BE RELINED OR REBASED? IF NOT, PLEASE EXPLAIN WHY NOT.
PA97	REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL STANDARDS OF PRACTICE.
PA98	PLEASE INDICATE IF THE CLIENT IS CURRENTLY BEING TUBE FED.
PB02	PLEASE PROVIDE THE REQUIRED DATED SIGNATURES ON THE ATTACHMENTS.
PB03	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING THE LOSS/DESTRUCTION/THEFT OF THE HEARING AID.
PB04	DESCRIBE THE CLIENTS ABILITY TO STAND OR AMBULATE SUFFICIENTLY TO ACCOMPLISH SELF-CARE ACTIVITIES.
PB07	PLEASE SUBMIT AN ORTHODONTIC STUDY MODEL OR DIAGNOSTIC CASTS.
PB09	PLEASE PROVIDE A PHOTOGRAPH OF THE INVOLVED AREA(S).
PB10	PLEASE PROVIDE AN ESTIMATION (IN GRAMS) OF THE TOTAL AMOUNT OF TISSUE TO BE RESECTED.
PB11	PLEASE SUBMIT THE PLAN OF CARE FOR CO-TREATMENT.
PB12	FURNISH A DETAILED DESCRIPTION FOR THE PROCEDURE CODE REQUESTED.
PB13	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB15	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.

Denial Code	Long Description
PB18	PLEASE COMPLETE THE ATTACHED OUT-OF-STATE PROVIDER DATA SHEET, F-11001, AND RESUBMIT.
PB20	A SIGNED AND DATED PRESCRIPTION IS REQUIRED WITHIN THREE MONTHS OF RECEIPT BY COLORADO MEDICAID FOR INITIAL REQUESTS AND WITHIN 12 MONTHS OF RECEIPT BY COLORADO MEDICAID FOR SUBSEQUENT REQUESTS.
PB21	PLEASE COMPLETE THE APPROPRIATE PRIOR AUTHORIZATION ATTACHMENT. CONTACT PROVIDER SERVICES OR THE PRIOR AUTHORIZATION UNIT FOR ASSISTANCE.
PB23	PHYSICAL THERAPY ASSISTANT NOTES AND ALL FORMS SUBMITTED MUST BE COSIGNED BY A REGISTERED PHYSICAL THERAPIST.
PB31	ARE YOU REQUESTING A COMPLETE APPLIANCE, OR REPLACEMENT PARTS?
PB32	THE PROCEDURE CODE INDICATED ON THE REQUEST DOES NOT MATCH THE DESCRIPTION OF SERVICE; PLEASE CORRECT AND RESUBMIT.
PB35	THE SERVICE REQUESTED DOES NOT REQUIRE PRIOR AUTHORIZATION.
PB41	PLEASE FURNISH A CURRENT MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT, F-11090 (DATED WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID).
PB45	THE CERTIFICATION PERIOD ON THE PLAN OF CARE (POC) DOES NOT COVER THE REQUESTED GRANT/START DATE. PLEASE RESUBMIT YOUR REQUEST WITH A NEW POC.
PB49	A CERTIFIED OCCUPATIONAL THERAPY ASSISTANTS NOTES MUST BE COSIGNED BY AN OCCUPATIONAL THERAPIST REGISTERED.
PB51	ADDITIONAL INFORMATION IS REQUIRED ON PRIOR AUTHORIZATION TO ENABLE PRICING.
PB54	REQUESTED SERVICES DO NOT MATCH SERVICES ON THE PHYSICIANS ORDERS.
PB59	PLEASE PROVIDE AN INDIVIDUAL EDUCATIONAL PLAN (IEP), WHICH HAS BEEN SIGNED BY THE PROVIDER NO EARLIER THAN NINE MONTHS PRIOR TO RECEIPT AT COLORADO MEDICAID; OTHERWISE, DOCUMENT WHY NO IEP EXISTS.
PB65	PLEASE FURNISH THE ANTICIPATED TOTAL CHARGES FOR THIS REQUEST.
PB66	A PHOTOCOPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED; THE DATE MUST BE WITHIN SIX MONTHS OF RECEIPT BY COLORADO MEDICAID.
PB67	THE PRESCRIPTION DATE MUST INCLUDE MONTH, DAY, AND YEAR.
PB68	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID.
PB73	THE SERVICES IDENTIFIED ON THE PLAN OF CARE DO NOT APPEAR APPROPRIATE FOR THE PROCEDURE CODE(S) REQUESTED ON THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018.
PB74	THE CLIENT/PROVIDER DOES NOT HAVE RETROACTIVE ENROLLMENT.
PB75	THE REQUESTED START DATE IS MORE THAN 14 DAYS BEFORE OR 62 DAYS AFTER RECEIPT.
PB82	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
PB83	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A HOME HEALTH AIDE. PLEASE RESUBMIT AS A PERSONAL CARE WORKER OR PROVIDE ADDITIONAL DOCUMENTATION.
PB86	THE SERVICES REQUESTED ARE NOT BEING PROVIDED IN THE CLIENTS RESIDENCE. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL.
PB87	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A NURSE. PLEASE RESUBMIT AS A HOME HEALTH AIDE OR PROVIDE ADDITIONAL DOCUMENTATION.
PB92	PLEASE FURNISH THE CLIENTS COMPLETE ADDRESS.
PB94	IF THE CLIENT IS A RESIDENT OF A NURSING HOME, SUPPLY THE COMPLETE NAME AND ADDRESS OF THE NURSING HOME.
PB99	THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018, MUST BE SIGNED AND DATED.
PC01	PLEASE SUPPLY THE RENDERING PROVIDERS PROVIDER NUMBER.
PC03	THE DRUG ENFORCEMENT ADMINISTRATION NUMBER IS MISSING OR INVALID.
PC06	PLEASE DESCRIBE YOUR PROGRAM; INCLUDE ENTRY DATE, TERMINATION DATE, HOURS PER WEEK, AND NUMBER OF WEEKS OF PRIMARY INTENSIVE SERVICE REQUESTED.
PC07	PLEASE DESCRIBE YOUR "AFTERCARE/FOLLOW-UP" PLANS FOR THIS CLIENT.
PC08	PLEASE SUPPLY DOCUMENTATION OF PREVIOUS SUBSTANCE ABUSE SERVICES WITH DATE(S) AND OUTCOME.
PC09	PLEASE DESCRIBE IN DETAIL THE TREATMENT OBJECTIVES/GOALS FOR THIS CLIENT.

Denial Code	Long Description
PC10	PLEASE DESCRIBE THE FAMILY SITUATION/DYNAMICS. EXPLAIN HOW THE FAMILY WILL BE INCORPORATED INTO THE CLIENTS PLAN OF CARE.
PC12	PLEASE EXPLAIN IF YOUR SERVICE ENCOURAGES THE CLIENT TO ATTEND SELF-HELP GROUPS.
PC13	PLEASE SUPPLY A SPECIFIC SCHEDULE OF ACTIVITIES, INCLUDING DAY, TIME OF DAY, LENGTH OF SESSION, AND SERVICE TO BE RENDERED DURING THAT TIME.
PC15	PLEASE FURNISH DIAGNOSTIC RATIONALE.
PC17	PLEASE DOCUMENT IF THE CLIENT EVER RECEIVED SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT.
PC19	PLEASE FURNISH MORE EXTENSIVE AND IN-DEPTH HISTORICAL AND PSYCHOSOCIAL DATA.
PC20	PLEASE SUPPLY THE DATE THE CLIENT BECAME TOTALLY ENDENTULOUS.
PC23	PLEASE SUBMIT A PHYSICIANS STATEMENT REGARDING THE MEDICAL NECESSITY OF DENTURES FOR THIS CLIENT. THE PHYSICIANS STATEMENT MUST DOCUMENT THE MEDICAL NEED FOR DENTURES.
PC24	THE SERVICE REQUESTED WAS PREVIOUSLY AUTHORIZED. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT INDICATING THIS FACT IS REQUIRED.
PC25	PLEASE SUPPLY SUFFICIENT MITIGATING CIRCUMSTANCES TO WARRANT THE CONSTRUCTION OF NEW DENTURES(S).
PC26	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
PC28	PLEASE SUBMIT A PHYSICIANS STATEMENT INDICATING DENTURES ARE NECESSARY FOR THIS NURSING HOME CLIENT.
PC29	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING LOSS OR DESTRUCTION OF DENTURE(S). INCLUDE SIGNED STATEMENT FROM CLIENT OR FACILITY DIRECTOR REGARDING HOW, WHEN AND WHERE LOST.
PC30	PLEASE PROVIDE COMPLETE INTRAORAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PC31	PLEASE DESCRIBE ANY RELATED DEFORMITIES OF THE FEET.
PC34	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD WITH REQUESTED DME ITEM(S) AND DOCUMENT IF THE CLIENT CAN USE SAFELY AND INDEPENDENTLY.
PC35	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD AND DESCRIBE THE RESULTS AND EFFECTIVENESS OF THE SERVICE REQUESTED.
PC39	PLEASE INDICATE LITER FLOW PER MINUTE, HOURS OF USE PER 24 HOUR PERIOD, AND THE EXPECTED DURATION OF NEED.
PC40	THE ITEM DOES NOT REQUIRE PRIOR AUTHORIZATION UNTIL THE LIFE EXPECTANCY HAS BEEN REACHED.
PC41	PLEASE SUPPLY INFORMATION INDICATING THE NECESSITY OF POSITIONING THE CLIENT'S BODY IN MULTIPLE POSITIONS.
PC42	PLEASE INDICATE IF THE BED HEIGHT MUST BE CHANGED TO ALLOW FOR SAFE TRANSFER OR ADEQUATE BED CARE.
PC43	SUPPLY A PHYSICIANS STATEMENT INDICATING TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR UNIT HAS REDUCED PAIN, IMPROVED/INCREASED THE CLIENTS ACTIVITY LEVEL, AND/OR REDUCED CLIENTS USE OF PAIN MEDICATION.
PC44	A CURRENT AUTHORIZATION FOR THIS SERVICE IS ON FILE FOR ANOTHER PROVIDER. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT OF THAT FACT IS REQUIRED BY THE CLIENT OF FIRST PROVIDER.
PC59	DOCUMENT DECLINE OR PROGRESS IN SPECIFIC, MEASURABLE, OBJECTIVE TERMS.
PC60	DOCUMENT IF CLIENT HAS DEMONSTRATED A GOOD APPOINTMENT COMPLIANCE RECORD.
PC61	THE PHYSICIANS SIGNATURE DATE MUST NOT EXCEED 90 DAYS FROM THE DATE OF RECEIPT BY COLORADO MEDICAID.
PC62	REQUESTS FOR A CONTINUATION OF THERAPY SHOULD NOT BE SUBMITTED MORE THAN FOUR WEEKS PRIOR TO THE EXPIRATION DATE OF THE CURRENT AUTHORIZATION.
PC63	PLEASE FURNISH THE STYLE AND MANUFACTURER OF THE FRAME.
PC64	PLEASE FURNISH THE CLIENTS LENS FORMULA.
PC66	ALL REQUESTS FOR TINTS REQUIRE DOCUMENTATION OF THE VISUAL OR MEDICAL CONDITION RELATED TO PHOTOPHOBIA.
PC67	PLEASE DOCUMENT THE REASON AND JUSTIFICATION FOR REPLACEMENT BEYOND THE FIRST LENS/FRAME.
PC68	DOCUMENT IF ALL REMAINING MAXILLARY AND/OR MANDIBULAR TEETH ARE DECAY-FREE, PROPERLY RESTORED, AND PERIODONTICALLY SOUND.

Denial Code	Long Description
PC72	SUPPLY MORE DETAIL REGARDING PROGRESS (ATTACHMENT OF GOALS, ETC.). CORRELATE PROGRESS TO PREVIOUS GOALS AND IDENTIFIED LIMITATIONS.
PC77	PLEASE SUBMIT A PLAN OF CARE DESCRIBING THE SERVICES THAT WOULD BE PROVIDED.
PC78	PLEASE DOCUMENT SPECIFIC, MEASURABLE GOALS.
PC82	THE PRIOR AUTHORIZATION (PA) SYSTEM CAN PROCESS ONLY 26 DETAILS PER PA REQUEST. PLEASE RESUBMIT YOUR REQUEST WITH NO MORE THAN 26 DETAILS.
PC83	PLEASE SUPPLY A PHYSICIANS PRESCRIPTION DATED WITHIN ONE MONTH OF REQUESTED SUBSTANCE ABUSE DAY TREATMENT.
PC84	PLEASE PROVIDE INFORMATION INDICATING THIS CLIENT IS APPROPRIATELY DETOXIFIED FROM ALCOHOL AND/OR OTHER DRUGS.
PC85	PLEASE PROVIDE INFORMATION TO INDICATE THE CLIENTS ABILITY TO ABSTAIN FROM ALCOHOL OR DRUGS WHILE IN THE SUBSTANCE ABUSE DAY TREATMENT PROGRAM.
PC86	PLEASE INDICATE IF THIS CLIENT IS WILLING TO PARTICIPATE IN AFTERCARE OR CONTINUING CARE SERVICES.
PC87	PROVIDE MORE INFORMATION ON TREATMENT HISTORY; INCLUDE SERVICE PROVIDED, DATES, AND OUTCOME. PROVIDE DETAIL OF PREVIOUS TREATMENT.
PC88	PLEASE PROVIDE MORE RATIONALE FOR THE APPROPRIATENESS AND MEDICAL NECESSITY OF SUBSTANCE ABUSE DAY TREATMENT.
PC89	PROVIDE A TREATMENT PLAN THAT CONTAINS MEASURABLE GOALS AND OBJECTIVES CORRESPONDING TO THE IDENTIFIED DEFICIT.
PC91	PLEASE PROVIDE MORE INFORMATION ON FAMILY INVOLVEMENT TREATMENT.
PC92	PLEASE PROVIDE MORE HISTORY AND EXPLANATION ABOUT THE ISSUE OF ABSTINENCE FOR THIS CLIENT.
PC94	PLEASE PROVIDE THE ANTICIPATED BEGINNING DATE AND/OR THE ESTIMATED SUBSTANCE ABUSE DAY TREATMENT DISCHARGE DATE.
PC95	PLEASE SUPPLY JUSTIFICATION FOR BEGINNING CLIENT IN SERVICE PRIOR TO AUTHORIZATION BEING OBTAINED.
PC96	THE INITIAL THREE HOURS OF SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IN A CALENDAR YEAR DO NOT REQUIRE PRIOR AUTHORIZATION.
PC97	REIMBURSEMENT FOR INITIAL SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IS LIMITED TO THREE HOURS IN A CALENDAR YEAR AND DOES NOT REQUIRE PRIOR AUTHORIZATION.
PC98	THIS DRUG IS CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE BILL USING THE APPROPRIATE NATIONAL DRUG CODE (NDC) OR SUBMIT A COMPLETED DRUG ADDITION REQUEST FORM IF THE NDC IS NOT LISTED IN THE DRUG INDEX.
PC99	THIS DRUG IS NOT CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL, CURRENT ADMINISTRATIVE RULE, OR COLORADO DRUG INDEX FOR COVERAGE LIMITATIONS.
PD01	DOCUMENT THAT CLIENT HAS ACHIEVED GOOD ORAL HYGIENE, PERIODONTAL CASE TYPE 1 OR 2, AND IS MOTIVATED TO MAINTAIN SAME.
PD03	PLEASE PROVIDE AN ARTERIAL BLOOD GAS READING OR PULSE OXIMETRY RESULTS DONE ON ROOM AIR SIGNED AND DATED BY A MEDICAL DOCTOR. THIS SHOULD BE DONE WITHIN 60 DAYS OF REQUESTED SERVICE.
PD04	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 30 DAYS OF RECEIPT BY COLORADO MEDICAID.
PD07	SUBMIT A PHOTOCOPY OF A VALID PRESCRIPTION, ISSUED WITHIN THE PAST YEAR, OR COMPLETE SECTION B OF THE PRIOR AUTHORIZATION/DRUG ATTACHMENT (PA/DGA), F-11049.
PD10	BRAND MEDICALLY NECESSARY MUST BE IN THE PRESCRIBERS OWN HANDWRITING AND WRITTEN DIRECTLY ON THE PRESCRIPTION OR A SEPARATE ORDER ATTACHED TO THE ORIGINAL PRESCRIPTION.
PD12	COMPLETE DENTURES, PARTIAL DENTURES, DENTURE RELINES, AND FIXED PROSTHODONTIC SERVICES ARE NOT COVERED SERVICES FOR ADULTS FOR DATES OF SERVICE ON AND AFTER OCTOBER 1, 1995.
PD22	PLEASE COMPLETE ALL REQUIRED ELEMENTS ON THE PERSONAL CARE SCREENING TOOL (PCST), F-11133.
PD24	THIS PRIOR AUTHORIZATION REQUEST IS UNABLE TO BE PROCESSED. PLEASE RESUBMIT WITH ADDITIONAL REQUIRED FORMS, INCLUDING THE ENTIRE PERSONAL CARE SCREENING TOOL (PCST), F-11133; PERSONAL CARE ADDENDUM, F-11136; AND SUPPORTING DOCUMENTATION, AS DIRECTED.

Denial Code	Long Description
PD25	THERE IS A PERSONAL CARE SCREENING TOOL (PCST), F-11133, COMPLETED BY ANOTHER AGENCY. CONTACT THE AGENCY TO TRANSFER SCREEN.
PD26	THERE IS A LIMITED TERM CARE FUNCTIONAL SCREEN (LTC-FS) COMPLETED BY ANOTHER AGENCY. THE PERSONAL CARE SCREENING TOOL (PCST), F-11133, INFORMATION IS IN CONFLICT WITH LTC-FS.
PD27	ONLY ONE LEVEL OF FUNCTION MAY BE SELECTED FOR ALL ELEMENTS EXCEPT TOILETING. COLORADO MEDICAID IS UNABLE TO PROCESS THE PRIOR AUTHORIZATION REQUEST.
PD28	NO UNITS MAY BE REQUESTED USING THIS PRIOR AUTHORIZATION PROCESS. PLEASE SUBMIT WITH THE APPROPRIATE ATTACHMENTS FOR REQUESTING SPECIFIC PERSONAL CARE WORKER UNITS.
PD29	CLIENT IS NOT ELIGIBLE FOR THE REQUESTED SERVICE(S) AS OF THE REQUESTED START DATE.
PD30	NO TRAVEL TIME MAY BE AUTHORIZED WHEN NO PERSONAL CARE WORKER SERVICE IS AUTHORIZED.
PD32	PROVIDER NOT CERTIFIED TO RENDER THE SERVICE(S) REQUESTED.
PD34	BASED ON THE DOCUMENTATION SUBMITTED, THIS REQUEST CAN NOT BE PRIOR AUTHORIZED. REFER TO THE PA MESSAGES FROM THE CONSULTANT FOR COMPLETE EXPLANATION.
PD98	PLEASE DOCUMENT HOW AND WHEN EACH PREVIOUSLY AUTHORIZED PRO RE NATA VISIT WAS USED.

Children's Extensive Support (CES)

Denial Code	Long Description
0201	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
0233	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0235	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0237	CLIENT IDENTIFICATION NUMBER DOES NOT MATCH CLIENTS FIRST NAME.
0238	THE CLIENT IDENTIFICATION NUMBER DOES NOT MATCH THE CLIENTS LAST NAME.
0242	SECONDARY DIAGNOSIS CODE IS INVALID.
0248	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0249	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0251	PROCEDURE CODE MODIFIER IN FIRST POSITION IS INVALID.
0252	THE PROCEDURE CODE MODIFIER IN SECOND POSITION IS INVALID FOR REQUESTED START DATE OR DATE OF RECEIPT.
0253	THE PROCEDURE CODE MODIFIER IN THIRD POSITION IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
0258	THE PRIMARY DIAGNOSIS CODE IS REQUIRED.
0272	THE PRIMARY DIAGNSOSIS CODE IS INVALID.
0400	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0853	HCPCS - ANNUAL UPDATE
0885	NEVER EVENTS MODIFIERS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
0886	NEVER EVENTS DIAGNOSIS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
1000	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
1002	RENDERING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1003	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1007	RENDERING PROVIDER ID IS NOT ON FILE.
1047	THE RENDERING PROVIDERS CERTIFICATION HAS BEEN CANCELLED.
1048	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1801	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
1804	A CERTIFIED SUBSTANCE ABUSE DAY TREATMENT PROVIDER MUST SUBMIT A SUBSTANCE ABUSE DAY TREATMENT PROCEDURE CODE.
1806	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.

Denial Code	Long Description
1808	THE BILLING PROVIDER DOES NOT HAVE THE REQUIRED CERTIFICATION ADDENDUM ON FILE.
1900	THE BILLING PROVIDERS TAXONOMY CODE IS INVALID.
1901	THE RENDERING PROVIDERS TAXONOMY CODE IS INVALID.
1927	A NATIONAL PROVIDER IDENTIFIER IS REQUIRED FOR THE BILLING PROVIDER.
1934	A NATIONAL PROVIDER INDENTIFIER IS REQUIRED FOR THE RENDERING PROVIDER.
1936	THE BILLING PROVIDER NUMBER IS INVALID.
1937	THE RENDERING PROVIDER NUMBER IS INVALID.
1960	INTERNAL PROCESSING IS REQUIRED.
1963	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.
1964	THE BILLING PROVIDER INDICATED IS NOT ALLOWABLE AS A BILLING PROVIDER.
1965	RENDERING PROVIDER NUMBER IS MISSING/INVALID FOR THIS PROCEDURE PROVIDER.
1974	PRESCRIBING/REFERRING/ORDERING PROVIDER INDICATED IS NOT CERTIFIED AS A PRESCRIBING/REFERRING/ORDERING PROVIDER.
1975	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
1976	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
2001	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2003	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2017	THE CLIENT IS ENROLLED IN A MEDICAID OR OTHER MANAGED CARE PROGRAM.
2037	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2603	CLIENT LOCKED-IN TO A PROVIDER OR ENROLLED IN A HOSPICE. CONTACT CLIENTS HOSPICE FOR PAYMENT OF SERVICES OR RESUBMIT WITH DOCUMENTATION OF UNRELATED NATURE OF CARE.
3324	THE MODIFIER HAS BEEN DISCONTINUED BY THE CENTERS OF MEDICARE AND MEDICAID SERVICES OR THE AMERICAN MEDICAL ASSOCIATION FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
3337	THE PROCEDURE CODE HAS BEEN TERMINATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AMERICAN MEDICAL ASSOCIATION, OR AMERICAN DENTAL ASSOCIATION FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT. RESUBMIT WITH VALID A PROCEDURE CODE.
3339	THE PROCEDURE BILLED IS NOT PAYABLE ACCORDING TO DEFICIT REDUCTION ACT (DEFRA) GUIDELINES.
3351	THE PROCEDURE IS NOT COVERED FOR CLIENTS WITH A NURSING HOME AUTHORIZATION ON THE REQUESTED START DATE OR DATE OF RECEIPT.
3353	THE PROCEDURE IS NOT A COVERED SERVICE FOR HOME AND COMMUNITY-BASED WAIVER CLIENTS.
4021	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4027	THE DIAGNOSIS CODE IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
4031	THE PROCEDURE SUBMITTED IS NOT APPROPRIATE FOR CLIENTS GENDER.
4032	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4034	THE PROCEDURE CODE HAS AN AGE RESTRICTION.
4036	THE PLACE OF SERVICE CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4040	THE PRIMARY DIAGNOSIS CODE IS NOT ON FILE.
4041	THE SECONDARY DIAGNOSIS IS NOT ON FILE.
4046	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4127	INTERNAL PROCESSING IS REQUIRED.
4131	INTERNAL PROCESSING IS REQUIRED.
4141	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4149	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4150	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4236	ETIOLOGY DIAGNOSIS CODE(S) (E-CODES) ARE INVALID AS THE PRIMARY DIAGNOSIS.
4244	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4245	THE FOURTH POSITION MODIFIER IS INVALID FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT.
4256	THE PROCEDURE CODE AND MODIFIER COMBINATION IS NOT PAYABLE FOR THE CLIENTS BENEFIT PLAN.
4257	THE MODIFIERS SUBMITTED ARE EITHER INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT OR THE MODIFIERS ARE MISSING.
4311	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4315	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.

Denial Code	Long Description
4316	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4371	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4372	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4711	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR CLIENTS AGE.
4714	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS AGE.
4731	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS DIAGNOSIS.
4742	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4743	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4744	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4745	DIAGNOSIS AND/OR PROCEDURE AND/OR PLACE OF SERVICE (POS) CODE IS NOT COVERED FOR EXPRESS ENROLLMENT CLIENTS.
4746	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4801	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4802	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
4821	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
4871	PLEASE REFER TO PA MESSAGES FOR RETURN INFORMATION.
4963	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS GENDER.
4990	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
7500	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
7509	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
P001	THE BILLING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THE SERVICES.
P002	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P003	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P005	THE PRIOR AUTHORIZATION CAN NOT BE END DATED. THE PRIOR AUTHORIZATION STATUS IS NOT APPROVED OR APPROVED WITH REVISIONS.
P006	PLEASE FURNISH THE PROCEDURE CODE AND CORRESPONDING DESCRIPTION.
P008	THE BILLING PROVIDER NUMBER IS INVALID.
P009	THE BILLING PROVIDER NUMBER IS INVALID.
P010	THE REQUESTED END DATE IS INVALID.
P011	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P012	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P013	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P014	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P015	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P016	THE REQUESTED START DATE IS MISSING OR INVALID.
P019	THE REQUESTED START DATE IS MISSING OR INVALID.
P020	THE RENDERING PROVIDER NUMBER IS INVALID.
P021	THE RENDERING PROVIDER NUMBER IS INVALID.
P022	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P023	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P024	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P026	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P027	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P030	FIRST MODIFIER IS INVALID.
P031	FIRST MODIFIER IS INVALID.
P032	SECOND MODIFIER IS INVALID.

Denial Code	Long Description
P033	SECOND MODIFIER IS INVALID.
P034	THIRD MODIFIER IS INVALID.
P035	THIRD MODIFIER IS INVALID.
P036	FOURTH MODIFIER IS INVALID.
P037	FOURTH MODIFIER IS INVALID.
P038	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P039	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P040	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P041	CLIENTS FIRST NAME IS MISSING.
P042	CLIENTS LAST NAME IS MISSING.
P043	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P044	BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES REQUESTED.
P045	FIRST MODIFIER IS INVALID.
P046	SECOND MODIFIER IS INVALID.
P047	THIRD MODIFIER IS INVALID.
P048	FOURTH MODIFIER IS INVALID.
P052	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P053	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P054	RENDERING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES FOR THE BENEFIT PLAN.
P055	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P061	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P062	THE CLIENT ID AND/OR NAME INDICATED ON THE PA REQUEST IS INCORRECT. THE CLIENT ID AND/OR NAME HAS BEEN UPDATED. PLEASE VERIFY THE ID AND/OR NAME IS CORRECT.
P064	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
P067	THE FREQUENCY OF HOURS REQUESTED ARE NOT APPROPRIATE FOR THIS CLIENT AND HAVE BEEN MODIFIED ACCORDINGLY.
P079	BILLING PROVIDER IS ON PAYMENT SUSPENSION DUE TO CREDIBLE ALLEGATION OF FRAUD.
P120	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAS BEEN REDUCED.
P121	THE SERVICE/ PROCEDURE REQUESTED IS NOT SUPPORTED BY SUBMITTED DOCUMENTATION.
P126	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
P128	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.
P138	SERVICE(S) DO NOT MEET COLORADO MEDICAID GUIDELINES.
P167	REQUESTED DOCUMENTATION HAS NOT BEEN SUBMITTED.
P178	THE SERVICE REQUESTED IS NOT MEDICALLY NECESSARY.
P179	THE MEDICAL NECESSITY FOR THIS SERVICE IS NOT SUPPORTED BY THE SUBMITTED DOCUMENTATION.
P233	THE DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE ADDITIONAL CARE.
P257	THIS CLIENTS FUNCTIONAL ASSESSMENT SCORES PLACE THIS CLIENT OUTSIDE ELIGIBILITY FOR DAY TREATMENT.
P274	OUR RECORDS INDICATE THIS CLIENT IS INVOLVED IN EFFECTIVE AND APPROPRIATE SERVICE ELSEWHERE.
P292	INTENSIVE REHABILITATION HOURS ARE NO LONGER APPROPRIATE AS INDICATED BY HISTORY, DIAGNOSIS, AND/ OR FUNCTIONAL ASSESSMENT SCORES.
P328	THE SERVICES REQUESTED INCLUDE NON-COVERED SERVICES, AND HOURS ARE REDUCED ACCORDINGLY.
P339	THE CLIENTS PAST HISTORY INDICATES REDUCED TREATMENT HOURS ARE WARRANTED.
P342	THE REQUEST DOES NOT MEET GENERALLY ACCEPTED CONDITIONS REQUIRING FLUORIDE TREATMENTS.
P346	SERVICES EXCEED COLORADO MEDICAID LIMITATION AND DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE MEDICAL NECESSITY OF THE SERVICE.
P349	THE SERVICE REQUESTED WAS PERFORMED LESS THAN FIVE YEARS AGO.

Denial Code	Long Description
P353	THE EXISTING APPLIANCE HAS NOT BEEN WORN FOR THREE YEARS.
P367	THE CLIENT HAS BEEN TOTALLY WITHOUT TEETH AND AN APPLIANCE FOR FIVE YEARS.
P392	THE CLIENT IS MISSING AN ANTERIOR TOOTH AND/OR HAS TWO OR MORE POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P405	THE SERVICE(S) REQUESTED COULD ADEQUATELY BE PERFORMED IN THE DENTAL OFFICE.
P406	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE OF GOOD PERIODONTAL HEALTH (AMERICAN ACADEMY OF PERIODONTOLOGY PERIODONTAL CLASSIFICATION OF TYPE I OR II).
P407	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE VISIBLE ON RADIOGRAPHS THAT AT LEAST 50 PERCENT OF THE CLINICAL CROWN IS INTACT.
P409	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING SIX OR MORE TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED, INCLUDING THIRD MOLARS.
P410	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING ONE OR MORE ANTERIOR TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED.
P411	DOCUMENTATION DOES NOT SUPPORT THE NEED FOR PERIODONTIC SERVICES. POCKETS ARE LESS THAN 4MM AND/OR GREATER THAN 6MM FOR CLIENT AND/OR THE CLIENT IS UNDER THE AGE OF 13.
P412	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA.
P413	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA. THIS PA HAS BEEN GRANTED AS APPROVED NOT APPROVED WITH REVISIONS. THE DURATION REQUESTED MAY HAVE BEEN REDUCED TO REFLECT COVERAGE LIMITATIONS, PRESCRIBER ORDERS, CONFLICTI
P417	THE SERVICE(S) REQUESTED COULD BE ADEQUATELY PERFORMED WITH LOCAL ANESTHESIA.
P437	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO POOR ORAL HYGIENE.
P444	THIS LINE ITEM IS A DUPLICATE OF ANOTHER LINE ITEM ON THIS PRIOR AUTHORIZATION (PA) REQUEST. PLEASE CORRECT.
P446	THIS IS A DUPLICATE OF AN EXISTING PRIOR AUTHORIZATION (PA) REQUEST. YOU MAY CONTACT PROVIDER SERVICES IF YOU REQUIRE ASSISTANCE. DUPLICATE PA REQUEST
P448	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO DECAY HISTORY.
P449	QUESTIONABLE LONG TERM PROGNOSIS DUE TO GUM AND BONE DISEASE.
P456	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO APPARENT ROOT INFECTION.
P457	OUR RECORDS INDICATE THIS CLIENT HAS EXCEEDED ESTABLISHED PROGRAM LIMITATIONS. COLORADO MEDICAID WILL NOT AUTHORIZE NEW DENTURES.
P458	DOCUMENTATION PROVIDED INDICATES A LESS ELABORATE PROCEDURE SHOULD BE CONSIDERED.
P502	RENTAL ONLY ALLOWED; MEDICAL NEED FOR PURCHASE HAS NOT BEEN DOCUMENTED.
P503	PURCHASE ONLY ALLOWED; MEDICAL NEED FOR RENTAL HAS NOT BEEN DOCUMENTED.
P504	OCCUPATIONAL THERAPY GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P505	THE SERVICE REQUESTED IS INCLUDED IN THE NURSING HOME RATE STRUCTURE.
P511	THIS NATIONAL DRUG CODE IS ONLY BILLABLE AS PART OF A COMPOUND DRUG.
P515	THE PRESENCE OF A HANDICAPPING MALOCCLUSION OR HANDICAPPING DENTOFACIAL DEFORMITY IS NOT SUPPORTED BY THE DOCUMENTATION SUBMITTED.
P521	THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVERED BY COLORADO MEDICAID.
P522	GASTRO-INTESTINAL SURGERY FOR THE PURPOSE OF WEIGHT CONTROL IS COVERED ONLY AS A LIFE THREATENING PROCEDURE.
P523	THE TREATMENT REQUEST IS NOT CONSISTENT WITH THE CLIENT'S DIAGNOSIS.
P524	PSYCHOTHERAPY PROVIDED IN THE CLIENTS HOME IS NOT A COVERED BENEFIT OF COLORADO MEDICAID .
P525	THE INFORMATION PROVIDED IS NOT CONSISTENT WITH THE INTENSITY OF SERVICES REQUESTED.
P526	INTENSIVE MULTIPLE MODALITY TREATMENT IS NOT CONSISTENT WITH THE INFORMATION PROVIDED.
P527	MULTIPLE PROVIDERS OF TREATMENT ARE NOT INDICATED FOR THIS CLIENT.
P528	THE DURATION OF TREATMENT SESSIONS EXCEED CURRENT COLORADO MEDICAID GUIDELINES.
P534	DOCUMENTATION OF POOR PHYSICAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P535	OTHER PHYSICAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.

Denial Code	Long Description
P536	THE PHYSICAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P537	USE OF PHYSICAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P538	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF A PHYSICAL THERAPIST.
P539	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS AND LIVING ARRANGEMENT.
P540	GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P541	THE PROCEDURE(S) REQUESTED ARE NOT MEDICAL IN NATURE.
P542	DOCUMENTATION OF POOR OCCUPATIONAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P543	DOCUMENTATION OF POOR SPEECH THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P544	OTHER OCCUPATIONAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P546	THE OCCUPATIONAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P547	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF PHYSICAL THERAPY.
P548	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P549	ACTIVITIES TO PROMOTE DIVERSION OR GENERAL MOTIVATION ARE NONCOVERED COLORADO MEDICAID SERVICES.
P550	REVISIONS OF THE REQUEST IS NECESSITATED BY THE CLIENTS MINIMAL PROGRESS.
P551	RESTORATIVE NURSING INVOLVEMENT COULD BE INCREASED.
P552	CLIENTS DEMONSTRATED RESPONSE TO CURRENT THERAPY DOES NOT WARRANT THE INTENSE FREQUENCY REQUESTED.
P553	MAINTENANCE IS TWO TIMES PER WEEK OR LESS.
P554	THE SPEECH THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P555	USE OF OCCUPATIONAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P556	USE OF SPEECH THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P557	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF AN OCCUPATIONAL THERAPIST.
P558	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
P559	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P560	THE MATERIALS/ SERVICES REQUESTED ARE PRINCIPALLY COSMETIC IN NATURE.
P561	THE LENS FORMULA DOES NOT JUSTIFY REPLACEMENT.
P562	THE CHANGE IN THE LENS FORMULA DOES NOT WARRANT MULTIPLE REPLACEMENTS.
P563	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P564	LENSES ONLY ARE APPROVED; PLEASE DISPENSE A CONTRACTED FRAME. THE NON-CONTRACTED FRAME IS NOT MEDICALLY JUSTIFIED.
P565	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P566	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P567	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF OCCUPATIONAL THERAPY.
P568	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF SPEECH THERAPY.
P569	LEVEL, INTENSITY, OR EXTENT OF SERVICE(S) REQUESTED HAS BEEN MODIFIED CONSISTENT WITH MEDICAL NEED AS DEFINED IN THE PLAN OF CARE.
P570	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P571	THE SERVICE ASKED FOR IS NOT COVERED BY COLORADO MEDICAID AS THESE TASKS CAN BE DONE BY NURSES OR ACTIVITY STAFF.

Denial Code	Long Description
P572	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P573	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.
P574	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P575	MEDICAL NEED FOR EQUIPMENT/ SUPPLY REQUESTED IS NOT SUPPORTED BY DOCUMENTATION SUBMITTED.
P576	OTHER SPEECH THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P577	DOCUMENTATION SUBMITTED IDENTIFIES THAT THE CLIENT HAS FEWER THAN TWO POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P582	LESS EXPENSIVE ALTERNATIVE SERVICES ARE AVAILABLE FOR THIS CLIENT.
P634	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P711	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING PERIODONTAL SCALING AND ROOT PLANNING.
P712	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING GINGIVECTOMY.
P754	AN APPROVED SUBSTANCE ABUSE DAY TREATMENT PROGRAM CANNOT EXCEED A SIX WEEK PERIOD.
P761	THE CLIENT DOES NOT APPEAR TO BE ABLE OR WILLING TO ABSTAIN FROM ALCOHOL/DRUG USAGE WHILE IN TREATMENT. THEREFORE, SUBSTANCE ABUSE DAY TREATMENT SERVICES ARE NOT APPROVED.
P764	THIS CLIENT HAS COMPLETED INTENSIVE SUBSTANCE ABUSE TREATMENT WITHIN THE PAST 12 MONTHS. THE DOCUMENTATION PROVIDED IS NOT ADEQUATE TO JUSTIFY ADDITIONAL INTENSIVE TREATMENT AT THIS TIME.
P785	A LESS THAN SIX-WEEK HEALING PERIOD HAS BEEN SPECIFIED FOR THIS PRIOR AUTHORIZATION. THEREFORE IT IS NOT NECESSARY TO WAIT THE FULL SIX WEEKS AFTER EXTRACTIONS BEFORE TAKING DENTURE IMPRESSIONS.
P818	SIX-WEEK HEALING TIME IS REQUIRED BETWEEN EDENTULATION AND FINAL IMPRESSIONS. PAYMENT FOR DENTURES WILL BE DENIED OR RECOUPED IF HEALING PERIOD IS NOT OBSERVED.
P849	COLORADO MEDICAID HAS DETERMINED THERE WERE (ARE) SEVERAL HOME HEALTH AGENCIES WILLING TO PROVIDE MEDICALLY NECESSARY SKILLED NURSING SERVICES TO THIS CLIENT.
P864	THE DOCUMENTATION YOU HAVE SUBMITTED DOES NOT MEET THE REQUIREMENTS OF COLORADO MEDICAID.
P873	THE MEDICAL NECESSITY FOR THE HOURS REQUESTED IS NOT SUPPORTED BY THE INFORMATION SUBMITTED.
P874	THE DOCUMENTATION SUBMITTED INDICATES THE TASKS SPECIFIED CAN BE COMPLETED DURING THE VISITS APPROVED.
P878	THE DOCUMENTATION SUBMITTED DOES NOT INDICATE THAT MEDICALLY ORIENTED TASKS ARE MEDICALLY NECESSARY; THEREFORE PERSONAL CARE SERVICES HAVE BEEN APPROVED.
P880	THE QUANTITY OF SERVICES AUTHORIZED FOR THIS CLIENTS PERSONAL CARE HAS BEEN AMENDED BASED ON INFORMATION RECEIVED FROM ONE OR MORE OF THESE SOURCES: THE CLIENT, THEIR PHYSICIAN, AND/OR THE IN-HOME VISIT BY STAFF OF THE OIG (OFFICE OF INSPECTOR GENERAL).
P885	THE USE OF THIS DRUG FOR THE INTENDED PURPOSE IS NOT COVERED BY COLORADO MEDICAID, CONSISTENT WITH COLORADO ADMINISTRATIVE CODE AND FEDERAL LAW.
P924	THE MEDICAL RECORDS SUBMITTED WITH THE CURRENT REQUEST CONFLICT OR DISAGREE WITH OUR MEDICAL RECORDS ON THIS CLIENT.
P950	INDEPENDENT NURSES, PLEASE NOTE PAYABLE SERVICES MAY NOT EXCEED 12 HOURS/DAY OR 60 HOURS/WEEK.
P951	SERVICES CAN ONLY BE AUTHORIZED THROUGH ONE YEAR FROM THE PRESCRIPTION DATE.
P952	LEAD INSPECTION IS A COVERED COLORADO MEDICAID SERVICE WHEN THE CHILD HAS BEEN SHOWN TO HAVE LEAD POISONING (E.G., CHILD HAS A BLOOD LEAD LEVEL > 19 UG/DL OR TWO CONSECUTIVE BLOOD LEAD LEVELS OF 15-19 UG/DL DONE AT LEAST 90 DAYS APART). THE INSPECTION MUS
P953	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P954	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.

Denial Code	Long Description
P956	THE REQUEST CAN ONLY BE BACKDATED A MAXIMUM OF 14 DAYS FROM FIRST DATE RECEIVED BY COLORADO MEDICAID.
P957	COMPLETE PERIODONTAL CHARTING AT TIME OF SERVICE, AND SUBMIT CHARTING, COPY OF OPERATIVE REPORT, TOGETHER WITH A COPY OF THE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF), F-11035, TO PA UNIT ATTENTION DENTAL CONTSULTANT.
P958	NOTE THAT CODE D4341 HAS BEEN CHANGED. REFER TO THE DECISION NOTICE FOR AUTHORIZED QUANTITY.
P960	YOUR PA HAS BEEN APPROVED FOR 90 DAYS. THE 90 DAY APPROVAL DOES NOT IMPLY THE PA REQUEST MEETS PRIOR AUTHORIZATION CRITERIA. AFTER ADDITIONAL INFORMATION IS AVAILABLE IN INTERCHANGE, COLORADO MEDICAID WILL CREATE AN AMENDMENT REQUEST TO EXTEND THE PA FOR
P961	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P962	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
PA10	THE REQUESTED END DATE IS INVALID.
PA12	PLEASE FURNISH A WRITTEN DESCRIPTION OF THE CLIENTS DIAGNOSIS.
PA13	PROVIDE DIAGNOSES WITH DATES OF ONSET.
PA14	IDENTIFY PROBLEMS TO BE TREATED.
PA15	THE AUDIOLOGISTS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1), F-11020, AND PRIOR AUTHORIZATION REQUEST/HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2), F-11021.
PA16	THE PHYSICIANS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION/PHYSICIAN OTOLOGICAL REPORT (PA/POR), F-11019.
PA17	SUBMIT BRIEF HISTORY WITH REFERRAL INFORMATION, LIVING SITUATION, FUNCTIONAL STATUS, AND OTHER PERTINENT INFORMATION. WHAT CHANGE OF STATUS RESULTED IN REFERRAL AT THIS TIME?
PA18	PLEASE FURNISH THE CLIENTS HEIGHT AND WEIGHT.
PA19	PLEASE SUBMIT CLINICAL INFORMATION SUFFICIENT TO VERIFY THE NEED FOR THE REQUESTED SERVICE(S).
PA20	PLEASE RESUBMIT WITH COMPLETE PERIODONTAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PA21	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL EDUCATIONAL PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA22	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL PROGRAM PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA23	REFER TO THE DURABLE MEDICAL EQUIPMENT INDEX FOR APPROPRIATE CODE AND DESCRIPTION. DO NOT USE AN "UNLISTED" CODE.
PA24	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUALIZED FAMILY SERVICE PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA25	INFORMATION ON THE REQUEST FORM IS ILLEGIBLE, AND THE REQUEST CANNOT BE PROCESSED.
PA26	RE-EVALUATE YOUR GOALS. EMPHASIS SHOULD BE ON FUNCTIONAL SELF-CARE. GOALS MUST BE RELATED TO FUNCTIONAL OUTCOME.
PA27	PLEASE CLARIFY THE NUMBER OF HOURS PER WEEK REQUESTED.
PA28	PLEASE CLARIFY THE NUMBER OF HOURS PER DAY REQUESTED.
PA29	PLEASE CLARIFY THE NUMBER OF VISITS PER DAY REQUESTED.
PA30	ATTACH SUPPORTIVE DOCUMENTATION; HOME EXERCISE PROGRAM AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA31	THE DIAGNOSIS CODE INDICATED ON THE REQUEST DOES NOT CORRESPOND TO THE DIAGNOSIS CODE DESCRIPTION.
PA32	PLEASE SUBMIT ADDITIONAL INFORMATION SUFFICIENT TO VERIFY APPROPRIATENESS AND NEED FOR TRANSPLANT.
PA33	PLEASE SUBMIT THE INITIAL AND PROGRESSIVE OBJECTIVE FINDINGS.
PA34	ATTACH SUPPORTIVE DOCUMENTATION, FACILITY PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.

Denial Code	Long Description
PA35	PLEASE SUBMIT THE CLIENTS ORIGINAL COMPLAINTS AND EXAMINATION FINDINGS.
PA36	ATTACH SUPPORTIVE DOCUMENTATION, IN-HOME AUTISM PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA37	PLEASE SUBMIT YOUR TREATMENT PLAN FOR THIS CLIENT.
PA38	ATTACH SUPPORTIVE DOCUMENTATION AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA39	INITIAL EVALUATIONS MUST BE PERFORMED BY AN OCCUPATIONAL THERAPIST REGISTERED (OTR), PER AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA) STANDARDS.
PA41	IDENTIFY THE PLACE OF SERVICE AND ITS EFFECT ON SUPPORTING THE DESIRED TREATMENT OUTCOME.
PA42	PLEASE INDICATE THE HOURS OF USE OF OXYGEN PER 24-HOUR PERIOD.
PA43	PROVIDE BASELINE DOCUMENTATION FOR THIS CLIENTS LIMITATIONS USING UNITS OF MEASUREMENT THAT ARE APPLIED CONSISTENTLY WHEN REPORTING STATUS.
PA44	IDENTIFY FUNCTIONAL LIMITATIONS AS THEY ARE RELATED TO IDENTIFIED CONDITIONS.
PA46	CORRELATE PLAN OF CARE TO REQUESTED PROCEDURE CODES.
PA47	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE FREQUENCY/DURATION REQUESTED.
PA48	PLEASE PROVIDE THE NAME AND CREDENTIALS OF THE RENDERING PROVIDER.
PA50	COLORADO MEDICAID RECORDS INDICATE THE CLIENT OWNS A WHEELCHAIR. DOCUMENT THE REASON AND NEED FOR REPLACEMENT AND COST TO REPAIR CURRENT WHEELCHAIR.
PA51	PLEASE DISTINGUISH PRIMARY AND SUPPORTIVE MODALITIES.
PA52	PLEASE SUBMIT A PROGRESS REPORT.
PA53	MULTIPLE FAMILY CLIENTS TREATMENT BY THE SAME PROVIDER REQUIRES FURTHER INFORMATION DOCUMENTING COORDINATION OF TREATMENT PLAN.
PA54	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE MINUTES REQUESTED.
PA55	MEDICAL NECESSITY OF TREATMENT REQUIRES ADDITIONAL DOCUMENTATION.
PA56	GIVEN AGE, DIAGNOSES, CURRENT LEVEL OF FUNCTION, PAST RESPONSE TO TREATMENT, AND LIVING SITUATION, EXPAND ON POTENTIAL FOR SIGNIFICANT FUNCTIONAL PROGRESS WITHIN THE NEXT SIX MONTHS. EMPHASIZE WHY PROGRESS IS EXPECTED WITH SERVICES AT THIS TIME.
PA57	SUBMIT THE INITIAL FINDINGS. INCLUDE A COMPREHENSIVE EVALUATION.
PA58	SUBMIT PROGRESSIVE, OBJECTIVE FINDINGS. INCLUDE A PERTINENT RE-EVALUATION.
PA59	PLEASE SUPPLY INFORMATION REGARDING THE CLIENTS MEDICATION REQUIREMENTS, IF ANY.
PA60	PLEASE SPECIFY IF THE CLIENT IS IN AN EDUCATIONAL SETTING.
PA61	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA62	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
PA63	THE SKILLS OF A THERAPIST ARE PURPOSEFUL AND SKILLED INTERVENTIONS REQUIRED TO CONTINUALLY DESIGN, IMPLEMENT, REASSESS, MODIFY/GRADE, AND/OR DISCONTINUE A PLAN OF CARE IN A TIMELY MANNER, BASED ON THE COMPLEXITY OF THE CLIENTS MEDICAL CONDITION AND/OR CO
PA64	PLEASE SUBMIT A THERAPY PLAN OF CARE, INCLUDING A CURRENT, DATED EVALUATION.
PA65	A PLAN OF CARE SIGNED AND DATED BY THE PHYSICIAN IS REQUIRED.
PA66	THE SKILLS OF A THERAPIST ARE REQUIRED WHEN ONLY THE THERAPIST CAN SAFELY AND EFFECTIVELY DELIVER THE THERAPEUTIC PROCEDURES BECAUSE OF THEIR UNIQUE KNOWLEDGE, TRAINING, AND EXPERTISE. DESCRIBE THE REASON THAT SOMEONE OTHER THAN A THERAPIST CANNOT SAFELY
PA67	PLEASE SPECIFY IF THE CLIENTS WORK SITE DEMANDS GOOD BINAURAL HEARING.
PA68	DESCRIBE THE REASON, BASED ON THE CLIENTS COGNITIVE, PHYSICAL, COMMUNICATION, OR RESOURCE STATUS, THAT A HOME PROGRAM, EQUIPMENT, OR ENVIRONMENTAL ADAPTATIONS ALONE CANNOT MEET CLIENTS NEEDS.
PA69	PLEASE SPECIFY IF THE CLIENT HAS AN ACCOMPANYING DISABILITY THAT ADDS TO THE HEARING PROBLEM.
PA70	DISTINGUISH REQUESTED PROCEDURES AND GOALS FROM OTHER SERVICES THIS CLIENT RECEIVES. THEY MAY NOT BE DUPLICATIVE.
PA71	PLEASE INDICATE THE NUMBER OF DAYS REQUESTED.

Denial Code	Long Description
PA73	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA74	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA75	PLEASE DOCUMENT CARRYOVER OF THE THERAPY PROGRAM TO NURSING.
PA76	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA79	PROVIDE EVIDENCE OF SIGNIFICANT FUNCTIONAL PROGRESS IN LAST SIX MONTHS.
PA84	THE GRANT DATE OF THIS REQUEST CANNOT BE PRIOR TO THE SIGNATURE DATE OF THE PRESCRIBING PHYSICIAN.
PA86	PROVIDE EVIDENCE OF SKILLS GAINED IN THERAPY CARRYING OVER TO OTHER SETTINGS WITHIN SIX MONTHS.
PA87	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE NUMBER OF SESSIONS REQUESTED.
PA88	THE REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL SCOPE OF PRACTICE.
PA89	PRIOR AUTHORIZATION IS NOT REQUIRED UNTIL LIMITATION OF SERVICE HAS BEEN REACHED.
PA91	PLEASE SUBMIT REQUIRED X-RAYS.
PA92	PLEASE PROVIDE AN EXPLANATION FOR THE MATERIAL SUBMITTED WITH THE REQUEST.
PA95	PLEASE DESCRIBE HOW THE PROVISION OF THIS SERVICE WOULD PREVENT INSTITUTIONALIZATION OF THE CLIENT.
PA96	COULD THE EXISTING DENTURE(S) BE RELINED OR REBASED? IF NOT, PLEASE EXPLAIN WHY NOT.
PA97	REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL STANDARDS OF PRACTICE.
PA98	PLEASE INDICATE IF THE CLIENT IS CURRENTLY BEING TUBE FED.
PB02	PLEASE PROVIDE THE REQUIRED DATED SIGNATURES ON THE ATTACHMENTS.
PB03	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING THE LOSS/DESTRUCTION/THEFT OF THE HEARING AID.
PB04	DESCRIBE THE CLIENTS ABILITY TO STAND OR AMBULATE SUFFICIENTLY TO ACCOMPLISH SELF-CARE ACTIVITIES.
PB07	PLEASE SUBMIT AN ORTHODONTIC STUDY MODEL OR DIAGNOSTIC CASTS.
PB09	PLEASE PROVIDE A PHOTOGRAPH OF THE INVOLVED AREA(S).
PB10	PLEASE PROVIDE AN ESTIMATION (IN GRAMS) OF THE TOTAL AMOUNT OF TISSUE TO BE RESECTED.
PB11	PLEASE SUBMIT THE PLAN OF CARE FOR CO-TREATMENT.
PB12	FURNISH A DETAILED DESCRIPTION FOR THE PROCEDURE CODE REQUESTED.
PB13	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB15	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB18	PLEASE COMPLETE THE ATTACHED OUT-OF-STATE PROVIDER DATA SHEET, F-11001, AND RESUBMIT.
PB20	A SIGNED AND DATED PRESCRIPTION IS REQUIRED WITHIN THREE MONTHS OF RECEIPT BY COLORADO MEDICAID FOR INITIAL REQUESTS AND WITHIN 12 MONTHS OF RECEIPT BY COLORADO MEDICAID FOR SUBSEQUENT REQUESTS.
PB21	PLEASE COMPLETE THE APPROPRIATE PRIOR AUTHORIZATION ATTACHMENT. CONTACT PROVIDER SERVICES OR THE PRIOR AUTHORIZATION UNIT FOR ASSISTANCE.
PB23	PHYSICAL THERAPY ASSISTANT NOTES AND ALL FORMS SUBMITTED MUST BE COSIGNED BY A REGISTERED PHYSICAL THERAPIST.
PB31	ARE YOU REQUESTING A COMPLETE APPLIANCE, OR REPLACEMENT PARTS?
PB32	THE PROCEDURE CODE INDICATED ON THE REQUEST DOES NOT MATCH THE DESCRIPTION OF SERVICE; PLEASE CORRECT AND RESUBMIT.
PB35	THE SERVICE REQUESTED DOES NOT REQUIRE PRIOR AUTHORIZATION.
PB41	PLEASE FURNISH A CURRENT MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT, F-11090 (DATED WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID).
PB45	THE CERTIFICATION PERIOD ON THE PLAN OF CARE (POC) DOES NOT COVER THE REQUESTED GRANT/START DATE. PLEASE RESUBMIT YOUR REQUEST WITH A NEW POC.
PB49	A CERTIFIED OCCUPATIONAL THERAPY ASSISTANTS NOTES MUST BE COSIGNED BY AN OCCUPATIONAL THERAPIST REGISTERED.
PB51	ADDITIONAL INFORMATION IS REQUIRED ON PRIOR AUTHORIZATION TO ENABLE PRICING.

Denial Code	Long Description
PB54	REQUESTED SERVICES DO NOT MATCH SERVICES ON THE PHYSICIANS ORDERS.
PB59	PLEASE PROVIDE AN INDIVIDUAL EDUCATIONAL PLAN (IEP), WHICH HAS BEEN SIGNED BY THE PROVIDER NO EARLIER THAN NINE MONTHS PRIOR TO RECEIPT AT COLORADO MEDICAID; OTHERWISE, DOCUMENT WHY NO IEP EXISTS.
PB65	PLEASE FURNISH THE ANTICIPATED TOTAL CHARGES FOR THIS REQUEST.
PB66	A PHOTOCOPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED; THE DATE MUST BE WITHIN SIX MONTHS OF RECEIPT BY COLORADO MEDICAID.
PB67	THE PRESCRIPTION DATE MUST INCLUDE MONTH, DAY, AND YEAR.
PB68	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID.
PB73	THE SERVICES IDENTIFIED ON THE PLAN OF CARE DO NOT APPEAR APPROPRIATE FOR THE PROCEDURE CODE(S) REQUESTED ON THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018.
PB74	THE CLIENT/PROVIDER DOES NOT HAVE RETROACTIVE ENROLLMENT.
PB75	THE REQUESTED START DATE IS MORE THAN 14 DAYS BEFORE OR 62 DAYS AFTER RECEIPT.
PB82	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
PB83	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A HOME HEALTH AIDE. PLEASE RESUBMIT AS A PERSONAL CARE WORKER OR PROVIDE ADDITIONAL DOCUMENTATION.
PB86	THE SERVICES REQUESTED ARE NOT BEING PROVIDED IN THE CLIENTS RESIDENCE. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL.
PB87	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A NURSE. PLEASE RESUBMIT AS A HOME HEALTH AIDE OR PROVIDE ADDITIONAL DOCUMENTATION.
PB92	PLEASE FURNISH THE CLIENTS COMPLETE ADDRESS.
PB94	IF THE CLIENT IS A RESIDENT OF A NURSING HOME, SUPPLY THE COMPLETE NAME AND ADDRESS OF THE NURSING HOME.
PB99	THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018, MUST BE SIGNED AND DATED.
PC01	PLEASE SUPPLY THE RENDERING PROVIDERS PROVIDER NUMBER.
PC03	THE DRUG ENFORCEMENT ADMINISTRATION NUMBER IS MISSING OR INVALID.
PC06	PLEASE DESCRIBE YOUR PROGRAM; INCLUDE ENTRY DATE, TERMINATION DATE, HOURS PER WEEK, AND NUMBER OF WEEKS OF PRIMARY INTENSIVE SERVICE REQUESTED.
PC07	PLEASE DESCRIBE YOUR "AFTERCARE/FOLLOW-UP" PLANS FOR THIS CLIENT.
PC08	PLEASE SUPPLY DOCUMENTATION OF PREVIOUS SUBSTANCE ABUSE SERVICES WITH DATE(S) AND OUTCOME.
PC09	PLEASE DESCRIBE IN DETAIL THE TREATMENT OBJECTIVES/GOALS FOR THIS CLIENT.
PC10	PLEASE DESCRIBE THE FAMILY SITUATION/DYNAMICS. EXPLAIN HOW THE FAMILY WILL BE INCORPORATED INTO THE CLIENTS PLAN OF CARE.
PC12	PLEASE EXPLAIN IF YOUR SERVICE ENCOURAGES THE CLIENT TO ATTEND SELF-HELP GROUPS.
PC13	PLEASE SUPPLY A SPECIFIC SCHEDULE OF ACTIVITIES, INCLUDING DAY, TIME OF DAY, LENGTH OF SESSION, AND SERVICE TO BE RENDERED DURING THAT TIME.
PC15	PLEASE FURNISH DIAGNOSTIC RATIONALE.
PC17	PLEASE DOCUMENT IF THE CLIENT EVER RECEIVED SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT.
PC19	PLEASE FURNISH MORE EXTENSIVE AND IN-DEPTH HISTORICAL AND PSYCHOSOCIAL DATA.
PC20	PLEASE SUPPLY THE DATE THE CLIENT BECAME TOTALLY ENDENTULOUS.
PC23	PLEASE SUBMIT A PHYSICIANS STATEMENT REGARDING THE MEDICAL NECESSITY OF DENTURES FOR THIS CLIENT. THE PHYSICIANS STATEMENT MUST DOCUMENT THE MEDICAL NEED FOR DENTURES.
PC24	THE SERVICE REQUESTED WAS PREVIOUSLY AUTHORIZED. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT INDICATING THIS FACT IS REQUIRED.
PC25	PLEASE SUPPLY SUFFICIENT MITIGATING CIRCUMSTANCES TO WARRANT THE CONSTRUCTION OF NEW DENTURES(S).
PC26	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
PC28	PLEASE SUBMIT A PHYSICIANS STATEMENT INDICATING DENTURES ARE NECESSARY FOR THIS NURSING HOME CLIENT.
PC29	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING LOSS OR DESTRUCTION OF DENTURE(S). INCLUDE SIGNED STATEMENT FROM CLIENT OR FACILITY DIRECTOR REGARDING HOW, WHEN AND WHERE LOST.

Denial Code	Long Description
PC30	PLEASE PROVIDE COMPLETE INTRAORAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PC31	PLEASE DESCRIBE ANY RELATED DEFORMITIES OF THE FEET.
PC34	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD WITH REQUESTED DME ITEM(S) AND DOCUMENT IF THE CLIENT CAN USE SAFELY AND INDEPENDENTLY.
PC35	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD AND DESCRIBE THE RESULTS AND EFFECTIVENESS OF THE SERVICE REQUESTED.
PC39	PLEASE INDICATE LITER FLOW PER MINUTE, HOURS OF USE PER 24 HOUR PERIOD, AND THE EXPECTED DURATION OF NEED.
PC40	THE ITEM DOES NOT REQUIRE PRIOR AUTHORIZATION UNTIL THE LIFE EXPECTANCY HAS BEEN REACHED.
PC41	PLEASE SUPPLY INFORMATION INDICATING THE NECESSITY OF POSITIONING THE CLIENT'S BODY IN MULTIPLE POSITIONS.
PC42	PLEASE INDICATE IF THE BED HEIGHT MUST BE CHANGED TO ALLOW FOR SAFE TRANSFER OR ADEQUATE BED CARE.
PC43	SUPPLY A PHYSICIANS STATEMENT INDICATING TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR UNIT HAS REDUCED PAIN, IMPROVED/INCREASED THE CLIENTS ACTIVITY LEVEL, AND/OR REDUCED CLIENTS USE OF PAIN MEDICATION.
PC44	A CURRENT AUTHORIZATION FOR THIS SERVICE IS ON FILE FOR ANOTHER PROVIDER. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT OF THAT FACT IS REQUIRED BY THE CLIENT OF FIRST PROVIDER.
PC59	DOCUMENT DECLINE OR PROGRESS IN SPECIFIC, MEASURABLE, OBJECTIVE TERMS.
PC60	DOCUMENT IF CLIENT HAS DEMONSTRATED A GOOD APPOINTMENT COMPLIANCE RECORD.
PC61	THE PHYSICIANS SIGNATURE DATE MUST NOT EXCEED 90 DAYS FROM THE DATE OF RECEIPT BY COLORADO MEDICAID.
PC62	REQUESTS FOR A CONTINUATION OF THERAPY SHOULD NOT BE SUBMITTED MORE THAN FOUR WEEKS PRIOR TO THE EXPIRATION DATE OF THE CURRENT AUTHORIZATION.
PC63	PLEASE FURNISH THE STYLE AND MANUFACTURER OF THE FRAME.
PC64	PLEASE FURNISH THE CLIENTS LENS FORMULA.
PC66	ALL REQUESTS FOR TINTS REQUIRE DOCUMENTATION OF THE VISUAL OR MEDICAL CONDITION RELATED TO PHOTOPHOBIA.
PC67	PLEASE DOCUMENT THE REASON AND JUSTIFICATION FOR REPLACEMENT BEYOND THE FIRST LENS/FRAME.
PC68	DOCUMENT IF ALL REMAINING MAXILLARY AND/OR MANDIBULAR TEETH ARE DECAY-FREE, PROPERLY RESTORED, AND PERIODONTICALLY SOUND.
PC72	SUPPLY MORE DETAIL REGARDING PROGRESS (ATTACHMENT OF GOALS, ETC.). CORRELATE PROGRESS TO PREVIOUS GOALS AND IDENTIFIED LIMITATIONS.
PC77	PLEASE SUBMIT A PLAN OF CARE DESCRIBING THE SERVICES THAT WOULD BE PROVIDED.
PC78	PLEASE DOCUMENT SPECIFIC, MEASURABLE GOALS.
PC82	THE PRIOR AUTHORIZATION (PA) SYSTEM CAN PROCESS ONLY 26 DETAILS PER PA REQUEST. PLEASE RESUBMIT YOUR REQUEST WITH NO MORE THAN 26 DETAILS.
PC83	PLEASE SUPPLY A PHYSICIANS PRESCRIPTION DATED WITHIN ONE MONTH OF REQUESTED SUBSTANCE ABUSE DAY TREATMENT.
PC84	PLEASE PROVIDE INFORMATION INDICATING THIS CLIENT IS APPROPRIATELY DETOXIFIED FROM ALCOHOL AND/OR OTHER DRUGS.
PC85	PLEASE PROVIDE INFORMATION TO INDICATE THE CLIENTS ABILITY TO ABSTAIN FROM ALCOHOL OR DRUGS WHILE IN THE SUBSTANCE ABUSE DAY TREATMENT PROGRAM.
PC86	PLEASE INDICATE IF THIS CLIENT IS WILLING TO PARTICIPATE IN AFTERCARE OR CONTINUING CARE SERVICES.
PC87	PROVIDE MORE INFORMATION ON TREATMENT HISTORY; INCLUDE SERVICE PROVIDED, DATES, AND OUTCOME. PROVIDE DETAIL OF PREVIOUS TREATMENT.
PC88	PLEASE PROVIDE MORE RATIONALE FOR THE APPROPRIATENESS AND MEDICAL NECESSITY OF SUBSTANCE ABUSE DAY TREATMENT.
PC89	PROVIDE A TREATMENT PLAN THAT CONTAINS MEASURABLE GOALS AND OBJECTIVES CORRESPONDING TO THE IDENTIFIED DEFICIT.
PC91	PLEASE PROVIDE MORE INFORMATION ON FAMILY INVOLVEMENT TREATMENT.

Denial Code	Long Description
PC92	PLEASE PROVIDE MORE HISTORY AND EXPLANATION ABOUT THE ISSUE OF ABSTINENCE FOR THIS CLIENT.
PC94	PLEASE PROVIDE THE ANTICIPATED BEGINNING DATE AND/OR THE ESTIMATED SUBSTANCE ABUSE DAY TREATMENT DISCHARGE DATE.
PC95	PLEASE SUPPLY JUSTIFICATION FOR BEGINNING CLIENT IN SERVICE PRIOR TO AUTHORIZATION BEING OBTAINED.
PC96	THE INITIAL THREE HOURS OF SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IN A CALENDAR YEAR DO NOT REQUIRE PRIOR AUTHORIZATION.
PC97	REIMBURSEMENT FOR INITIAL SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IS LIMITED TO THREE HOURS IN A CALENDAR YEAR AND DOES NOT REQUIRE PRIOR AUTHORIZATION.
PC98	THIS DRUG IS CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE BILL USING THE APPROPRIATE NATIONAL DRUG CODE (NDC) OR SUBMIT A COMPLETED DRUG ADDITION REQUEST FORM IF THE NDC IS NOT LISTED IN THE DRUG INDEX.
PC99	THIS DRUG IS NOT CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL, CURRENT ADMINISTRATIVE RULE, OR COLORADO DRUG INDEX FOR COVERAGE LIMITATIONS.
PD01	DOCUMENT THAT CLIENT HAS ACHIEVED GOOD ORAL HYGIENE, PERIODONTAL CASE TYPE 1 OR 2, AND IS MOTIVATED TO MAINTAIN SAME.
PD03	PLEASE PROVIDE AN ARTERIAL BLOOD GAS READING OR PULSE OXIMETRY RESULTS DONE ON ROOM AIR SIGNED AND DATED BY A MEDICAL DOCTOR. THIS SHOULD BE DONE WITHIN 60 DAYS OF REQUESTED SERVICE.
PD04	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 30 DAYS OF RECEIPT BY COLORADO MEDICAID.
PD07	SUBMIT A PHOTOCOPY OF A VALID PRESCRIPTION, ISSUED WITHIN THE PAST YEAR, OR COMPLETE SECTION B OF THE PRIOR AUTHORIZATION/DRUG ATTACHMENT (PA/DGA), F-11049.
PD10	BRAND MEDICALLY NECESSARY MUST BE IN THE PRESCRIBERS OWN HANDWRITING AND WRITTEN DIRECTLY ON THE PRESCRIPTION OR A SEPARATE ORDER ATTACHED TO THE ORIGINAL PRESCRIPTION.
PD12	COMPLETE DENTURES, PARTIAL DENTURES, DENTURE RELINES, AND FIXED PROSTHODONTIC SERVICES ARE NOT COVERED SERVICES FOR ADULTS FOR DATES OF SERVICE ON AND AFTER OCTOBER 1, 1995.
PD22	PLEASE COMPLETE ALL REQUIRED ELEMENTS ON THE PERSONAL CARE SCREENING TOOL (PCST), F-11133.
PD24	THIS PRIOR AUTHORIZATION REQUEST IS UNABLE TO BE PROCESSED. PLEASE RESUBMIT WITH ADDITIONAL REQUIRED FORMS, INCLUDING THE ENTIRE PERSONAL CARE SCREENING TOOL (PCST), F-11133; PERSONAL CARE ADDENDUM, F-11136; AND SUPPORTING DOCUMENTATION, AS DIRECTED.
PD25	THERE IS A PERSONAL CARE SCREENING TOOL (PCST), F-11133, COMPLETED BY ANOTHER AGENCY. CONTACT THE AGENCY TO TRANSFER SCREEN.
PD26	THERE IS A LIMITED TERM CARE FUNCTIONAL SCREEN (LTC-FS) COMPLETED BY ANOTHER AGENCY. THE PERSONAL CARE SCREENING TOOL (PCST), F-11133, INFORMATION IS IN CONFLICT WITH LTC-FS.
PD27	ONLY ONE LEVEL OF FUNCTION MAY BE SELECTED FOR ALL ELEMENTS EXCEPT TOILETING. COLORADO MEDICAID IS UNABLE TO PROCESS THE PRIOR AUTHORIZATION REQUEST.
PD28	NO UNITS MAY BE REQUESTED USING THIS PRIOR AUTHORIZATION PROCESS. PLEASE SUBMIT WITH THE APPROPRIATE ATTACHMENTS FOR REQUESTING SPECIFIC PERSONAL CARE WORKER UNITS.
PD29	CLIENT IS NOT ELIGIBLE FOR THE REQUESTED SERVICE(S) AS OF THE REQUESTED START DATE.
PD30	NO TRAVEL TIME MAY BE AUTHORIZED WHEN NO PERSONAL CARE WORKER SERVICE IS AUTHORIZED.
PD32	PROVIDER NOT CERTIFIED TO RENDER THE SERVICE(S) REQUESTED.
PD34	BASED ON THE DOCUMENTATION SUBMITTED, THIS REQUEST CAN NOT BE PRIOR AUTHORIZED. REFER TO THE PA MESSAGES FROM THE CONSULTANT FOR COMPLETE EXPLANATION.
PD98	PLEASE DOCUMENT HOW AND WHEN EACH PREVIOUSLY AUTHORIZED PRO RE NATA VISIT WAS USED.

Children's Habilitation Residential Program (CHRP)

Denial Code	Long Description
0201	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
0233	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0235	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0237	CLIENT IDENTIFICATION NUMBER DOES NOT MATCH CLIENTS FIRST NAME.
0238	THE CLIENT IDENTIFICATION NUMBER DOES NOT MATCH THE CLIENTS LAST NAME.
0242	SECONDARY DIAGNOSIS CODE IS INVALID.
0248	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0249	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0251	PROCEDURE CODE MODIFIER IN FIRST POSITION IS INVALID.
0252	THE PROCEDURE CODE MODIFIER IN SECOND POSITION IS INVALID FOR REQUESTED START DATE OR DATE OF RECEIPT.
0253	THE PROCEDURE CODE MODIFIER IN THIRD POSITION IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
0258	THE PRIMARY DIAGNOSIS CODE IS REQUIRED.
0272	THE PRIMARY DIAGNSOSIS CODE IS INVALID.
0400	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0853	HCPCS - ANNUAL UPDATE
0885	NEVER EVENTS MODIFIERS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
0886	NEVER EVENTS DIAGNOSIS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
1000	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
1002	RENDERING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1003	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1007	RENDERING PROVIDER ID IS NOT ON FILE.
1047	THE RENDERING PROVIDERS CERTIFICATION HAS BEEN CANCELLED.
1048	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1801	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
1804	A CERTIFIED SUBSTANCE ABUSE DAY TREATMENT PROVIDER MUST SUBMIT A SUBSTANCE ABUSE DAY TREATMENT PROCEDURE CODE.
1806	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
1808	THE BILLING PROVIDER DOES NOT HAVE THE REQUIRED CERTIFICATION ADDENDUM ON FILE.
1900	THE BILLING PROVIDERS TAXONOMY CODE IS INVALID.
1901	THE RENDERING PROVIDERS TAXONOMY CODE IS INVALID.
1927	A NATIONAL PROVIDER IDENTIFIER IS REQUIRED FOR THE BILLING PROVIDER.
1934	A NATIONAL PROVIDER INDENTIFIER IS REQUIRED FOR THE RENDERING PROVIDER.
1936	THE BILLING PROVIDER NUMBER IS INVALID.
1937	THE RENDERING PROVIDER NUMBER IS INVALID.
1960	INTERNAL PROCESSING IS REQUIRED.
1963	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.
1964	THE BILLING PROVIDER INDICATED IS NOT ALLOWABLE AS A BILLING PROVIDER.
1965	RENDERING PROVIDER NUMBER IS MISSING/INVALID FOR THIS PROCEDURE PROVIDER.
1974	PRESCRIBING/REFERRING/ORDERING PROVIDER INDICATED IS NOT CERTIFIED AS A PRESCRIBING/REFERRING/ORDERING PROVIDER.
1975	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
1976	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
2001	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2003	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2017	THE CLIENT IS ENROLLED IN A MEDICAID OR OTHER MANAGED CARE PROGRAM.

Denial Code	Long Description
2037	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2603	CLIENT LOCKED-IN TO A PROVIDER OR ENROLLED IN A HOSPICE. CONTACT CLIENTS HOSPICE FOR PAYMENT OF SERVICES OR RESUBMIT WITH DOCUMENTATION OF UNRELATED NATURE OF CARE.
3324	THE MODIFIER HAS BEEN DISCONTINUED BY THE CENTERS OF MEDICARE AND MEDICAID SERVICES OR THE AMERICAN MEDICAL ASSOCIATION FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
3337	THE PROCEDURE CODE HAS BEEN TERMINATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AMERICAN MEDICAL ASSOCIATION, OR AMERICAN DENTAL ASSOCIATION FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT. RESUBMIT WITH VALID A PROCEDURE CODE.
3339	THE PROCEDURE BILLED IS NOT PAYABLE ACCORDING TO DEFICIT REDUCTION ACT (DEFRA) GUIDELINES.
3351	THE PROCEDURE IS NOT COVERED FOR CLIENTS WITH A NURSING HOME AUTHORIZATION ON THE REQUESTED START DATE OR DATE OF RECEIPT.
3353	THE PROCEDURE IS NOT A COVERED SERVICE FOR HOME AND COMMUNITY-BASED WAIVER CLIENTS.
4021	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4027	THE DIAGNOSIS CODE IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
4031	THE PROCEDURE SUBMITTED IS NOT APPROPRIATE FOR CLIENTS GENDER.
4032	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4034	THE PROCEDURE CODE HAS AN AGE RESTRICTION.
4036	THE PLACE OF SERVICE CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4040	THE PRIMARY DIAGNOSIS CODE IS NOT ON FILE.
4041	THE SECONDARY DIAGNOSIS IS NOT ON FILE.
4046	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4127	INTERNAL PROCESSING IS REQUIRED.
4131	INTERNAL PROCESSING IS REQUIRED.
4141	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4149	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4150	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4236	ETIOLOGY DIAGNOSIS CODE(S) (E-CODES) ARE INVALID AS THE PRIMARY DIAGNOSIS.
4244	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4245	THE FOURTH POSITION MODIFIER IS INVALID FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT.
4256	THE PROCEDURE CODE AND MODIFIER COMBINATION IS NOT PAYABLE FOR THE CLIENTS BENEFIT PLAN.
4257	THE MODIFIERS SUBMITTED ARE EITHER INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT OR THE MODIFIERS ARE MISSING.
4311	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4315	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4316	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4371	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4372	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4711	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR CLIENTS AGE.
4714	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS AGE.
4731	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS DIAGNOSIS.
4742	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4743	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4744	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4745	DIAGNOSIS AND/OR PROCEDURE AND/OR PLACE OF SERVICE (POS) CODE IS NOT COVERED FOR EXPRESS ENROLLMENT CLIENTS.
4746	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4801	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4802	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
4821	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
4871	PLEASE REFER TO PA MESSAGES FOR RETURN INFORMATION.

Denial Code	Long Description
4963	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS GENDER.
4990	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
7500	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
7509	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
P001	THE BILLING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THE SERVICES.
P002	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P003	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P005	THE PRIOR AUTHORIZATION CAN NOT BE END DATED. THE PRIOR AUTHORIZATION STATUS IS NOT APPROVED OR APPROVED WITH REVISIONS.
P006	PLEASE FURNISH THE PROCEDURE CODE AND CORRESPONDING DESCRIPTION.
P008	THE BILLING PROVIDER NUMBER IS INVALID.
P009	THE BILLING PROVIDER NUMBER IS INVALID.
P010	THE REQUESTED END DATE IS INVALID.
P011	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P012	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P013	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P014	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P015	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P016	THE REQUESTED START DATE IS MISSING OR INVALID.
P019	THE REQUESTED START DATE IS MISSING OR INVALID.
P020	THE RENDERING PROVIDER NUMBER IS INVALID.
P021	THE RENDERING PROVIDER NUMBER IS INVALID.
P022	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P023	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P024	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P026	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P027	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P030	FIRST MODIFIER IS INVALID.
P031	FIRST MODIFIER IS INVALID.
P032	SECOND MODIFIER IS INVALID.
P033	SECOND MODIFIER IS INVALID.
P034	THIRD MODIFIER IS INVALID.
P035	THIRD MODIFIER IS INVALID.
P036	FOURTH MODIFIER IS INVALID.
P037	FOURTH MODIFIER IS INVALID.
P038	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P039	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P040	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P041	CLIENTS FIRST NAME IS MISSING.
P042	CLIENTS LAST NAME IS MISSING.
P043	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P044	BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES REQUESTED.
P045	FIRST MODIFIER IS INVALID.
P046	SECOND MODIFIER IS INVALID.
P047	THIRD MODIFIER IS INVALID.
P048	FOURTH MODIFIER IS INVALID.

Denial Code	Long Description
P052	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P053	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P054	RENDERING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES FOR THE BENEFIT PLAN.
P055	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P061	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P062	THE CLIENT ID AND/OR NAME INDICATED ON THE PA REQUEST IS INCORRECT. THE CLIENT ID AND/OR NAME HAS BEEN UPDATED. PLEASE VERIFY THE ID AND/OR NAME IS CORRECT.
P064	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
P067	THE FREQUENCY OF HOURS REQUESTED ARE NOT APPROPRIATE FOR THIS CLIENT AND HAVE BEEN MODIFIED ACCORDINGLY.
P079	BILLING PROVIDER IS ON PAYMENT SUSPENSION DUE TO CREDIBLE ALLEGATION OF FRAUD.
P120	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAS BEEN REDUCED.
P121	THE SERVICE/ PROCEDURE REQUESTED IS NOT SUPPORTED BY SUBMITTED DOCUMENTATION.
P126	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
P128	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.
P138	SERVICE(S) DO NOT MEET COLORADO MEDICAID GUIDELINES.
P167	REQUESTED DOCUMENTATION HAS NOT BEEN SUBMITTED.
P178	THE SERVICE REQUESTED IS NOT MEDICALLY NECESSARY.
P179	THE MEDICAL NECESSITY FOR THIS SERVICE IS NOT SUPPORTED BY THE SUBMITTED DOCUMENTATION.
P233	THE DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE ADDITIONAL CARE.
P257	THIS CLIENTS FUNCTIONAL ASSESSMENT SCORES PLACE THIS CLIENT OUTSIDE ELIGIBILITY FOR DAY TREATMENT.
P274	OUR RECORDS INDICATE THIS CLIENT IS INVOLVED IN EFFECTIVE AND APPROPRIATE SERVICE ELSEWHERE.
P292	INTENSIVE REHABILITATION HOURS ARE NO LONGER APPROPRIATE AS INDICATED BY HISTORY, DIAGNOSIS, AND/ OR FUNCTIONAL ASSESSMENT SCORES.
P328	THE SERVICES REQUESTED INCLUDE NON-COVERED SERVICES, AND HOURS ARE REDUCED ACCORDINGLY.
P339	THE CLIENTS PAST HISTORY INDICATES REDUCED TREATMENT HOURS ARE WARRANTED.
P342	THE REQUEST DOES NOT MEET GENERALLY ACCEPTED CONDITIONS REQUIRING FLUORIDE TREATMENTS.
P346	SERVICES EXCEED COLORADO MEDICAID LIMITATION AND DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE MEDICAL NECESSITY OF THE SERVICE.
P349	THE SERVICE REQUESTED WAS PERFORMED LESS THAN FIVE YEARS AGO.
P353	THE EXISTING APPLIANCE HAS NOT BEEN WORN FOR THREE YEARS.
P367	THE CLIENT HAS BEEN TOTALLY WITHOUT TEETH AND AN APPLIANCE FOR FIVE YEARS.
P392	THE CLIENT IS MISSING AN ANTERIOR TOOTH AND/OR HAS TWO OR MORE POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P405	THE SERVICE(S) REQUESTED COULD ADEQUATELY BE PERFORMED IN THE DENTAL OFFICE.
P406	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE OF GOOD PERIODONTAL HEALTH (AMERICAN ACADEMY OF PERIODONTOLOGY PERIODONTAL CLASSIFICATION OF TYPE I OR II).
P407	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE VISIBLE ON RADIOGRAPHS THAT AT LEAST 50 PERCENT OF THE CLINICAL CROWN IS INTACT.
P409	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING SIX OR MORE TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED, INCLUDING THIRD MOLARS.
P410	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING ONE OR MORE ANTERIOR TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED.
P411	DOCUMENTATION DOES NOT SUPPORT THE NEED FOR PERIODONTIC SERVICES. POCKETS ARE LESS THAN 4MM AND/OR GREATER THAN 6MM FOR CLIENT AND/OR THE CLIENT IS UNDER THE AGE OF 13.
P412	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA.

Denial Code	Long Description
P413	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA. THIS PA HAS BEEN GRANTED AS APPROVED NOT APPROVED WITH REVISIONS. THE DURATION REQUESTED MAY HAVE BEEN REDUCED TO REFLECT COVERAGE LIMITATIONS, PRESCRIBER ORDERS, CONFLICTI
P417	THE SERVICE(S) REQUESTED COULD BE ADEQUATELY PERFORMED WITH LOCAL ANESTHESIA.
P437	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO POOR ORAL HYGIENE.
P444	THIS LINE ITEM IS A DUPLICATE OF ANOTHER LINE ITEM ON THIS PRIOR AUTHORIZATION (PA) REQUEST. PLEASE CORRECT.
P446	THIS IS A DUPLICATE OF AN EXISTING PRIOR AUTHORIZATION (PA) REQUEST. YOU MAY CONTACT PROVIDER SERVICES IF YOU REQUIRE ASSISTANCE. DUPLICATE PA REQUEST
P448	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO DECAY HISTORY.
P449	QUESTIONABLE LONG TERM PROGNOSIS DUE TO GUM AND BONE DISEASE.
P456	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO APPARENT ROOT INFECTION.
P457	OUR RECORDS INDICATE THIS CLIENT HAS EXCEEDED ESTABLISHED PROGRAM LIMITATIONS. COLORADO MEDICAID WILL NOT AUTHORIZE NEW DENTURES.
P458	DOCUMENTATION PROVIDED INDICATES A LESS ELABORATE PROCEDURE SHOULD BE CONSIDERED.
P502	RENTAL ONLY ALLOWED; MEDICAL NEED FOR PURCHASE HAS NOT BEEN DOCUMENTED.
P503	PURCHASE ONLY ALLOWED; MEDICAL NEED FOR RENTAL HAS NOT BEEN DOCUMENTED.
P504	OCCUPATIONAL THERAPY GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P505	THE SERVICE REQUESTED IS INCLUDED IN THE NURSING HOME RATE STRUCTURE.
P511	THIS NATIONAL DRUG CODE IS ONLY BILLABLE AS PART OF A COMPOUND DRUG.
P515	THE PRESENCE OF A HANDICAPPING MALOCCLUSION OR HANDICAPPING DENTOFACIAL DEFORMITY IS NOT SUPPORTED BY THE DOCUMENTATION SUBMITTED.
P521	THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVERED BY COLORADO MEDICAID.
P522	GASTRO-INTESTINAL SURGERY FOR THE PURPOSE OF WEIGHT CONTROL IS COVERED ONLY AS A LIFE THREATENING PROCEDURE.
P523	THE TREATMENT REQUEST IS NOT CONSISTENT WITH THE CLIENT'S DIAGNOSIS.
P524	PSYCHOTHERAPY PROVIDED IN THE CLIENTS HOME IS NOT A COVERED BENEFIT OF COLORADO MEDICAID .
P525	THE INFORMATION PROVIDED IS NOT CONSISTENT WITH THE INTENSITY OF SERVICES REQUESTED.
P526	INTENSIVE MULTIPLE MODALITY TREATMENT IS NOT CONSISTENT WITH THE INFORMATION PROVIDED.
P527	MULTIPLE PROVIDERS OF TREATMENT ARE NOT INDICATED FOR THIS CLIENT.
P528	THE DURATION OF TREATMENT SESSIONS EXCEED CURRENT COLORADO MEDICAID GUIDELINES.
P534	DOCUMENTATION OF POOR PHYSICAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P535	OTHER PHYSICAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P536	THE PHYSICAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P537	USE OF PHYSICAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P538	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF A PHYSICAL THERAPIST.
P539	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS AND LIVING ARRANGEMENT.
P540	GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P541	THE PROCEDURE(S) REQUESTED ARE NOT MEDICAL IN NATURE.
P542	DOCUMENTATION OF POOR OCCUPATIONAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P543	DOCUMENTATION OF POOR SPEECH THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P544	OTHER OCCUPATIONAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P546	THE OCCUPATIONAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.

Denial Code	Long Description
P547	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF PHYSICAL THERAPY.
P548	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P549	ACTIVITIES TO PROMOTE DIVERSION OR GENERAL MOTIVATION ARE NONCOVERED COLORADO MEDICAID SERVICES.
P550	REVISIONS OF THE REQUEST IS NECESSITATED BY THE CLIENTS MINIMAL PROGRESS.
P551	RESTORATIVE NURSING INVOLVEMENT COULD BE INCREASED.
P552	CLIENTS DEMONSTRATED RESPONSE TO CURRENT THERAPY DOES NOT WARRANT THE INTENSE FREQUENCY REQUESTED.
P553	MAINTENANCE IS TWO TIMES PER WEEK OR LESS.
P554	THE SPEECH THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P555	USE OF OCCUPATIONAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P556	USE OF SPEECH THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P557	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF AN OCCUPATIONAL THERAPIST.
P558	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
P559	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P560	THE MATERIALS/ SERVICES REQUESTED ARE PRINCIPALLY COSMETIC IN NATURE.
P561	THE LENS FORMULA DOES NOT JUSTIFY REPLACEMENT.
P562	THE CHANGE IN THE LENS FORMULA DOES NOT WARRANT MULTIPLE REPLACEMENTS.
P563	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P564	LENSES ONLY ARE APPROVED; PLEASE DISPENSE A CONTRACTED FRAME. THE NON-CONTRACTED FRAME IS NOT MEDICALLY JUSTIFIED.
P565	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P566	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P567	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF OCCUPATIONAL THERAPY.
P568	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF SPEECH THERAPY.
P569	LEVEL, INTENSITY, OR EXTENT OF SERVICE(S) REQUESTED HAS BEEN MODIFIED CONSISTENT WITH MEDICAL NEED AS DEFINED IN THE PLAN OF CARE.
P570	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P571	THE SERVICE ASKED FOR IS NOT COVERED BY COLORADO MEDICAID AS THESE TASKS CAN BE DONE BY NURSES OR ACTIVITY STAFF.
P572	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P573	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.
P574	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P575	MEDICAL NEED FOR EQUIPMENT/ SUPPLY REQUESTED IS NOT SUPPORTED BY DOCUMENTATION SUBMITTED.
P576	OTHER SPEECH THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P577	DOCUMENTATION SUBMITTED IDENTIFIES THAT THE CLIENT HAS FEWER THAN TWO POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P582	LESS EXPENSIVE ALTERNATIVE SERVICES ARE AVAILABLE FOR THIS CLIENT.
P634	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P711	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING PERIODONTAL SCALING AND ROOT PLANNING.
P712	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING GINGIVECTOMY.
P754	AN APPROVED SUBSTANCE ABUSE DAY TREATMENT PROGRAM CANNOT EXCEED A SIX WEEK PERIOD.

Denial Code	Long Description
P761	THE CLIENT DOES NOT APPEAR TO BE ABLE OR WILLING TO ABSTAIN FROM ALCOHOL/DRUG USAGE WHILE IN TREATMENT. THEREFORE, SUBSTANCE ABUSE DAY TREATMENT SERVICES ARE NOT APPROVED.
P764	THIS CLIENT HAS COMPLETED INTENSIVE SUBSTANCE ABUSE TREATMENT WITHIN THE PAST 12 MONTHS. THE DOCUMENTATION PROVIDED IS NOT ADEQUATE TO JUSTIFY ADDITIONAL INTENSIVE TREATMENT AT THIS TIME.
P785	A LESS THAN SIX-WEEK HEALING PERIOD HAS BEEN SPECIFIED FOR THIS PRIOR AUTHORIZATION. THEREFORE IT IS NOT NECESSARY TO WAIT THE FULL SIX WEEKS AFTER EXTRACTIONS BEFORE TAKING DENTURE IMPRESSIONS.
P818	SIX-WEEK HEALING TIME IS REQUIRED BETWEEN EDENTULATION AND FINAL IMPRESSIONS. PAYMENT FOR DENTURES WILL BE DENIED OR RECOUPED IF HEALING PERIOD IS NOT OBSERVED.
P849	COLORADO MEDICAID HAS DETERMINED THERE WERE (ARE) SEVERAL HOME HEALTH AGENCIES WILLING TO PROVIDE MEDICALLY NECESSARY SKILLED NURSING SERVICES TO THIS CLIENT.
P864	THE DOCUMENTATION YOU HAVE SUBMITTED DOES NOT MEET THE REQUIREMENTS OF COLORADO MEDICAID.
P873	THE MEDICAL NECESSITY FOR THE HOURS REQUESTED IS NOT SUPPORTED BY THE INFORMATION SUBMITTED.
P874	THE DOCUMENTATION SUBMITTED INDICATES THE TASKS SPECIFIED CAN BE COMPLETED DURING THE VISITS APPROVED.
P878	THE DOCUMENTATION SUBMITTED DOES NOT INDICATE THAT MEDICALLY ORIENTED TASKS ARE MEDICALLY NECESSARY; THEREFORE PERSONAL CARE SERVICES HAVE BEEN APPROVED.
P880	THE QUANTITY OF SERVICES AUTHORIZED FOR THIS CLIENTS PERSONAL CARE HAS BEEN AMENDED BASED ON INFORMATION RECEIVED FROM ONE OR MORE OF THESE SOURCES: THE CLIENT, THEIR PHYSICIAN, AND/OR THE IN-HOME VISIT BY STAFF OF THE OIG (OFFICE OF INSPECTOR GENERAL).
P885	THE USE OF THIS DRUG FOR THE INTENDED PURPOSE IS NOT COVERED BY COLORADO MEDICAID, CONSISTENT WITH COLORADO ADMINISTRATIVE CODE AND FEDERAL LAW.
P924	THE MEDICAL RECORDS SUBMITTED WITH THE CURRENT REQUEST CONFLICT OR DISAGREE WITH OUR MEDICAL RECORDS ON THIS CLIENT.
P950	INDEPENDENT NURSES, PLEASE NOTE PAYABLE SERVICES MAY NOT EXCEED 12 HOURS/DAY OR 60 HOURS/WEEK.
P951	SERVICES CAN ONLY BE AUTHORIZED THROUGH ONE YEAR FROM THE PRESCRIPTION DATE.
P952	LEAD INSPECTION IS A COVERED COLORADO MEDICAID SERVICE WHEN THE CHILD HAS BEEN SHOWN TO HAVE LEAD POISONING (E.G., CHILD HAS A BLOOD LEAD LEVEL > 19 UG/DL OR TWO CONSECUTIVE BLOOD LEAD LEVELS OF 15-19 UG/DL DONE AT LEAST 90 DAYS APART). THE INSPECTION MUS
P953	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P954	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P956	THE REQUEST CAN ONLY BE BACKDATED A MAXIMUM OF 14 DAYS FROM FIRST DATE RECEIVED BY COLORADO MEDICAID.
P957	COMPLETE PERIODONTAL CHARTING AT TIME OF SERVICE, AND SUBMIT CHARTING, COPY OF OPERATIVE REPORT, TOGETHER WITH A COPY OF THE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF), F-11035, TO PA UNIT ATTENTION DENTAL CONTSULTANT.
P958	NOTE THAT CODE D4341 HAS BEEN CHANGED. REFER TO THE DECISION NOTICE FOR AUTHORIZED QUANTITY.
P960	YOUR PA HAS BEEN APPROVED FOR 90 DAYS. THE 90 DAY APPROVAL DOES NOT IMPLY THE PA REQUEST MEETS PRIOR AUTHORIZATION CRITERIA. AFTER ADDITIONAL INFORMATION IS AVAILABLE IN INTERCHANGE, COLORADO MEDICAID WILL CREATE AN AMENDMENT REQUEST TO EXTEND THE PA FOR
P961	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P962	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
PA10	THE REQUESTED END DATE IS INVALID.
PA12	PLEASE FURNISH A WRITTEN DESCRIPTION OF THE CLIENTS DIAGNOSIS.

Denial Code	Long Description
PA13	PROVIDE DIAGNOSES WITH DATES OF ONSET.
PA14	IDENTIFY PROBLEMS TO BE TREATED.
PA15	THE AUDIOLOGISTS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1), F-11020, AND PRIOR AUTHORIZATION REQUEST/HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2), F-11021.
PA16	THE PHYSICIANS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION/PHYSICIAN OTOLOGICAL REPORT (PA/POR), F-11019.
PA17	SUBMIT BRIEF HISTORY WITH REFERRAL INFORMATION, LIVING SITUATION, FUNCTIONAL STATUS, AND OTHER PERTINENT INFORMATION. WHAT CHANGE OF STATUS RESULTED IN REFERRAL AT THIS TIME?
PA18	PLEASE FURNISH THE CLIENTS HEIGHT AND WEIGHT.
PA19	PLEASE SUBMIT CLINICAL INFORMATION SUFFICIENT TO VERIFY THE NEED FOR THE REQUESTED SERVICE(S).
PA20	PLEASE RESUBMIT WITH COMPLETE PERIODONTAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PA21	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL EDUCATIONAL PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA22	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL PROGRAM PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA23	REFER TO THE DURABLE MEDICAL EQUIPMENT INDEX FOR APPROPRIATE CODE AND DESCRIPTION. DO NOT USE AN "UNLISTED" CODE.
PA24	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUALIZED FAMILY SERVICE PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA25	INFORMATION ON THE REQUEST FORM IS ILLEGIBLE, AND THE REQUEST CANNOT BE PROCESSED.
PA26	RE-EVALUATE YOUR GOALS. EMPHASIS SHOULD BE ON FUNCTIONAL SELF-CARE. GOALS MUST BE RELATED TO FUNCTIONAL OUTCOME.
PA27	PLEASE CLARIFY THE NUMBER OF HOURS PER WEEK REQUESTED.
PA28	PLEASE CLARIFY THE NUMBER OF HOURS PER DAY REQUESTED.
PA29	PLEASE CLARIFY THE NUMBER OF VISITS PER DAY REQUESTED.
PA30	ATTACH SUPPORTIVE DOCUMENTATION; HOME EXERCISE PROGRAM AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA31	THE DIAGNOSIS CODE INDICATED ON THE REQUEST DOES NOT CORRESPOND TO THE DIAGNOSIS CODE DESCRIPTION.
PA32	PLEASE SUBMIT ADDITIONAL INFORMATION SUFFICIENT TO VERIFY APPROPRIATENESS AND NEED FOR TRANSPLANT.
PA33	PLEASE SUBMIT THE INITIAL AND PROGRESSIVE OBJECTIVE FINDINGS.
PA34	ATTACH SUPPORTIVE DOCUMENTATION, FACILITY PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA35	PLEASE SUBMIT THE CLIENTS ORIGINAL COMPLAINTS AND EXAMINATION FINDINGS.
PA36	ATTACH SUPPORTIVE DOCUMENTATION, IN-HOME AUTISM PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA37	PLEASE SUBMIT YOUR TREATMENT PLAN FOR THIS CLIENT.
PA38	ATTACH SUPPORTIVE DOCUMENTATION AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA39	INITIAL EVALUATIONS MUST BE PERFORMED BY AN OCCUPATIONAL THERAPIST REGISTERED (OTR), PER AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA) STANDARDS.
PA41	IDENTIFY THE PLACE OF SERVICE AND ITS EFFECT ON SUPPORTING THE DESIRED TREATMENT OUTCOME.
PA42	PLEASE INDICATE THE HOURS OF USE OF OXYGEN PER 24-HOUR PERIOD.
PA43	PROVIDE BASELINE DOCUMENTATION FOR THIS CLIENTS LIMITATIONS USING UNITS OF MEASUREMENT THAT ARE APPLIED CONSISTENTLY WHEN REPORTING STATUS.
PA44	IDENTIFY FUNCTIONAL LIMITATIONS AS THEY ARE RELATED TO IDENTIFIED CONDITIONS.
PA46	CORRELATE PLAN OF CARE TO REQUESTED PROCEDURE CODES.
PA47	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE FREQUENCY/DURATION REQUESTED.

Denial Code	Long Description
PA48	PLEASE PROVIDE THE NAME AND CREDENTIALS OF THE RENDERING PROVIDER.
PA50	COLORADO MEDICAID RECORDS INDICATE THE CLIENT OWNS A WHEELCHAIR. DOCUMENT THE REASON AND NEED FOR REPLACEMENT AND COST TO REPAIR CURRENT WHEELCHAIR.
PA51	PLEASE DISTINGUISH PRIMARY AND SUPPORTIVE MODALITIES.
PA52	PLEASE SUBMIT A PROGRESS REPORT.
PA53	MULTIPLE FAMILY CLIENTS TREATMENT BY THE SAME PROVIDER REQUIRES FURTHER INFORMATION DOCUMENTING COORDINATION OF TREATMENT PLAN.
PA54	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE MINUTES REQUESTED.
PA55	MEDICAL NECESSITY OF TREATMENT REQUIRES ADDITIONAL DOCUMENTATION.
PA56	GIVEN AGE, DIAGNOSES, CURRENT LEVEL OF FUNCTION, PAST RESPONSE TO TREATMENT, AND LIVING SITUATION, EXPAND ON POTENTIAL FOR SIGNIFICANT FUNCTIONAL PROGRESS WITHIN THE NEXT SIX MONTHS. EMPHASIZE WHY PROGRESS IS EXPECTED WITH SERVICES AT THIS TIME.
PA57	SUBMIT THE INITIAL FINDINGS. INCLUDE A COMPREHENSIVE EVALUATION.
PA58	SUBMIT PROGRESSIVE, OBJECTIVE FINDINGS. INCLUDE A PERTINENT RE-EVALUATION.
PA59	PLEASE SUPPLY INFORMATION REGARDING THE CLIENTS MEDICATION REQUIREMENTS, IF ANY.
PA60	PLEASE SPECIFY IF THE CLIENT IS IN AN EDUCATIONAL SETTING.
PA61	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA62	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
PA63	THE SKILLS OF A THERAPIST ARE PURPOSEFUL AND SKILLED INTERVENTIONS REQUIRED TO CONTINUALLY DESIGN, IMPLEMENT, REASSESS, MODIFY/GRADE, AND/OR DISCONTINUE A PLAN OF CARE IN A TIMELY MANNER, BASED ON THE COMPLEXITY OF THE CLIENTS MEDICAL CONDITION AND/OR CO
PA64	PLEASE SUBMIT A THERAPY PLAN OF CARE, INCLUDING A CURRENT, DATED EVALUATION.
PA65	A PLAN OF CARE SIGNED AND DATED BY THE PHYSICIAN IS REQUIRED.
PA66	THE SKILLS OF A THERAPIST ARE REQUIRED WHEN ONLY THE THERAPIST CAN SAFELY AND EFFECTIVELY DELIVER THE THERAPEUTIC PROCEDURES BECAUSE OF THEIR UNIQUE KNOWLEDGE, TRAINING, AND EXPERTISE. DESCRIBE THE REASON THAT SOMEONE OTHER THAN A THERAPIST CANNOT SAFELY
PA67	PLEASE SPECIFY IF THE CLIENTS WORK SITE DEMANDS GOOD BINAURAL HEARING.
PA68	DESCRIBE THE REASON, BASED ON THE CLIENTS COGNITIVE, PHYSICAL, COMMUNICATION, OR RESOURCE STATUS, THAT A HOME PROGRAM, EQUIPMENT, OR ENVIRONMENTAL ADAPTATIONS ALONE CANNOT MEET CLIENTS NEEDS.
PA69	PLEASE SPECIFY IF THE CLIENT HAS AN ACCOMPANYING DISABILITY THAT ADDS TO THE HEARING PROBLEM.
PA70	DISTINGUISH REQUESTED PROCEDURES AND GOALS FROM OTHER SERVICES THIS CLIENT RECEIVES. THEY MAY NOT BE DUPLICATIVE.
PA71	PLEASE INDICATE THE NUMBER OF DAYS REQUESTED.
PA73	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA74	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA75	PLEASE DOCUMENT CARRYOVER OF THE THERAPY PROGRAM TO NURSING.
PA76	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA79	PROVIDE EVIDENCE OF SIGNIFICANT FUNCTIONAL PROGRESS IN LAST SIX MONTHS.
PA84	THE GRANT DATE OF THIS REQUEST CANNOT BE PRIOR TO THE SIGNATURE DATE OF THE PRESCRIBING PHYSICIAN.
PA86	PROVIDE EVIDENCE OF SKILLS GAINED IN THERAPY CARRYING OVER TO OTHER SETTINGS WITHIN SIX MONTHS.
PA87	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE NUMBER OF SESSIONS REQUESTED.
PA88	THE REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL SCOPE OF PRACTICE.
PA89	PRIOR AUTHORIZATION IS NOT REQUIRED UNTIL LIMITATION OF SERVICE HAS BEEN REACHED.
PA91	PLEASE SUBMIT REQUIRED X-RAYS.

Denial Code	Long Description
PA92	PLEASE PROVIDE AN EXPLANATION FOR THE MATERIAL SUBMITTED WITH THE REQUEST.
PA95	PLEASE DESCRIBE HOW THE PROVISION OF THIS SERVICE WOULD PREVENT INSTITUTIONALIZATION OF THE CLIENT.
PA96	COULD THE EXISTING DENTURE(S) BE RELINED OR REBASED? IF NOT, PLEASE EXPLAIN WHY NOT.
PA97	REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL STANDARDS OF PRACTICE.
PA98	PLEASE INDICATE IF THE CLIENT IS CURRENTLY BEING TUBE FED.
PB02	PLEASE PROVIDE THE REQUIRED DATED SIGNATURES ON THE ATTACHMENTS.
PB03	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING THE LOSS/DESTRUCTION/THEFT OF THE HEARING AID.
PB04	DESCRIBE THE CLIENTS ABILITY TO STAND OR AMBULATE SUFFICIENTLY TO ACCOMPLISH SELF-CARE ACTIVITIES.
PB07	PLEASE SUBMIT AN ORTHODONTIC STUDY MODEL OR DIAGNOSTIC CASTS.
PB09	PLEASE PROVIDE A PHOTOGRAPH OF THE INVOLVED AREA(S).
PB10	PLEASE PROVIDE AN ESTIMATION (IN GRAMS) OF THE TOTAL AMOUNT OF TISSUE TO BE RESECTED.
PB11	PLEASE SUBMIT THE PLAN OF CARE FOR CO-TREATMENT.
PB12	FURNISH A DETAILED DESCRIPTION FOR THE PROCEDURE CODE REQUESTED.
PB13	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB15	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB18	PLEASE COMPLETE THE ATTACHED OUT-OF-STATE PROVIDER DATA SHEET, F-11001, AND RESUBMIT.
PB20	A SIGNED AND DATED PRESCRIPTION IS REQUIRED WITHIN THREE MONTHS OF RECEIPT BY COLORADO MEDICAID FOR INITIAL REQUESTS AND WITHIN 12 MONTHS OF RECEIPT BY COLORADO MEDICAID FOR SUBSEQUENT REQUESTS.
PB21	PLEASE COMPLETE THE APPROPRIATE PRIOR AUTHORIZATION ATTACHMENT. CONTACT PROVIDER SERVICES OR THE PRIOR AUTHORIZATION UNIT FOR ASSISTANCE.
PB23	PHYSICAL THERAPY ASSISTANT NOTES AND ALL FORMS SUBMITTED MUST BE COSIGNED BY A REGISTERED PHYSICAL THERAPIST.
PB31	ARE YOU REQUESTING A COMPLETE APPLIANCE, OR REPLACEMENT PARTS?
PB32	THE PROCEDURE CODE INDICATED ON THE REQUEST DOES NOT MATCH THE DESCRIPTION OF SERVICE; PLEASE CORRECT AND RESUBMIT.
PB35	THE SERVICE REQUESTED DOES NOT REQUIRE PRIOR AUTHORIZATION.
PB41	PLEASE FURNISH A CURRENT MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT, F-11090 (DATED WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID).
PB45	THE CERTIFICATION PERIOD ON THE PLAN OF CARE (POC) DOES NOT COVER THE REQUESTED GRANT/START DATE. PLEASE RESUBMIT YOUR REQUEST WITH A NEW POC.
PB49	A CERTIFIED OCCUPATIONAL THERAPY ASSISTANTS NOTES MUST BE COSIGNED BY AN OCCUPATIONAL THERAPIST REGISTERED.
PB51	ADDITIONAL INFORMATION IS REQUIRED ON PRIOR AUTHORIZATION TO ENABLE PRICING.
PB54	REQUESTED SERVICES DO NOT MATCH SERVICES ON THE PHYSICIANS ORDERS.
PB59	PLEASE PROVIDE AN INDIVIDUAL EDUCATIONAL PLAN (IEP), WHICH HAS BEEN SIGNED BY THE PROVIDER NO EARLIER THAN NINE MONTHS PRIOR TO RECEIPT AT COLORADO MEDICAID; OTHERWISE, DOCUMENT WHY NO IEP EXISTS.
PB65	PLEASE FURNISH THE ANTICIPATED TOTAL CHARGES FOR THIS REQUEST.
PB66	A PHOTOCOPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED; THE DATE MUST BE WITHIN SIX MONTHS OF RECEIPT BY COLORADO MEDICAID.
PB67	THE PRESCRIPTION DATE MUST INCLUDE MONTH, DAY, AND YEAR.
PB68	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID.
PB73	THE SERVICES IDENTIFIED ON THE PLAN OF CARE DO NOT APPEAR APPROPRIATE FOR THE PROCEDURE CODE(S) REQUESTED ON THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018.
PB74	THE CLIENT/PROVIDER DOES NOT HAVE RETROACTIVE ENROLLMENT.
PB75	THE REQUESTED START DATE IS MORE THAN 14 DAYS BEFORE OR 62 DAYS AFTER RECEIPT.
PB82	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
PB83	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A HOME HEALTH AIDE. PLEASE RESUBMIT AS A PERSONAL CARE WORKER OR PROVIDE ADDITIONAL DOCUMENTATION.

Denial Code	Long Description
PB86	THE SERVICES REQUESTED ARE NOT BEING PROVIDED IN THE CLIENTS RESIDENCE. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL.
PB87	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A NURSE. PLEASE RESUBMIT AS A HOME HEALTH AIDE OR PROVIDE ADDITIONAL DOCUMENTATION.
PB92	PLEASE FURNISH THE CLIENTS COMPLETE ADDRESS.
PB94	IF THE CLIENT IS A RESIDENT OF A NURSING HOME, SUPPLY THE COMPLETE NAME AND ADDRESS OF THE NURSING HOME.
PB99	THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018, MUST BE SIGNED AND DATED.
PC01	PLEASE SUPPLY THE RENDERING PROVIDERS PROVIDER NUMBER.
PC03	THE DRUG ENFORCEMENT ADMINISTRATION NUMBER IS MISSING OR INVALID.
PC06	PLEASE DESCRIBE YOUR PROGRAM; INCLUDE ENTRY DATE, TERMINATION DATE, HOURS PER WEEK, AND NUMBER OF WEEKS OF PRIMARY INTENSIVE SERVICE REQUESTED.
PC07	PLEASE DESCRIBE YOUR "AFTERCARE/FOLLOW-UP" PLANS FOR THIS CLIENT.
PC08	PLEASE SUPPLY DOCUMENTATION OF PREVIOUS SUBSTANCE ABUSE SERVICES WITH DATE(S) AND OUTCOME.
PC09	PLEASE DESCRIBE IN DETAIL THE TREATMENT OBJECTIVES/GOALS FOR THIS CLIENT.
PC10	PLEASE DESCRIBE THE FAMILY SITUATION/DYNAMICS. EXPLAIN HOW THE FAMILY WILL BE INCORPORATED INTO THE CLIENTS PLAN OF CARE.
PC12	PLEASE EXPLAIN IF YOUR SERVICE ENCOURAGES THE CLIENT TO ATTEND SELF-HELP GROUPS.
PC13	PLEASE SUPPLY A SPECIFIC SCHEDULE OF ACTIVITIES, INCLUDING DAY, TIME OF DAY, LENGTH OF SESSION, AND SERVICE TO BE RENDERED DURING THAT TIME.
PC15	PLEASE FURNISH DIAGNOSTIC RATIONALE.
PC17	PLEASE DOCUMENT IF THE CLIENT EVER RECEIVED SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT.
PC19	PLEASE FURNISH MORE EXTENSIVE AND IN-DEPTH HISTORICAL AND PSYCHOSOCIAL DATA.
PC20	PLEASE SUPPLY THE DATE THE CLIENT BECAME TOTALLY ENDENTULOUS.
PC23	PLEASE SUBMIT A PHYSICIANS STATEMENT REGARDING THE MEDICAL NECESSITY OF DENTURES FOR THIS CLIENT. THE PHYSICIANS STATEMENT MUST DOCUMENT THE MEDICAL NEED FOR DENTURES.
PC24	THE SERVICE REQUESTED WAS PREVIOUSLY AUTHORIZED. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT INDICATING THIS FACT IS REQUIRED.
PC25	PLEASE SUPPLY SUFFICIENT MITIGATING CIRCUMSTANCES TO WARRANT THE CONSTRUCTION OF NEW DENTURES(S).
PC26	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
PC28	PLEASE SUBMIT A PHYSICIANS STATEMENT INDICATING DENTURES ARE NECESSARY FOR THIS NURSING HOME CLIENT.
PC29	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING LOSS OR DESTRUCTION OF DENTURE(S). INCLUDE SIGNED STATEMENT FROM CLIENT OR FACILITY DIRECTOR REGARDING HOW, WHEN AND WHERE LOST.
PC30	PLEASE PROVIDE COMPLETE INTRAORAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PC31	PLEASE DESCRIBE ANY RELATED DEFORMITIES OF THE FEET.
PC34	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD WITH REQUESTED DME ITEM(S) AND DOCUMENT IF THE CLIENT CAN USE SAFELY AND INDEPENDENTLY.
PC35	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD AND DESCRIBE THE RESULTS AND EFFECTIVENESS OF THE SERVICE REQUESTED.
PC39	PLEASE INDICATE LITER FLOW PER MINUTE, HOURS OF USE PER 24 HOUR PERIOD, AND THE EXPECTED DURATION OF NEED.
PC40	THE ITEM DOES NOT REQUIRE PRIOR AUTHORIZATION UNTIL THE LIFE EXPECTANCY HAS BEEN REACHED.
PC41	PLEASE SUPPLY INFORMATION INDICATING THE NECESSITY OF POSITIONING THE CLIENT'S BODY IN MULTIPLE POSITIONS.
PC42	PLEASE INDICATE IF THE BED HEIGHT MUST BE CHANGED TO ALLOW FOR SAFE TRANSFER OR ADEQUATE BED CARE.
PC43	SUPPLY A PHYSICIANS STATEMENT INDICATING TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR UNIT HAS REDUCED PAIN, IMPROVED/INCREASED THE CLIENTS ACTIVITY LEVEL, AND/OR REDUCED CLIENTS USE OF PAIN MEDICATION.

Denial Code	Long Description
PC44	A CURRENT AUTHORIZATION FOR THIS SERVICE IS ON FILE FOR ANOTHER PROVIDER. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT OF THAT FACT IS REQUIRED BY THE CLIENT OF FIRST PROVIDER.
PC59	DOCUMENT DECLINE OR PROGRESS IN SPECIFIC, MEASURABLE, OBJECTIVE TERMS.
PC60	DOCUMENT IF CLIENT HAS DEMONSTRATED A GOOD APPOINTMENT COMPLIANCE RECORD.
PC61	THE PHYSICIANS SIGNATURE DATE MUST NOT EXCEED 90 DAYS FROM THE DATE OF RECEIPT BY COLORADO MEDICAID.
PC62	REQUESTS FOR A CONTINUATION OF THERAPY SHOULD NOT BE SUBMITTED MORE THAN FOUR WEEKS PRIOR TO THE EXPIRATION DATE OF THE CURRENT AUTHORIZATION.
PC63	PLEASE FURNISH THE STYLE AND MANUFACTURER OF THE FRAME.
PC64	PLEASE FURNISH THE CLIENTS LENS FORMULA.
PC66	ALL REQUESTS FOR TINTS REQUIRE DOCUMENTATION OF THE VISUAL OR MEDICAL CONDITION RELATED TO PHOTOPHOBIA.
PC67	PLEASE DOCUMENT THE REASON AND JUSTIFICATION FOR REPLACEMENT BEYOND THE FIRST LENS/FRAME.
PC68	DOCUMENT IF ALL REMAINING MAXILLARY AND/OR MANDIBULAR TEETH ARE DECAY-FREE, PROPERLY RESTORED, AND PERIODONTICALLY SOUND.
PC72	SUPPLY MORE DETAIL REGARDING PROGRESS (ATTACHMENT OF GOALS, ETC.). CORRELATE PROGRESS TO PREVIOUS GOALS AND IDENTIFIED LIMITATIONS.
PC77	PLEASE SUBMIT A PLAN OF CARE DESCRIBING THE SERVICES THAT WOULD BE PROVIDED.
PC78	PLEASE DOCUMENT SPECIFIC, MEASURABLE GOALS.
PC82	THE PRIOR AUTHORIZATION (PA) SYSTEM CAN PROCESS ONLY 26 DETAILS PER PA REQUEST. PLEASE RESUBMIT YOUR REQUEST WITH NO MORE THAN 26 DETAILS.
PC83	PLEASE SUPPLY A PHYSICIANS PRESCRIPTION DATED WITHIN ONE MONTH OF REQUESTED SUBSTANCE ABUSE DAY TREATMENT.
PC84	PLEASE PROVIDE INFORMATION INDICATING THIS CLIENT IS APPROPRIATELY DETOXIFIED FROM ALCOHOL AND/OR OTHER DRUGS.
PC85	PLEASE PROVIDE INFORMATION TO INDICATE THE CLIENTS ABILITY TO ABSTAIN FROM ALCOHOL OR DRUGS WHILE IN THE SUBSTANCE ABUSE DAY TREATMENT PROGRAM.
PC86	PLEASE INDICATE IF THIS CLIENT IS WILLING TO PARTICIPATE IN AFTERCARE OR CONTINUING CARE SERVICES.
PC87	PROVIDE MORE INFORMATION ON TREATMENT HISTORY; INCLUDE SERVICE PROVIDED, DATES, AND OUTCOME. PROVIDE DETAIL OF PREVIOUS TREATMENT.
PC88	PLEASE PROVIDE MORE RATIONALE FOR THE APPROPRIATENESS AND MEDICAL NECESSITY OF SUBSTANCE ABUSE DAY TREATMENT.
PC89	PROVIDE A TREATMENT PLAN THAT CONTAINS MEASURABLE GOALS AND OBJECTIVES CORRESPONDING TO THE IDENTIFIED DEFICIT.
PC91	PLEASE PROVIDE MORE INFORMATION ON FAMILY INVOLVEMENT TREATMENT.
PC92	PLEASE PROVIDE MORE HISTORY AND EXPLANATION ABOUT THE ISSUE OF ABSTINENCE FOR THIS CLIENT.
PC94	PLEASE PROVIDE THE ANTICIPATED BEGINNING DATE AND/OR THE ESTIMATED SUBSTANCE ABUSE DAY TREATMENT DISCHARGE DATE.
PC95	PLEASE SUPPLY JUSTIFICATION FOR BEGINNING CLIENT IN SERVICE PRIOR TO AUTHORIZATION BEING OBTAINED.
PC96	THE INITIAL THREE HOURS OF SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IN A CALENDAR YEAR DO NOT REQUIRE PRIOR AUTHORIZATION.
PC97	REIMBURSEMENT FOR INITIAL SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IS LIMITED TO THREE HOURS IN A CALENDAR YEAR AND DOES NOT REQUIRE PRIOR AUTHORIZATION.
PC98	THIS DRUG IS CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE BILL USING THE APPROPRIATE NATIONAL DRUG CODE (NDC) OR SUBMIT A COMPLETED DRUG ADDITION REQUEST FORM IF THE NDC IS NOT LISTED IN THE DRUG INDEX.
PC99	THIS DRUG IS NOT CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL, CURRENT ADMINISTRATIVE RULE, OR COLORADO DRUG INDEX FOR COVERAGE LIMITATIONS.
PD01	DOCUMENT THAT CLIENT HAS ACHIEVED GOOD ORAL HYGIENE, PERIODONTAL CASE TYPE 1 OR 2, AND IS MOTIVATED TO MAINTAIN SAME.

Denial Code	Long Description
PD03	PLEASE PROVIDE AN ARTERIAL BLOOD GAS READING OR PULSE OXIMETRY RESULTS DONE ON ROOM AIR SIGNED AND DATED BY A MEDICAL DOCTOR. THIS SHOULD BE DONE WITHIN 60 DAYS OF REQUESTED SERVICE.
PD04	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 30 DAYS OF RECEIPT BY COLORADO MEDICAID.
PD07	SUBMIT A PHOTOCOPY OF A VALID PRESCRIPTION, ISSUED WITHIN THE PAST YEAR, OR COMPLETE SECTION B OF THE PRIOR AUTHORIZATION/DRUG ATTACHMENT (PA/DGA), F-11049.
PD10	BRAND MEDICALLY NECESSARY MUST BE IN THE PRESCRIBERS OWN HANDWRITING AND WRITTEN DIRECTLY ON THE PRESCRIPTION OR A SEPARATE ORDER ATTACHED TO THE ORIGINAL PRESCRIPTION.
PD12	COMPLETE DENTURES, PARTIAL DENTURES, DENTURE RELINES, AND FIXED PROSTHODONTIC SERVICES ARE NOT COVERED SERVICES FOR ADULTS FOR DATES OF SERVICE ON AND AFTER OCTOBER 1, 1995.
PD22	PLEASE COMPLETE ALL REQUIRED ELEMENTS ON THE PERSONAL CARE SCREENING TOOL (PCST), F-11133.
PD24	THIS PRIOR AUTHORIZATION REQUEST IS UNABLE TO BE PROCESSED. PLEASE RESUBMIT WITH ADDITIONAL REQUIRED FORMS, INCLUDING THE ENTIRE PERSONAL CARE SCREENING TOOL (PCST), F-11133; PERSONAL CARE ADDENDUM, F-11136; AND SUPPORTING DOCUMENTATION, AS DIRECTED.
PD25	THERE IS A PERSONAL CARE SCREENING TOOL (PCST), F-11133, COMPLETED BY ANOTHER AGENCY. CONTACT THE AGENCY TO TRANSFER SCREEN.
PD26	THERE IS A LIMITED TERM CARE FUNCTIONAL SCREEN (LTC-FS) COMPLETED BY ANOTHER AGENCY. THE PERSONAL CARE SCREENING TOOL (PCST), F-11133, INFORMATION IS IN CONFLICT WITH LTC-FS.
PD27	ONLY ONE LEVEL OF FUNCTION MAY BE SELECTED FOR ALL ELEMENTS EXCEPT TOILETING. COLORADO MEDICAID IS UNABLE TO PROCESS THE PRIOR AUTHORIZATION REQUEST.
PD28	NO UNITS MAY BE REQUESTED USING THIS PRIOR AUTHORIZATION PROCESS. PLEASE SUBMIT WITH THE APPROPRIATE ATTACHMENTS FOR REQUESTING SPECIFIC PERSONAL CARE WORKER UNITS.
PD29	CLIENT IS NOT ELIGIBLE FOR THE REQUESTED SERVICE(S) AS OF THE REQUESTED START DATE.
PD30	NO TRAVEL TIME MAY BE AUTHORIZED WHEN NO PERSONAL CARE WORKER SERVICE IS AUTHORIZED.
PD32	PROVIDER NOT CERTIFIED TO RENDER THE SERVICE(S) REQUESTED.
PD34	BASED ON THE DOCUMENTATION SUBMITTED, THIS REQUEST CAN NOT BE PRIOR AUTHORIZED. REFER TO THE PA MESSAGES FROM THE CONSULTANT FOR COMPLETE EXPLANATION.
PD98	PLEASE DOCUMENT HOW AND WHEN EACH PREVIOUSLY AUTHORIZED PRO RE NATA VISIT WAS USED.

Children's Home and Community-Based Services Waiver (CHCBS)

Denial Code	Long Description
0201	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
0233	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0235	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0237	CLIENT IDENTIFICATION NUMBER DOES NOT MATCH CLIENTS FIRST NAME.
0238	THE CLIENT IDENTIFICATION NUMBER DOES NOT MATCH THE CLIENTS LAST NAME.
0242	SECONDARY DIAGNOSIS CODE IS INVALID.
0248	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0249	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0251	PROCEDURE CODE MODIFIER IN FIRST POSITION IS INVALID.
0252	THE PROCEDURE CODE MODIFIER IN SECOND POSITION IS INVALID FOR REQUESTED START DATE OR DATE OF RECEIPT.
0253	THE PROCEDURE CODE MODIFIER IN THIRD POSITION IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
0258	THE PRIMARY DIAGNOSIS CODE IS REQUIRED.
0272	THE PRIMARY DIAGNSOSIS CODE IS INVALID.

Denial Code	Long Description
0400	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0853	HCPCS - ANNUAL UPDATE
0885	NEVER EVENTS MODIFIERS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
0886	NEVER EVENTS DIAGNOSIS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
1000	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
1002	RENDERING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1003	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1007	RENDERING PROVIDER ID IS NOT ON FILE.
1047	THE RENDERING PROVIDERS CERTIFICATION HAS BEEN CANCELLED.
1048	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1801	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
1804	A CERTIFIED SUBSTANCE ABUSE DAY TREATMENT PROVIDER MUST SUBMIT A SUBSTANCE ABUSE DAY TREATMENT PROCEDURE CODE.
1806	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
1808	THE BILLING PROVIDER DOES NOT HAVE THE REQUIRED CERTIFICATION ADDENDUM ON FILE.
1900	THE BILLING PROVIDERS TAXONOMY CODE IS INVALID.
1901	THE RENDERING PROVIDERS TAXONOMY CODE IS INVALID.
1927	A NATIONAL PROVIDER IDENTIFIER IS REQUIRED FOR THE BILLING PROVIDER.
1934	A NATIONAL PROVIDER INDENTIFIER IS REQUIRED FOR THE RENDERING PROVIDER.
1936	THE BILLING PROVIDER NUMBER IS INVALID.
1937	THE RENDERING PROVIDER NUMBER IS INVALID.
1960	INTERNAL PROCESSING IS REQUIRED.
1963	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.
1964	THE BILLING PROVIDER INDICATED IS NOT ALLOWABLE AS A BILLING PROVIDER.
1965	RENDERING PROVIDER NUMBER IS MISSING/INVALID FOR THIS PROCEDURE PROVIDER.
1974	PRESCRIBING/REFERRING/ORDERING PROVIDER INDICATED IS NOT CERTIFIED AS A PRESCRIBING/REFERRING/ORDERING PROVIDER.
1975	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
1976	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
2001	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2003	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2017	THE CLIENT IS ENROLLED IN A MEDICAID OR OTHER MANAGED CARE PROGRAM.
2037	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2603	CLIENT LOCKED-IN TO A PROVIDER OR ENROLLED IN A HOSPICE. CONTACT CLIENTS HOSPICE FOR PAYMENT OF SERVICES OR RESUBMIT WITH DOCUMENTATION OF UNRELATED NATURE OF CARE.
3324	THE MODIFIER HAS BEEN DISCONTINUED BY THE CENTERS OF MEDICARE AND MEDICAID SERVICES OR THE AMERICAN MEDICAL ASSOCIATION FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
3337	THE PROCEDURE CODE HAS BEEN TERMINATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AMERICAN MEDICAL ASSOCIATION, OR AMERICAN DENTAL ASSOCIATION FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT. RESUBMIT WITH VALID A PROCEDURE CODE.
3339	THE PROCEDURE BILLED IS NOT PAYABLE ACCORDING TO DEFICIT REDUCTION ACT (DEFRA) GUIDELINES.
3351	THE PROCEDURE IS NOT COVERED FOR CLIENTS WITH A NURSING HOME AUTHORIZATION ON THE REQUESTED START DATE OR DATE OF RECEIPT.
3353	THE PROCEDURE IS NOT A COVERED SERVICE FOR HOME AND COMMUNITY-BASED WAIVER CLIENTS.
4021	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4027	THE DIAGNOSIS CODE IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
4031	THE PROCEDURE SUBMITTED IS NOT APPROPRIATE FOR CLIENTS GENDER.
4032	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4034	THE PROCEDURE CODE HAS AN AGE RESTRICTION.
4036	THE PLACE OF SERVICE CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4040	THE PRIMARY DIAGNOSIS CODE IS NOT ON FILE.
4041	THE SECONDARY DIAGNOSIS IS NOT ON FILE.

Denial Code	Long Description
4046	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4127	INTERNAL PROCESSING IS REQUIRED.
4131	INTERNAL PROCESSING IS REQUIRED.
4141	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4149	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4150	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4236	ETIOLOGY DIAGNOSIS CODE(S) (E-CODES) ARE INVALID AS THE PRIMARY DIAGNOSIS.
4244	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4245	THE FOURTH POSITION MODIFIER IS INVALID FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT.
4256	THE PROCEDURE CODE AND MODIFIER COMBINATION IS NOT PAYABLE FOR THE CLIENTS BENEFIT PLAN.
4257	THE MODIFIERS SUBMITTED ARE EITHER INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT OR THE MODIFIERS ARE MISSING.
4311	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4315	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4316	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4371	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4372	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4711	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR CLIENTS AGE.
4714	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS AGE.
4731	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS DIAGNOSIS.
4742	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4743	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4744	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4745	DIAGNOSIS AND/OR PROCEDURE AND/OR PLACE OF SERVICE (POS) CODE IS NOT COVERED FOR EXPRESS ENROLLMENT CLIENTS.
4746	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4801	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4802	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
4821	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
4871	PLEASE REFER TO PA MESSAGES FOR RETURN INFORMATION.
4963	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS GENDER.
4990	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
7500	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
7509	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
P001	THE BILLING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THE SERVICES.
P002	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P003	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P005	THE PRIOR AUTHORIZATION CAN NOT BE END DATED. THE PRIOR AUTHORIZATION STATUS IS NOT APPROVED OR APPROVED WITH REVISIONS.
P006	PLEASE FURNISH THE PROCEDURE CODE AND CORRESPONDING DESCRIPTION.
P008	THE BILLING PROVIDER NUMBER IS INVALID.
P009	THE BILLING PROVIDER NUMBER IS INVALID.
P010	THE REQUESTED END DATE IS INVALID.
P011	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P012	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P013	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.

Denial Code	Long Description
P014	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P015	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P016	THE REQUESTED START DATE IS MISSING OR INVALID.
P019	THE REQUESTED START DATE IS MISSING OR INVALID.
P020	THE RENDERING PROVIDER NUMBER IS INVALID.
P021	THE RENDERING PROVIDER NUMBER IS INVALID.
P022	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P023	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P024	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P026	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P027	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P030	FIRST MODIFIER IS INVALID.
P031	FIRST MODIFIER IS INVALID.
P032	SECOND MODIFIER IS INVALID.
P033	SECOND MODIFIER IS INVALID.
P034	THIRD MODIFIER IS INVALID.
P035	THIRD MODIFIER IS INVALID.
P036	FOURTH MODIFIER IS INVALID.
P037	FOURTH MODIFIER IS INVALID.
P038	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P039	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P040	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P041	CLIENTS FIRST NAME IS MISSING.
P042	CLIENTS LAST NAME IS MISSING.
P043	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P044	BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES REQUESTED.
P045	FIRST MODIFIER IS INVALID.
P046	SECOND MODIFIER IS INVALID.
P047	THIRD MODIFIER IS INVALID.
P048	FOURTH MODIFIER IS INVALID.
P052	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P053	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P054	RENDERING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES FOR THE BENEFIT PLAN.
P055	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P061	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P062	THE CLIENT ID AND/OR NAME INDICATED ON THE PA REQUEST IS INCORRECT. THE CLIENT ID AND/OR NAME HAS BEEN UPDATED. PLEASE VERIFY THE ID AND/OR NAME IS CORRECT.
P064	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
P067	THE FREQUENCY OF HOURS REQUESTED ARE NOT APPROPRIATE FOR THIS CLIENT AND HAVE BEEN MODIFIED ACCORDINGLY.
P079	BILLING PROVIDER IS ON PAYMENT SUSPENSION DUE TO CREDIBLE ALLEGATION OF FRAUD.
P120	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAS BEEN REDUCED.
P121	THE SERVICE/ PROCEDURE REQUESTED IS NOT SUPPORTED BY SUBMITTED DOCUMENTATION.
P126	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
P128	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.

Denial Code	Long Description
P138	SERVICE(S) DO NOT MEET COLORADO MEDICAID GUIDELINES.
P167	REQUESTED DOCUMENTATION HAS NOT BEEN SUBMITTED.
P178	THE SERVICE REQUESTED IS NOT MEDICALLY NECESSARY.
P179	THE MEDICAL NECESSITY FOR THIS SERVICE IS NOT SUPPORTED BY THE SUBMITTED DOCUMENTATION.
P233	THE DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE ADDITIONAL CARE.
P257	THIS CLIENTS FUNCTIONAL ASSESSMENT SCORES PLACE THIS CLIENT OUTSIDE ELIGIBILITY FOR DAY TREATMENT.
P274	OUR RECORDS INDICATE THIS CLIENT IS INVOLVED IN EFFECTIVE AND APPROPRIATE SERVICE ELSEWHERE.
P292	INTENSIVE REHABILITATION HOURS ARE NO LONGER APPROPRIATE AS INDICATED BY HISTORY, DIAGNOSIS, AND/ OR FUNCTIONAL ASSESSMENT SCORES.
P328	THE SERVICES REQUESTED INCLUDE NON-COVERED SERVICES, AND HOURS ARE REDUCED ACCORDINGLY.
P339	THE CLIENTS PAST HISTORY INDICATES REDUCED TREATMENT HOURS ARE WARRANTED.
P342	THE REQUEST DOES NOT MEET GENERALLY ACCEPTED CONDITIONS REQUIRING FLUORIDE TREATMENTS.
P346	SERVICES EXCEED COLORADO MEDICAID LIMITATION AND DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE MEDICAL NECESSITY OF THE SERVICE.
P349	THE SERVICE REQUESTED WAS PERFORMED LESS THAN FIVE YEARS AGO.
P353	THE EXISTING APPLIANCE HAS NOT BEEN WORN FOR THREE YEARS.
P367	THE CLIENT HAS BEEN TOTALLY WITHOUT TEETH AND AN APPLIANCE FOR FIVE YEARS.
P392	THE CLIENT IS MISSING AN ANTERIOR TOOTH AND/OR HAS TWO OR MORE POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P405	THE SERVICE(S) REQUESTED COULD ADEQUATELY BE PERFORMED IN THE DENTAL OFFICE.
P406	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE OF GOOD PERIODONTAL HEALTH (AMERICAN ACADEMY OF PERIODONTOLOGY PERIODONTAL CLASSIFICATION OF TYPE I OR II).
P407	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE VISIBLE ON RADIOGRAPHS THAT AT LEAST 50 PERCENT OF THE CLINICAL CROWN IS INTACT.
P409	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING SIX OR MORE TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED, INCLUDING THIRD MOLARS.
P410	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING ONE OR MORE ANTERIOR TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED.
P411	DOCUMENTATION DOES NOT SUPPORT THE NEED FOR PERIODONTIC SERVICES. POCKETS ARE LESS THAN 4MM AND/OR GREATER THAN 6MM FOR CLIENT AND/OR THE CLIENT IS UNDER THE AGE OF 13.
P412	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA.
P413	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA. THIS PA HAS BEEN GRANTED AS APPROVED NOT APPROVED WITH REVISIONS. THE DURATION REQUESTED MAY HAVE BEEN REDUCED TO REFLECT COVERAGE LIMITATIONS, PRESCRIBER ORDERS, CONFLICTI
P417	THE SERVICE(S) REQUESTED COULD BE ADEQUATELY PERFORMED WITH LOCAL ANESTHESIA.
P437	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO POOR ORAL HYGIENE.
P444	THIS LINE ITEM IS A DUPLICATE OF ANOTHER LINE ITEM ON THIS PRIOR AUTHORIZATION (PA) REQUEST. PLEASE CORRECT.
P446	THIS IS A DUPLICATE OF AN EXISTING PRIOR AUTHORIZATION (PA) REQUEST. YOU MAY CONTACT PROVIDER SERVICES IF YOU REQUIRE ASSISTANCE. DUPLICATE PA REQUEST
P448	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO DECAY HISTORY.
P449	QUESTIONABLE LONG TERM PROGNOSIS DUE TO GUM AND BONE DISEASE.
P456	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO APPARENT ROOT INFECTION.
P457	OUR RECORDS INDICATE THIS CLIENT HAS EXCEEDED ESTABLISHED PROGRAM LIMITATIONS. COLORADO MEDICAID WILL NOT AUTHORIZE NEW DENTURES.
P458	DOCUMENTATION PROVIDED INDICATES A LESS ELABORATE PROCEDURE SHOULD BE CONSIDERED.
P502	RENTAL ONLY ALLOWED; MEDICAL NEED FOR PURCHASE HAS NOT BEEN DOCUMENTED.
P503	PURCHASE ONLY ALLOWED; MEDICAL NEED FOR RENTAL HAS NOT BEEN DOCUMENTED.
P504	OCCUPATIONAL THERAPY GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P505	THE SERVICE REQUESTED IS INCLUDED IN THE NURSING HOME RATE STRUCTURE.
P511	THIS NATIONAL DRUG CODE IS ONLY BILLABLE AS PART OF A COMPOUND DRUG.

Denial Code	Long Description
P515	THE PRESENCE OF A HANDICAPPING MALOCCLUSION OR HANDICAPPING DENTOFACIAL DEFORMITY IS NOT SUPPORTED BY THE DOCUMENTATION SUBMITTED.
P521	THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVERED BY COLORADO MEDICAID.
P522	GASTRO-INTESTINAL SURGERY FOR THE PURPOSE OF WEIGHT CONTROL IS COVERED ONLY AS A LIFE THREATENING PROCEDURE.
P523	THE TREATMENT REQUEST IS NOT CONSISTENT WITH THE CLIENT'S DIAGNOSIS.
P524	PSYCHOTHERAPY PROVIDED IN THE CLIENTS HOME IS NOT A COVERED BENEFIT OF COLORADO MEDICAID.
P525	THE INFORMATION PROVIDED IS NOT CONSISTENT WITH THE INTENSITY OF SERVICES REQUESTED.
P526	INTENSIVE MULTIPLE MODALITY TREATMENT IS NOT CONSISTENT WITH THE INFORMATION PROVIDED.
P527	MULTIPLE PROVIDERS OF TREATMENT ARE NOT INDICATED FOR THIS CLIENT.
P528	THE DURATION OF TREATMENT SESSIONS EXCEED CURRENT COLORADO MEDICAID GUIDELINES.
P534	DOCUMENTATION OF POOR PHYSICAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P535	OTHER PHYSICAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P536	THE PHYSICAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P537	USE OF PHYSICAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P538	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF A PHYSICAL THERAPIST.
P539	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS AND LIVING ARRANGEMENT.
P540	GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P541	THE PROCEDURE(S) REQUESTED ARE NOT MEDICAL IN NATURE.
P542	DOCUMENTATION OF POOR OCCUPATIONAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P543	DOCUMENTATION OF POOR SPEECH THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P544	OTHER OCCUPATIONAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P546	THE OCCUPATIONAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P547	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF PHYSICAL THERAPY.
P548	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P549	ACTIVITIES TO PROMOTE DIVERSION OR GENERAL MOTIVATION ARE NONCOVERED COLORADO MEDICAID SERVICES.
P550	REVISIONS OF THE REQUEST IS NECESSITATED BY THE CLIENTS MINIMAL PROGRESS.
P551	RESTORATIVE NURSING INVOLVEMENT COULD BE INCREASED.
P552	CLIENTS DEMONSTRATED RESPONSE TO CURRENT THERAPY DOES NOT WARRANT THE INTENSE FREQUENCY REQUESTED.
P553	MAINTENANCE IS TWO TIMES PER WEEK OR LESS.
P554	THE SPEECH THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P555	USE OF OCCUPATIONAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P556	USE OF SPEECH THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P557	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF AN OCCUPATIONAL THERAPIST.
P558	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
P559	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P560	THE MATERIALS/ SERVICES REQUESTED ARE PRINCIPALLY COSMETIC IN NATURE.
P561	THE LENS FORMULA DOES NOT JUSTIFY REPLACEMENT.
P562	THE CHANGE IN THE LENS FORMULA DOES NOT WARRANT MULTIPLE REPLACEMENTS.

Denial Code	Long Description
P563	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P564	LENSES ONLY ARE APPROVED; PLEASE DISPENSE A CONTRACTED FRAME. THE NON-CONTRACTED FRAME IS NOT MEDICALLY JUSTIFIED.
P565	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P566	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P567	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF OCCUPATIONAL THERAPY.
P568	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF SPEECH THERAPY.
P569	LEVEL, INTENSITY, OR EXTENT OF SERVICE(S) REQUESTED HAS BEEN MODIFIED CONSISTENT WITH MEDICAL NEED AS DEFINED IN THE PLAN OF CARE.
P570	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P571	THE SERVICE ASKED FOR IS NOT COVERED BY COLORADO MEDICAID AS THESE TASKS CAN BE DONE BY NURSES OR ACTIVITY STAFF.
P572	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P573	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.
P574	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P575	MEDICAL NEED FOR EQUIPMENT/ SUPPLY REQUESTED IS NOT SUPPORTED BY DOCUMENTATION SUBMITTED.
P576	OTHER SPEECH THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P577	DOCUMENTATION SUBMITTED IDENTIFIES THAT THE CLIENT HAS FEWER THAN TWO POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P582	LESS EXPENSIVE ALTERNATIVE SERVICES ARE AVAILABLE FOR THIS CLIENT.
P634	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P711	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING PERIODONTAL SCALING AND ROOT PLANNING.
P712	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING GINGIVECTOMY.
P754	AN APPROVED SUBSTANCE ABUSE DAY TREATMENT PROGRAM CANNOT EXCEED A SIX WEEK PERIOD.
P761	THE CLIENT DOES NOT APPEAR TO BE ABLE OR WILLING TO ABSTAIN FROM ALCOHOL/DRUG USAGE WHILE IN TREATMENT. THEREFORE, SUBSTANCE ABUSE DAY TREATMENT SERVICES ARE NOT APPROVED.
P764	THIS CLIENT HAS COMPLETED INTENSIVE SUBSTANCE ABUSE TREATMENT WITHIN THE PAST 12 MONTHS. THE DOCUMENTATION PROVIDED IS NOT ADEQUATE TO JUSTIFY ADDITIONAL INTENSIVE TREATMENT AT THIS TIME.
P785	A LESS THAN SIX-WEEK HEALING PERIOD HAS BEEN SPECIFIED FOR THIS PRIOR AUTHORIZATION. THEREFORE IT IS NOT NECESSARY TO WAIT THE FULL SIX WEEKS AFTER EXTRACTIONS BEFORE TAKING DENTURE IMPRESSIONS.
P818	SIX-WEEK HEALING TIME IS REQUIRED BETWEEN EDENTULATION AND FINAL IMPRESSIONS. PAYMENT FOR DENTURES WILL BE DENIED OR RECOUPED IF HEALING PERIOD IS NOT OBSERVED.
P849	COLORADO MEDICAID HAS DETERMINED THERE WERE (ARE) SEVERAL HOME HEALTH AGENCIES WILLING TO PROVIDE MEDICALLY NECESSARY SKILLED NURSING SERVICES TO THIS CLIENT.
P864	THE DOCUMENTATION YOU HAVE SUBMITTED DOES NOT MEET THE REQUIREMENTS OF COLORADO MEDICAID.
P873	THE MEDICAL NECESSITY FOR THE HOURS REQUESTED IS NOT SUPPORTED BY THE INFORMATION SUBMITTED.
P874	THE DOCUMENTATION SUBMITTED INDICATES THE TASKS SPECIFIED CAN BE COMPLETED DURING THE VISITS APPROVED.
P878	THE DOCUMENTATION SUBMITTED DOES NOT INDICATE THAT MEDICALLY ORIENTED TASKS ARE MEDICALLY NECESSARY; THEREFORE PERSONAL CARE SERVICES HAVE BEEN APPROVED.

Denial Code	Long Description
P880	THE QUANTITY OF SERVICES AUTHORIZED FOR THIS CLIENTS PERSONAL CARE HAS BEEN AMENDED BASED ON INFORMATION RECEIVED FROM ONE OR MORE OF THESE SOURCES: THE CLIENT, THEIR PHYSICIAN, AND/OR THE IN-HOME VISIT BY STAFF OF THE OIG (OFFICE OF INSPECTOR GENERAL).
P885	THE USE OF THIS DRUG FOR THE INTENDED PURPOSE IS NOT COVERED BY COLORADO MEDICAID, CONSISTENT WITH COLORADO ADMINISTRATIVE CODE AND FEDERAL LAW.
P924	THE MEDICAL RECORDS SUBMITTED WITH THE CURRENT REQUEST CONFLICT OR DISAGREE WITH OUR MEDICAL RECORDS ON THIS CLIENT.
P950	INDEPENDENT NURSES, PLEASE NOTE PAYABLE SERVICES MAY NOT EXCEED 12 HOURS/DAY OR 60 HOURS/WEEK.
P951	SERVICES CAN ONLY BE AUTHORIZED THROUGH ONE YEAR FROM THE PRESCRIPTION DATE.
P952	LEAD INSPECTION IS A COVERED COLORADO MEDICAID SERVICE WHEN THE CHILD HAS BEEN SHOWN TO HAVE LEAD POISONING (E.G., CHILD HAS A BLOOD LEAD LEVEL > 19 UG/DL OR TWO CONSECUTIVE BLOOD LEAD LEVELS OF 15-19 UG/DL DONE AT LEAST 90 DAYS APART). THE INSPECTION MUS
P953	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P954	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P956	THE REQUEST CAN ONLY BE BACKDATED A MAXIMUM OF 14 DAYS FROM FIRST DATE RECEIVED BY COLORADO MEDICAID.
P957	COMPLETE PERIODONTAL CHARTING AT TIME OF SERVICE, AND SUBMIT CHARTING, COPY OF OPERATIVE REPORT, TOGETHER WITH A COPY OF THE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF), F-11035, TO PA UNIT ATTENTION DENTAL CONTSULTANT.
P958	NOTE THAT CODE D4341 HAS BEEN CHANGED. REFER TO THE DECISION NOTICE FOR AUTHORIZED QUANTITY.
P960	YOUR PA HAS BEEN APPROVED FOR 90 DAYS. THE 90 DAY APPROVAL DOES NOT IMPLY THE PA REQUEST MEETS PRIOR AUTHORIZATION CRITERIA. AFTER ADDITIONAL INFORMATION IS AVAILABLE IN INTERCHANGE, COLORADO MEDICAID WILL CREATE AN AMENDMENT REQUEST TO EXTEND THE PA FOR
P961	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P962	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
PA10	THE REQUESTED END DATE IS INVALID.
PA12	PLEASE FURNISH A WRITTEN DESCRIPTION OF THE CLIENTS DIAGNOSIS.
PA13	PROVIDE DIAGNOSES WITH DATES OF ONSET.
PA14	IDENTIFY PROBLEMS TO BE TREATED.
PA15	THE AUDIOLOGISTS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1), F-11020, AND PRIOR AUTHORIZATION REQUEST/HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2), F-11021.
PA16	THE PHYSICIANS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION/PHYSICIAN OTOLOGICAL REPORT (PA/POR), F-11019.
PA17	SUBMIT BRIEF HISTORY WITH REFERRAL INFORMATION, LIVING SITUATION, FUNCTIONAL STATUS, AND OTHER PERTINENT INFORMATION. WHAT CHANGE OF STATUS RESULTED IN REFERRAL AT THIS TIME?
PA18	PLEASE FURNISH THE CLIENTS HEIGHT AND WEIGHT.
PA19	PLEASE SUBMIT CLINICAL INFORMATION SUFFICIENT TO VERIFY THE NEED FOR THE REQUESTED SERVICE(S).
PA20	PLEASE RESUBMIT WITH COMPLETE PERIODONTAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PA21	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL EDUCATIONAL PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA22	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL PROGRAM PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA23	REFER TO THE DURABLE MEDICAL EQUIPMENT INDEX FOR APPROPRIATE CODE AND DESCRIPTION. DO NOT USE AN "UNLISTED" CODE.

Denial Code	Long Description
PA24	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUALIZED FAMILY SERVICE PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA25	INFORMATION ON THE REQUEST FORM IS ILLEGIBLE, AND THE REQUEST CANNOT BE PROCESSED.
PA26	RE-EVALUATE YOUR GOALS. EMPHASIS SHOULD BE ON FUNCTIONAL SELF-CARE. GOALS MUST BE RELATED TO FUNCTIONAL OUTCOME.
PA27	PLEASE CLARIFY THE NUMBER OF HOURS PER WEEK REQUESTED.
PA28	PLEASE CLARIFY THE NUMBER OF HOURS PER DAY REQUESTED.
PA29	PLEASE CLARIFY THE NUMBER OF VISITS PER DAY REQUESTED.
PA30	ATTACH SUPPORTIVE DOCUMENTATION; HOME EXERCISE PROGRAM AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA31	THE DIAGNOSIS CODE INDICATED ON THE REQUEST DOES NOT CORRESPOND TO THE DIAGNOSIS CODE DESCRIPTION.
PA32	PLEASE SUBMIT ADDITIONAL INFORMATION SUFFICIENT TO VERIFY APPROPRIATENESS AND NEED FOR TRANSPLANT.
PA33	PLEASE SUBMIT THE INITIAL AND PROGRESSIVE OBJECTIVE FINDINGS.
PA34	ATTACH SUPPORTIVE DOCUMENTATION, FACILITY PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA35	PLEASE SUBMIT THE CLIENTS ORIGINAL COMPLAINTS AND EXAMINATION FINDINGS.
PA36	ATTACH SUPPORTIVE DOCUMENTATION, IN-HOME AUTISM PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA37	PLEASE SUBMIT YOUR TREATMENT PLAN FOR THIS CLIENT.
PA38	ATTACH SUPPORTIVE DOCUMENTATION AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA39	INITIAL EVALUATIONS MUST BE PERFORMED BY AN OCCUPATIONAL THERAPIST REGISTERED (OTR), PER AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA) STANDARDS.
PA41	IDENTIFY THE PLACE OF SERVICE AND ITS EFFECT ON SUPPORTING THE DESIRED TREATMENT OUTCOME.
PA42	PLEASE INDICATE THE HOURS OF USE OF OXYGEN PER 24-HOUR PERIOD.
PA43	PROVIDE BASELINE DOCUMENTATION FOR THIS CLIENTS LIMITATIONS USING UNITS OF MEASUREMENT THAT ARE APPLIED CONSISTENTLY WHEN REPORTING STATUS.
PA44	IDENTIFY FUNCTIONAL LIMITATIONS AS THEY ARE RELATED TO IDENTIFIED CONDITIONS.
PA46	CORRELATE PLAN OF CARE TO REQUESTED PROCEDURE CODES.
PA47	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE FREQUENCY/DURATION REQUESTED.
PA48	PLEASE PROVIDE THE NAME AND CREDENTIALS OF THE RENDERING PROVIDER.
PA50	COLORADO MEDICAID RECORDS INDICATE THE CLIENT OWNS A WHEELCHAIR. DOCUMENT THE REASON AND NEED FOR REPLACEMENT AND COST TO REPAIR CURRENT WHEELCHAIR.
PA51	PLEASE DISTINGUISH PRIMARY AND SUPPORTIVE MODALITIES.
PA52	PLEASE SUBMIT A PROGRESS REPORT.
PA53	MULTIPLE FAMILY CLIENTS TREATMENT BY THE SAME PROVIDER REQUIRES FURTHER INFORMATION DOCUMENTING COORDINATION OF TREATMENT PLAN.
PA54	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE MINUTES REQUESTED.
PA55	MEDICAL NECESSITY OF TREATMENT REQUIRES ADDITIONAL DOCUMENTATION.
PA56	GIVEN AGE, DIAGNOSES, CURRENT LEVEL OF FUNCTION, PAST RESPONSE TO TREATMENT, AND LIVING SITUATION, EXPAND ON POTENTIAL FOR SIGNIFICANT FUNCTIONAL PROGRESS WITHIN THE NEXT SIX MONTHS. EMPHASIZE WHY PROGRESS IS EXPECTED WITH SERVICES AT THIS TIME.
PA57	SUBMIT THE INITIAL FINDINGS. INCLUDE A COMPREHENSIVE EVALUATION.
PA58	SUBMIT PROGRESSIVE, OBJECTIVE FINDINGS. INCLUDE A PERTINENT RE-EVALUATION.
PA59	PLEASE SUPPLY INFORMATION REGARDING THE CLIENTS MEDICATION REQUIREMENTS, IF ANY.
PA60	PLEASE SPECIFY IF THE CLIENT IS IN AN EDUCATIONAL SETTING.
PA61	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA62	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.

Denial Code	Long Description
PA63	THE SKILLS OF A THERAPIST ARE PURPOSEFUL AND SKILLED INTERVENTIONS REQUIRED TO CONTINUALLY DESIGN, IMPLEMENT, REASSESS, MODIFY/GRADE, AND/OR DISCONTINUE A PLAN OF CARE IN A TIMELY MANNER, BASED ON THE COMPLEXITY OF THE CLIENTS MEDICAL CONDITION AND/OR CO
PA64	PLEASE SUBMIT A THERAPY PLAN OF CARE, INCLUDING A CURRENT, DATED EVALUATION.
PA65	A PLAN OF CARE SIGNED AND DATED BY THE PHYSICIAN IS REQUIRED.
PA66	THE SKILLS OF A THERAPIST ARE REQUIRED WHEN ONLY THE THERAPIST CAN SAFELY AND EFFECTIVELY DELIVER THE THERAPEUTIC PROCEDURES BECAUSE OF THEIR UNIQUE KNOWLEDGE, TRAINING, AND EXPERTISE. DESCRIBE THE REASON THAT SOMEONE OTHER THAN A THERAPIST CANNOT SAFELY
PA67	PLEASE SPECIFY IF THE CLIENTS WORK SITE DEMANDS GOOD BINAURAL HEARING.
PA68	DESCRIBE THE REASON, BASED ON THE CLIENTS COGNITIVE, PHYSICAL, COMMUNICATION, OR RESOURCE STATUS, THAT A HOME PROGRAM, EQUIPMENT, OR ENVIRONMENTAL ADAPTATIONS ALONE CANNOT MEET CLIENTS NEEDS.
PA69	PLEASE SPECIFY IF THE CLIENT HAS AN ACCOMPANYING DISABILITY THAT ADDS TO THE HEARING PROBLEM.
PA70	DISTINGUISH REQUESTED PROCEDURES AND GOALS FROM OTHER SERVICES THIS CLIENT RECEIVES. THEY MAY NOT BE DUPLICATIVE.
PA71	PLEASE INDICATE THE NUMBER OF DAYS REQUESTED.
PA73	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA74	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA75	PLEASE DOCUMENT CARRYOVER OF THE THERAPY PROGRAM TO NURSING.
PA76	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA79	PROVIDE EVIDENCE OF SIGNIFICANT FUNCTIONAL PROGRESS IN LAST SIX MONTHS.
PA84	THE GRANT DATE OF THIS REQUEST CANNOT BE PRIOR TO THE SIGNATURE DATE OF THE PRESCRIBING PHYSICIAN.
PA86	PROVIDE EVIDENCE OF SKILLS GAINED IN THERAPY CARRYING OVER TO OTHER SETTINGS WITHIN SIX MONTHS.
PA87	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE NUMBER OF SESSIONS REQUESTED.
PA88	THE REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL SCOPE OF PRACTICE.
PA89	PRIOR AUTHORIZATION IS NOT REQUIRED UNTIL LIMITATION OF SERVICE HAS BEEN REACHED.
PA91	PLEASE SUBMIT REQUIRED X-RAYS.
PA92	PLEASE PROVIDE AN EXPLANATION FOR THE MATERIAL SUBMITTED WITH THE REQUEST.
PA95	PLEASE DESCRIBE HOW THE PROVISION OF THIS SERVICE WOULD PREVENT INSTITUTIONALIZATION OF THE CLIENT.
PA96	COULD THE EXISTING DENTURE(S) BE RELINED OR REBASED? IF NOT, PLEASE EXPLAIN WHY NOT.
PA97	REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL STANDARDS OF PRACTICE.
PA98	PLEASE INDICATE IF THE CLIENT IS CURRENTLY BEING TUBE FED.
PB02	PLEASE PROVIDE THE REQUIRED DATED SIGNATURES ON THE ATTACHMENTS.
PB03	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING THE LOSS/DESTRUCTION/THEFT OF THE HEARING AID.
PB04	DESCRIBE THE CLIENTS ABILITY TO STAND OR AMBULATE SUFFICIENTLY TO ACCOMPLISH SELF-CARE ACTIVITIES.
PB07	PLEASE SUBMIT AN ORTHODONTIC STUDY MODEL OR DIAGNOSTIC CASTS.
PB09	PLEASE PROVIDE A PHOTOGRAPH OF THE INVOLVED AREA(S).
PB10	PLEASE PROVIDE AN ESTIMATION (IN GRAMS) OF THE TOTAL AMOUNT OF TISSUE TO BE RESECTED.
PB11	PLEASE SUBMIT THE PLAN OF CARE FOR CO-TREATMENT.
PB12	FURNISH A DETAILED DESCRIPTION FOR THE PROCEDURE CODE REQUESTED.
PB13	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB15	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB18	PLEASE COMPLETE THE ATTACHED OUT-OF-STATE PROVIDER DATA SHEET, F-11001, AND RESUBMIT.

Denial Code	Long Description
PB20	A SIGNED AND DATED PRESCRIPTION IS REQUIRED WITHIN THREE MONTHS OF RECEIPT BY COLORADO MEDICAID FOR INITIAL REQUESTS AND WITHIN 12 MONTHS OF RECEIPT BY COLORADO MEDICAID FOR SUBSEQUENT REQUESTS.
PB21	PLEASE COMPLETE THE APPROPRIATE PRIOR AUTHORIZATION ATTACHMENT. CONTACT PROVIDER SERVICES OR THE PRIOR AUTHORIZATION UNIT FOR ASSISTANCE.
PB23	PHYSICAL THERAPY ASSISTANT NOTES AND ALL FORMS SUBMITTED MUST BE COSIGNED BY A REGISTERED PHYSICAL THERAPIST.
PB31	ARE YOU REQUESTING A COMPLETE APPLIANCE, OR REPLACEMENT PARTS?
PB32	THE PROCEDURE CODE INDICATED ON THE REQUEST DOES NOT MATCH THE DESCRIPTION OF SERVICE; PLEASE CORRECT AND RESUBMIT.
PB35	THE SERVICE REQUESTED DOES NOT REQUIRE PRIOR AUTHORIZATION.
PB41	PLEASE FURNISH A CURRENT MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT, F-11090 (DATED WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID).
PB45	THE CERTIFICATION PERIOD ON THE PLAN OF CARE (POC) DOES NOT COVER THE REQUESTED GRANT/START DATE. PLEASE RESUBMIT YOUR REQUEST WITH A NEW POC.
PB49	A CERTIFIED OCCUPATIONAL THERAPY ASSISTANTS NOTES MUST BE COSIGNED BY AN OCCUPATIONAL THERAPIST REGISTERED.
PB51	ADDITIONAL INFORMATION IS REQUIRED ON PRIOR AUTHORIZATION TO ENABLE PRICING.
PB54	REQUESTED SERVICES DO NOT MATCH SERVICES ON THE PHYSICIANS ORDERS.
PB59	PLEASE PROVIDE AN INDIVIDUAL EDUCATIONAL PLAN (IEP), WHICH HAS BEEN SIGNED BY THE PROVIDER NO EARLIER THAN NINE MONTHS PRIOR TO RECEIPT AT COLORADO MEDICAID; OTHERWISE, DOCUMENT WHY NO IEP EXISTS.
PB65	PLEASE FURNISH THE ANTICIPATED TOTAL CHARGES FOR THIS REQUEST.
PB66	A PHOTOCOPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED; THE DATE MUST BE WITHIN SIX MONTHS OF RECEIPT BY COLORADO MEDICAID.
PB67	THE PRESCRIPTION DATE MUST INCLUDE MONTH, DAY, AND YEAR.
PB68	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID.
PB73	THE SERVICES IDENTIFIED ON THE PLAN OF CARE DO NOT APPEAR APPROPRIATE FOR THE PROCEDURE CODE(S) REQUESTED ON THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018.
PB74	THE CLIENT/PROVIDER DOES NOT HAVE RETROACTIVE ENROLLMENT.
PB75	THE REQUESTED START DATE IS MORE THAN 14 DAYS BEFORE OR 62 DAYS AFTER RECEIPT.
PB82	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
PB83	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A HOME HEALTH AIDE. PLEASE RESUBMIT AS A PERSONAL CARE WORKER OR PROVIDE ADDITIONAL DOCUMENTATION.
PB86	THE SERVICES REQUESTED ARE NOT BEING PROVIDED IN THE CLIENTS RESIDENCE. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL.
PB87	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A NURSE. PLEASE RESUBMIT AS A HOME HEALTH AIDE OR PROVIDE ADDITIONAL DOCUMENTATION.
PB92	PLEASE FURNISH THE CLIENTS COMPLETE ADDRESS.
PB94	IF THE CLIENT IS A RESIDENT OF A NURSING HOME, SUPPLY THE COMPLETE NAME AND ADDRESS OF THE NURSING HOME.
PB99	THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018, MUST BE SIGNED AND DATED.
PC01	PLEASE SUPPLY THE RENDERING PROVIDERS PROVIDER NUMBER.
PC03	THE DRUG ENFORCEMENT ADMINISTRATION NUMBER IS MISSING OR INVALID.
PC06	PLEASE DESCRIBE YOUR PROGRAM; INCLUDE ENTRY DATE, TERMINATION DATE, HOURS PER WEEK, AND NUMBER OF WEEKS OF PRIMARY INTENSIVE SERVICE REQUESTED.
PC07	PLEASE DESCRIBE YOUR "AFTERCARE/FOLLOW-UP" PLANS FOR THIS CLIENT.
PC08	PLEASE SUPPLY DOCUMENTATION OF PREVIOUS SUBSTANCE ABUSE SERVICES WITH DATE(S) AND OUTCOME.
PC09	PLEASE DESCRIBE IN DETAIL THE TREATMENT OBJECTIVES/GOALS FOR THIS CLIENT.
PC10	PLEASE DESCRIBE THE FAMILY SITUATION/DYNAMICS. EXPLAIN HOW THE FAMILY WILL BE INCORPORATED INTO THE CLIENTS PLAN OF CARE.
PC12	PLEASE EXPLAIN IF YOUR SERVICE ENCOURAGES THE CLIENT TO ATTEND SELF-HELP GROUPS.

Denial Code	Long Description
PC13	PLEASE SUPPLY A SPECIFIC SCHEDULE OF ACTIVITIES, INCLUDING DAY, TIME OF DAY, LENGTH OF SESSION, AND SERVICE TO BE RENDERED DURING THAT TIME.
PC15	PLEASE FURNISH DIAGNOSTIC RATIONALE.
PC17	PLEASE DOCUMENT IF THE CLIENT EVER RECEIVED SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT.
PC19	PLEASE FURNISH MORE EXTENSIVE AND IN-DEPTH HISTORICAL AND PSYCHOSOCIAL DATA.
PC20	PLEASE SUPPLY THE DATE THE CLIENT BECAME TOTALLY ENDENTULOUS.
PC23	PLEASE SUBMIT A PHYSICIANS STATEMENT REGARDING THE MEDICAL NECESSITY OF DENTURES FOR THIS CLIENT. THE PHYSICIANS STATEMENT MUST DOCUMENT THE MEDICAL NEED FOR DENTURES.
PC24	THE SERVICE REQUESTED WAS PREVIOUSLY AUTHORIZED. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT INDICATING THIS FACT IS REQUIRED.
PC25	PLEASE SUPPLY SUFFICIENT MITIGATING CIRCUMSTANCES TO WARRANT THE CONSTRUCTION OF NEW DENTURES(S).
PC26	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
PC28	PLEASE SUBMIT A PHYSICIANS STATEMENT INDICATING DENTURES ARE NECESSARY FOR THIS NURSING HOME CLIENT.
PC29	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING LOSS OR DESTRUCTION OF DENTURE(S). INCLUDE SIGNED STATEMENT FROM CLIENT OR FACILITY DIRECTOR REGARDING HOW, WHEN AND WHERE LOST.
PC30	PLEASE PROVIDE COMPLETE INTRAORAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PC31	PLEASE DESCRIBE ANY RELATED DEFORMITIES OF THE FEET.
PC34	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD WITH REQUESTED DME ITEM(S) AND DOCUMENT IF THE CLIENT CAN USE SAFELY AND INDEPENDENTLY.
PC35	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD AND DESCRIBE THE RESULTS AND EFFECTIVENESS OF THE SERVICE REQUESTED.
PC39	PLEASE INDICATE LITER FLOW PER MINUTE, HOURS OF USE PER 24 HOUR PERIOD, AND THE EXPECTED DURATION OF NEED.
PC40	THE ITEM DOES NOT REQUIRE PRIOR AUTHORIZATION UNTIL THE LIFE EXPECTANCY HAS BEEN REACHED.
PC41	PLEASE SUPPLY INFORMATION INDICATING THE NECESSITY OF POSITIONING THE CLIENT'S BODY IN MULTIPLE POSITIONS.
PC42	PLEASE INDICATE IF THE BED HEIGHT MUST BE CHANGED TO ALLOW FOR SAFE TRANSFER OR ADEQUATE BED CARE.
PC43	SUPPLY A PHYSICIANS STATEMENT INDICATING TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR UNIT HAS REDUCED PAIN, IMPROVED/INCREASED THE CLIENTS ACTIVITY LEVEL, AND/OR REDUCED CLIENTS USE OF PAIN MEDICATION.
PC44	A CURRENT AUTHORIZATION FOR THIS SERVICE IS ON FILE FOR ANOTHER PROVIDER. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT OF THAT FACT IS REQUIRED BY THE CLIENT OF FIRST PROVIDER.
PC59	DOCUMENT DECLINE OR PROGRESS IN SPECIFIC, MEASURABLE, OBJECTIVE TERMS.
PC60	DOCUMENT IF CLIENT HAS DEMONSTRATED A GOOD APPOINTMENT COMPLIANCE RECORD.
PC61	THE PHYSICIANS SIGNATURE DATE MUST NOT EXCEED 90 DAYS FROM THE DATE OF RECEIPT BY COLORADO MEDICAID.
PC62	REQUESTS FOR A CONTINUATION OF THERAPY SHOULD NOT BE SUBMITTED MORE THAN FOUR WEEKS PRIOR TO THE EXPIRATION DATE OF THE CURRENT AUTHORIZATION.
PC63	PLEASE FURNISH THE STYLE AND MANUFACTURER OF THE FRAME.
PC64	PLEASE FURNISH THE CLIENTS LENS FORMULA.
PC66	ALL REQUESTS FOR TINTS REQUIRE DOCUMENTATION OF THE VISUAL OR MEDICAL CONDITION RELATED TO PHOTOPHOBIA.
PC67	PLEASE DOCUMENT THE REASON AND JUSTIFICATION FOR REPLACEMENT BEYOND THE FIRST LENS/FRAME.
PC68	DOCUMENT IF ALL REMAINING MAXILLARY AND/OR MANDIBULAR TEETH ARE DECAY-FREE, PROPERLY RESTORED, AND PERIODONTICALLY SOUND.
PC72	SUPPLY MORE DETAIL REGARDING PROGRESS (ATTACHMENT OF GOALS, ETC.). CORRELATE PROGRESS TO PREVIOUS GOALS AND IDENTIFIED LIMITATIONS.
PC77	PLEASE SUBMIT A PLAN OF CARE DESCRIBING THE SERVICES THAT WOULD BE PROVIDED.

Denial Code	Long Description
PC78	PLEASE DOCUMENT SPECIFIC, MEASURABLE GOALS.
PC82	THE PRIOR AUTHORIZATION (PA) SYSTEM CAN PROCESS ONLY 26 DETAILS PER PA REQUEST. PLEASE RESUBMIT YOUR REQUEST WITH NO MORE THAN 26 DETAILS.
PC83	PLEASE SUPPLY A PHYSICIANS PRESCRIPTION DATED WITHIN ONE MONTH OF REQUESTED SUBSTANCE ABUSE DAY TREATMENT.
PC84	PLEASE PROVIDE INFORMATION INDICATING THIS CLIENT IS APPROPRIATELY DETOXIFIED FROM ALCOHOL AND/OR OTHER DRUGS.
PC85	PLEASE PROVIDE INFORMATION TO INDICATE THE CLIENTS ABILITY TO ABSTAIN FROM ALCOHOL OR DRUGS WHILE IN THE SUBSTANCE ABUSE DAY TREATMENT PROGRAM.
PC86	PLEASE INDICATE IF THIS CLIENT IS WILLING TO PARTICIPATE IN AFTERCARE OR CONTINUING CARE SERVICES.
PC87	PROVIDE MORE INFORMATION ON TREATMENT HISTORY; INCLUDE SERVICE PROVIDED, DATES, AND OUTCOME. PROVIDE DETAIL OF PREVIOUS TREATMENT.
PC88	PLEASE PROVIDE MORE RATIONALE FOR THE APPROPRIATENESS AND MEDICAL NECESSITY OF SUBSTANCE ABUSE DAY TREATMENT.
PC89	PROVIDE A TREATMENT PLAN THAT CONTAINS MEASURABLE GOALS AND OBJECTIVES CORRESPONDING TO THE IDENTIFIED DEFICIT.
PC91	PLEASE PROVIDE MORE INFORMATION ON FAMILY INVOLVEMENT TREATMENT.
PC92	PLEASE PROVIDE MORE HISTORY AND EXPLANATION ABOUT THE ISSUE OF ABSTINENCE FOR THIS CLIENT.
PC94	PLEASE PROVIDE THE ANTICIPATED BEGINNING DATE AND/OR THE ESTIMATED SUBSTANCE ABUSE DAY TREATMENT DISCHARGE DATE.
PC95	PLEASE SUPPLY JUSTIFICATION FOR BEGINNING CLIENT IN SERVICE PRIOR TO AUTHORIZATION BEING OBTAINED.
PC96	THE INITIAL THREE HOURS OF SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IN A CALENDAR YEAR DO NOT REQUIRE PRIOR AUTHORIZATION.
PC97	REIMBURSEMENT FOR INITIAL SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IS LIMITED TO THREE HOURS IN A CALENDAR YEAR AND DOES NOT REQUIRE PRIOR AUTHORIZATION.
PC98	THIS DRUG IS CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE BILL USING THE APPROPRIATE NATIONAL DRUG CODE (NDC) OR SUBMIT A COMPLETED DRUG ADDITION REQUEST FORM IF THE NDC IS NOT LISTED IN THE DRUG INDEX.
PC99	THIS DRUG IS NOT CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL, CURRENT ADMINISTRATIVE RULE, OR COLORADO DRUG INDEX FOR COVERAGE LIMITATIONS.
PD01	DOCUMENT THAT CLIENT HAS ACHIEVED GOOD ORAL HYGIENE, PERIODONTAL CASE TYPE 1 OR 2, AND IS MOTIVATED TO MAINTAIN SAME.
PD03	PLEASE PROVIDE AN ARTERIAL BLOOD GAS READING OR PULSE OXIMETRY RESULTS DONE ON ROOM AIR SIGNED AND DATED BY A MEDICAL DOCTOR. THIS SHOULD BE DONE WITHIN 60 DAYS OF REQUESTED SERVICE.
PD04	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 30 DAYS OF RECEIPT BY COLORADO MEDICAID.
PD07	SUBMIT A PHOTOCOPY OF A VALID PRESCRIPTION, ISSUED WITHIN THE PAST YEAR, OR COMPLETE SECTION B OF THE PRIOR AUTHORIZATION/DRUG ATTACHMENT (PA/DGA), F-11049.
PD10	BRAND MEDICALLY NECESSARY MUST BE IN THE PRESCRIBERS OWN HANDWRITING AND WRITTEN DIRECTLY ON THE PRESCRIPTION OR A SEPARATE ORDER ATTACHED TO THE ORIGINAL PRESCRIPTION.
PD12	COMPLETE DENTURES, PARTIAL DENTURES, DENTURE RELINES, AND FIXED PROSTHODONTIC SERVICES ARE NOT COVERED SERVICES FOR ADULTS FOR DATES OF SERVICE ON AND AFTER OCTOBER 1, 1995.
PD22	PLEASE COMPLETE ALL REQUIRED ELEMENTS ON THE PERSONAL CARE SCREENING TOOL (PCST), F-11133.
PD24	THIS PRIOR AUTHORIZATION REQUEST IS UNABLE TO BE PROCESSED. PLEASE RESUBMIT WITH ADDITIONAL REQUIRED FORMS, INCLUDING THE ENTIRE PERSONAL CARE SCREENING TOOL (PCST), F-11133; PERSONAL CARE ADDENDUM, F-11136; AND SUPPORTING DOCUMENTATION, AS DIRECTED.
PD25	THERE IS A PERSONAL CARE SCREENING TOOL (PCST), F-11133, COMPLETED BY ANOTHER AGENCY. CONTACT THE AGENCY TO TRANSFER SCREEN.

Denial Code	Long Description
PD26	THERE IS A LIMITED TERM CARE FUNCTIONAL SCREEN (LTC-FS) COMPLETED BY ANOTHER AGENCY. THE PERSONAL CARE SCREENING TOOL (PCST), F-11133, INFORMATION IS IN CONFLICT WITH LTC-FS.
PD27	ONLY ONE LEVEL OF FUNCTION MAY BE SELECTED FOR ALL ELEMENTS EXCEPT TOILETING. COLORADO MEDICAID IS UNABLE TO PROCESS THE PRIOR AUTHORIZATION REQUEST.
PD28	NO UNITS MAY BE REQUESTED USING THIS PRIOR AUTHORIZATION PROCESS. PLEASE SUBMIT WITH THE APPROPRIATE ATTACHMENTS FOR REQUESTING SPECIFIC PERSONAL CARE WORKER UNITS.
PD29	CLIENT IS NOT ELIGIBLE FOR THE REQUESTED SERVICE(S) AS OF THE REQUESTED START DATE.
PD30	NO TRAVEL TIME MAY BE AUTHORIZED WHEN NO PERSONAL CARE WORKER SERVICE IS AUTHORIZED.
PD32	PROVIDER NOT CERTIFIED TO RENDER THE SERVICE(S) REQUESTED.
PD34	BASED ON THE DOCUMENTATION SUBMITTED, THIS REQUEST CAN NOT BE PRIOR AUTHORIZED. REFER TO THE PA MESSAGES FROM THE CONSULTANT FOR COMPLETE EXPLANATION.
PD98	PLEASE DOCUMENT HOW AND WHEN EACH PREVIOUSLY AUTHORIZED PRO RE NATA VISIT WAS USED.

Chiropractic

Denial Code	Long Description
0201	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
0233	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0235	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0237	CLIENT IDENTIFICATION NUMBER DOES NOT MATCH CLIENTS FIRST NAME.
0238	THE CLIENT IDENTIFICATION NUMBER DOES NOT MATCH THE CLIENTS LAST NAME.
0242	SECONDARY DIAGNOSIS CODE IS INVALID.
0248	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0249	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0251	PROCEDURE CODE MODIFIER IN FIRST POSITION IS INVALID.
0252	THE PROCEDURE CODE MODIFIER IN SECOND POSITION IS INVALID FOR REQUESTED START DATE OR DATE OF RECEIPT.
0253	THE PROCEDURE CODE MODIFIER IN THIRD POSITION IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
0258	THE PRIMARY DIAGNOSIS CODE IS REQUIRED.
0272	THE PRIMARY DIAGNSOSIS CODE IS INVALID.
0400	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0853	HCPCS - ANNUAL UPDATE
0885	NEVER EVENTS MODIFIERS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
0886	NEVER EVENTS DIAGNOSIS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
1000	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
1002	RENDERING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1003	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1007	RENDERING PROVIDER ID IS NOT ON FILE.
1047	THE RENDERING PROVIDERS CERTIFICATION HAS BEEN CANCELLED.
1048	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1801	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
1804	A CERTIFIED SUBSTANCE ABUSE DAY TREATMENT PROVIDER MUST SUBMIT A SUBSTANCE ABUSE DAY TREATMENT PROCEDURE CODE.
1806	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
1808	THE BILLING PROVIDER DOES NOT HAVE THE REQUIRED CERTIFICATION ADDENDUM ON FILE.
1900	THE BILLING PROVIDERS TAXONOMY CODE IS INVALID.
1901	THE RENDERING PROVIDERS TAXONOMY CODE IS INVALID.

Denial Code	Long Description
1927	A NATIONAL PROVIDER IDENTIFIER IS REQUIRED FOR THE BILLING PROVIDER.
1934	A NATIONAL PROVIDER INDENTIFIER IS REQUIRED FOR THE RENDERING PROVIDER.
1936	THE BILLING PROVIDER NUMBER IS INVALID.
1937	THE RENDERING PROVIDER NUMBER IS INVALID.
1960	INTERNAL PROCESSING IS REQUIRED.
1963	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.
1964	THE BILLING PROVIDER INDICATED IS NOT ALLOWABLE AS A BILLING PROVIDER.
1965	RENDERING PROVIDER NUMBER IS MISSING/INVALID FOR THIS PROCEDURE PROVIDER.
1974	PRESCRIBING/REFERRING/ORDERING PROVIDER INDICATED IS NOT CERTIFIED AS A PRESCRIBING/REFERRING/ORDERING PROVIDER.
1975	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
1976	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
2001	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2003	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2017	THE CLIENT IS ENROLLED IN A MEDICAID OR OTHER MANAGED CARE PROGRAM.
2037	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2603	CLIENT LOCKED-IN TO A PROVIDER OR ENROLLED IN A HOSPICE. CONTACT CLIENTS HOSPICE FOR PAYMENT OF SERVICES OR RESUBMIT WITH DOCUMENTATION OF UNRELATED NATURE OF CARE.
3324	THE MODIFIER HAS BEEN DISCONTINUED BY THE CENTERS OF MEDICARE AND MEDICAID SERVICES OR THE AMERICAN MEDICAL ASSOCIATION FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
3337	THE PROCEDURE CODE HAS BEEN TERMINATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AMERICAN MEDICAL ASSOCIATION, OR AMERICAN DENTAL ASSOCIATION FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT. RESUBMIT WITH VALID A PROCEDURE CODE.
3339	THE PROCEDURE BILLED IS NOT PAYABLE ACCORDING TO DEFICIT REDUCTION ACT (DEFRA) GUIDELINES.
3351	THE PROCEDURE IS NOT COVERED FOR CLIENTS WITH A NURSING HOME AUTHORIZATION ON THE REQUESTED START DATE OR DATE OF RECEIPT.
3353	THE PROCEDURE IS NOT A COVERED SERVICE FOR HOME AND COMMUNITY-BASED WAIVER CLIENTS.
4021	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4027	THE DIAGNOSIS CODE IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
4031	THE PROCEDURE SUBMITTED IS NOT APPROPRIATE FOR CLIENTS GENDER.
4032	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4034	THE PROCEDURE CODE HAS AN AGE RESTRICTION.
4036	THE PLACE OF SERVICE CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4040	THE PRIMARY DIAGNOSIS CODE IS NOT ON FILE.
4041	THE SECONDARY DIAGNOSIS IS NOT ON FILE.
4046	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4127	INTERNAL PROCESSING IS REQUIRED.
4131	INTERNAL PROCESSING IS REQUIRED.
4141	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4149	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4150	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4236	ETIOLOGY DIAGNOSIS CODE(S) (E-CODES) ARE INVALID AS THE PRIMARY DIAGNOSIS.
4244	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4245	THE FOURTH POSITION MODIFIER IS INVALID FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT.
4256	THE PROCEDURE CODE AND MODIFIER COMBINATION IS NOT PAYABLE FOR THE CLIENTS BENEFIT PLAN.
4257	THE MODIFIERS SUBMITTED ARE EITHER INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT OR THE MODIFIERS ARE MISSING.
4311	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4315	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4316	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4371	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4372	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.

Denial Code	Long Description
4711	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR CLIENTS AGE.
4714	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS AGE.
4731	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS DIAGNOSIS.
4742	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4743	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4744	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4745	DIAGNOSIS AND/OR PROCEDURE AND/OR PLACE OF SERVICE (POS) CODE IS NOT COVERED FOR EXPRESS ENROLLMENT CLIENTS.
4746	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4801	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4802	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
4821	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
4871	PLEASE REFER TO PA MESSAGES FOR RETURN INFORMATION.
4963	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS GENDER.
4990	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
7500	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
7509	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
P001	THE BILLING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THE SERVICES.
P002	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P003	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P005	THE PRIOR AUTHORIZATION CAN NOT BE END DATED. THE PRIOR AUTHORIZATION STATUS IS NOT APPROVED OR APPROVED WITH REVISIONS.
P006	PLEASE FURNISH THE PROCEDURE CODE AND CORRESPONDING DESCRIPTION.
P008	THE BILLING PROVIDER NUMBER IS INVALID.
P009	THE BILLING PROVIDER NUMBER IS INVALID.
P010	THE REQUESTED END DATE IS INVALID.
P011	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P012	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P013	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P014	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P015	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P016	THE REQUESTED START DATE IS MISSING OR INVALID.
P019	THE REQUESTED START DATE IS MISSING OR INVALID.
P020	THE RENDERING PROVIDER NUMBER IS INVALID.
P021	THE RENDERING PROVIDER NUMBER IS INVALID.
P022	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P023	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P024	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P026	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P027	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P030	FIRST MODIFIER IS INVALID.
P031	FIRST MODIFIER IS INVALID.
P032	SECOND MODIFIER IS INVALID.
P033	SECOND MODIFIER IS INVALID.
P034	THIRD MODIFIER IS INVALID.
P035	THIRD MODIFIER IS INVALID.

Denial Code	Long Description
P036	FOURTH MODIFIER IS INVALID.
P037	FOURTH MODIFIER IS INVALID.
P038	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P039	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P040	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P041	CLIENTS FIRST NAME IS MISSING.
P042	CLIENTS LAST NAME IS MISSING.
P043	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P044	BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES REQUESTED.
P045	FIRST MODIFIER IS INVALID.
P046	SECOND MODIFIER IS INVALID.
P047	THIRD MODIFIER IS INVALID.
P048	FOURTH MODIFIER IS INVALID.
P052	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P053	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P054	RENDERING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES FOR THE BENEFIT PLAN.
P055	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P061	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P062	THE CLIENT ID AND/OR NAME INDICATED ON THE PA REQUEST IS INCORRECT. THE CLIENT ID AND/OR NAME HAS BEEN UPDATED. PLEASE VERIFY THE ID AND/OR NAME IS CORRECT.
P064	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
P067	THE FREQUENCY OF HOURS REQUESTED ARE NOT APPROPRIATE FOR THIS CLIENT AND HAVE BEEN MODIFIED ACCORDINGLY.
P079	BILLING PROVIDER IS ON PAYMENT SUSPENSION DUE TO CREDIBLE ALLEGATION OF FRAUD.
P120	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAS BEEN REDUCED.
P121	THE SERVICE/ PROCEDURE REQUESTED IS NOT SUPPORTED BY SUBMITTED DOCUMENTATION.
P126	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
P128	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.
P138	SERVICE(S) DO NOT MEET COLORADO MEDICAID GUIDELINES.
P167	REQUESTED DOCUMENTATION HAS NOT BEEN SUBMITTED.
P178	THE SERVICE REQUESTED IS NOT MEDICALLY NECESSARY.
P179	THE MEDICAL NECESSITY FOR THIS SERVICE IS NOT SUPPORTED BY THE SUBMITTED DOCUMENTATION.
P233	THE DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE ADDITIONAL CARE.
P257	THIS CLIENTS FUNCTIONAL ASSESSMENT SCORES PLACE THIS CLIENT OUTSIDE ELIGIBILITY FOR DAY TREATMENT.
P274	OUR RECORDS INDICATE THIS CLIENT IS INVOLVED IN EFFECTIVE AND APPROPRIATE SERVICE ELSEWHERE.
P292	INTENSIVE REHABILITATION HOURS ARE NO LONGER APPROPRIATE AS INDICATED BY HISTORY, DIAGNOSIS, AND/ OR FUNCTIONAL ASSESSMENT SCORES.
P328	THE SERVICES REQUESTED INCLUDE NON-COVERED SERVICES, AND HOURS ARE REDUCED ACCORDINGLY.
P339	THE CLIENTS PAST HISTORY INDICATES REDUCED TREATMENT HOURS ARE WARRANTED.
P342	THE REQUEST DOES NOT MEET GENERALLY ACCEPTED CONDITIONS REQUIRING FLUORIDE TREATMENTS.
P346	SERVICES EXCEED COLORADO MEDICAID LIMITATION AND DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE MEDICAL NECESSITY OF THE SERVICE.
P349	THE SERVICE REQUESTED WAS PERFORMED LESS THAN FIVE YEARS AGO.
P353	THE EXISTING APPLIANCE HAS NOT BEEN WORN FOR THREE YEARS.
P367	THE CLIENT HAS BEEN TOTALLY WITHOUT TEETH AND AN APPLIANCE FOR FIVE YEARS.

Denial Code	Long Description
P392	THE CLIENT IS MISSING AN ANTERIOR TOOTH AND/OR HAS TWO OR MORE POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P405	THE SERVICE(S) REQUESTED COULD ADEQUATELY BE PERFORMED IN THE DENTAL OFFICE.
P406	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE OF GOOD PERIODONTAL HEALTH (AMERICAN ACADEMY OF PERIODONTOLOGY PERIODONTAL CLASSIFICATION OF TYPE I OR II).
P407	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE VISIBLE ON RADIOGRAPHS THAT AT LEAST 50 PERCENT OF THE CLINICAL CROWN IS INTACT.
P409	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING SIX OR MORE TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED, INCLUDING THIRD MOLARS.
P410	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING ONE OR MORE ANTERIOR TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED.
P411	DOCUMENTATION DOES NOT SUPPORT THE NEED FOR PERIODONTIC SERVICES. POCKETS ARE LESS THAN 4MM AND/OR GREATER THAN 6MM FOR CLIENT AND/OR THE CLIENT IS UNDER THE AGE OF 13.
P412	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA.
P413	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA. THIS PA HAS BEEN GRANTED AS APPROVED NOT APPROVED WITH REVISIONS. THE DURATION REQUESTED MAY HAVE BEEN REDUCED TO REFLECT COVERAGE LIMITATIONS, PRESCRIBER ORDERS, CONFLICTI
P417	THE SERVICE(S) REQUESTED COULD BE ADEQUATELY PERFORMED WITH LOCAL ANESTHESIA.
P437	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO POOR ORAL HYGIENE.
P444	THIS LINE ITEM IS A DUPLICATE OF ANOTHER LINE ITEM ON THIS PRIOR AUTHORIZATION (PA) REQUEST. PLEASE CORRECT.
P446	THIS IS A DUPLICATE OF AN EXISTING PRIOR AUTHORIZATION (PA) REQUEST. YOU MAY CONTACT PROVIDER SERVICES IF YOU REQUIRE ASSISTANCE. DUPLICATE PA REQUEST
P448	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO DECAY HISTORY.
P449	QUESTIONABLE LONG TERM PROGNOSIS DUE TO GUM AND BONE DISEASE.
P456	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO APPARENT ROOT INFECTION.
P457	OUR RECORDS INDICATE THIS CLIENT HAS EXCEEDED ESTABLISHED PROGRAM LIMITATIONS. COLORADO MEDICAID WILL NOT AUTHORIZE NEW DENTURES.
P458	DOCUMENTATION PROVIDED INDICATES A LESS ELABORATE PROCEDURE SHOULD BE CONSIDERED.
P502	RENTAL ONLY ALLOWED; MEDICAL NEED FOR PURCHASE HAS NOT BEEN DOCUMENTED.
P503	PURCHASE ONLY ALLOWED; MEDICAL NEED FOR RENTAL HAS NOT BEEN DOCUMENTED.
P504	OCCUPATIONAL THERAPY GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P505	THE SERVICE REQUESTED IS INCLUDED IN THE NURSING HOME RATE STRUCTURE.
P511	THIS NATIONAL DRUG CODE IS ONLY BILLABLE AS PART OF A COMPOUND DRUG.
P515	THE PRESENCE OF A HANDICAPPING MALOCCLUSION OR HANDICAPPING DENTOFACIAL DEFORMITY IS NOT SUPPORTED BY THE DOCUMENTATION SUBMITTED.
P521	THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVERED BY COLORADO MEDICAID.
P522	GASTRO-INTESTINAL SURGERY FOR THE PURPOSE OF WEIGHT CONTROL IS COVERED ONLY AS A LIFE THREATENING PROCEDURE.
P523	THE TREATMENT REQUEST IS NOT CONSISTENT WITH THE CLIENT'S DIAGNOSIS.
P524	PSYCHOTHERAPY PROVIDED IN THE CLIENTS HOME IS NOT A COVERED BENEFIT OF COLORADO MEDICAID.
P525	THE INFORMATION PROVIDED IS NOT CONSISTENT WITH THE INTENSITY OF SERVICES REQUESTED.
P526	INTENSIVE MULTIPLE MODALITY TREATMENT IS NOT CONSISTENT WITH THE INFORMATION PROVIDED.
P527	MULTIPLE PROVIDERS OF TREATMENT ARE NOT INDICATED FOR THIS CLIENT.
P528	THE DURATION OF TREATMENT SESSIONS EXCEED CURRENT COLORADO MEDICAID GUIDELINES.
P534	DOCUMENTATION OF POOR PHYSICAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P535	OTHER PHYSICAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P536	THE PHYSICAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P537	USE OF PHYSICAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.

Denial Code	Long Description
P538	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF A PHYSICAL THERAPIST.
P539	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS AND LIVING ARRANGEMENT.
P540	GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P541	THE PROCEDURE(S) REQUESTED ARE NOT MEDICAL IN NATURE.
P542	DOCUMENTATION OF POOR OCCUPATIONAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P543	DOCUMENTATION OF POOR SPEECH THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P544	OTHER OCCUPATIONAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P546	THE OCCUPATIONAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P547	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF PHYSICAL THERAPY.
P548	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P549	ACTIVITIES TO PROMOTE DIVERSION OR GENERAL MOTIVATION ARE NONCOVERED COLORADO MEDICAID SERVICES.
P550	REVISIONS OF THE REQUEST IS NECESSITATED BY THE CLIENTS MINIMAL PROGRESS.
P551	RESTORATIVE NURSING INVOLVEMENT COULD BE INCREASED.
P552	CLIENTS DEMONSTRATED RESPONSE TO CURRENT THERAPY DOES NOT WARRANT THE INTENSE FREQUENCY REQUESTED.
P553	MAINTENANCE IS TWO TIMES PER WEEK OR LESS.
P554	THE SPEECH THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P555	USE OF OCCUPATIONAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P556	USE OF SPEECH THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P557	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF AN OCCUPATIONAL THERAPIST.
P558	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
P559	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P560	THE MATERIALS/ SERVICES REQUESTED ARE PRINCIPALLY COSMETIC IN NATURE.
P561	THE LENS FORMULA DOES NOT JUSTIFY REPLACEMENT.
P562	THE CHANGE IN THE LENS FORMULA DOES NOT WARRANT MULTIPLE REPLACEMENTS.
P563	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P564	LENSES ONLY ARE APPROVED; PLEASE DISPENSE A CONTRACTED FRAME. THE NON-CONTRACTED FRAME IS NOT MEDICALLY JUSTIFIED.
P565	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P566	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P567	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF OCCUPATIONAL THERAPY.
P568	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF SPEECH THERAPY.
P569	LEVEL, INTENSITY, OR EXTENT OF SERVICE(S) REQUESTED HAS BEEN MODIFIED CONSISTENT WITH MEDICAL NEED AS DEFINED IN THE PLAN OF CARE.
P570	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P571	THE SERVICE ASKED FOR IS NOT COVERED BY COLORADO MEDICAID AS THESE TASKS CAN BE DONE BY NURSES OR ACTIVITY STAFF.
P572	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P573	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.

Denial Code	Long Description
P574	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P575	MEDICAL NEED FOR EQUIPMENT/ SUPPLY REQUESTED IS NOT SUPPORTED BY DOCUMENTATION SUBMITTED.
P576	OTHER SPEECH THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P577	DOCUMENTATION SUBMITTED IDENTIFIES THAT THE CLIENT HAS FEWER THAN TWO POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P582	LESS EXPENSIVE ALTERNATIVE SERVICES ARE AVAILABLE FOR THIS CLIENT.
P634	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P711	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING PERIODONTAL SCALING AND ROOT PLANNING.
P712	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING GINGIVECTOMY.
P754	AN APPROVED SUBSTANCE ABUSE DAY TREATMENT PROGRAM CANNOT EXCEED A SIX WEEK PERIOD.
P761	THE CLIENT DOES NOT APPEAR TO BE ABLE OR WILLING TO ABSTAIN FROM ALCOHOL/DRUG USAGE WHILE IN TREATMENT. THEREFORE, SUBSTANCE ABUSE DAY TREATMENT SERVICES ARE NOT APPROVED.
P764	THIS CLIENT HAS COMPLETED INTENSIVE SUBSTANCE ABUSE TREATMENT WITHIN THE PAST 12 MONTHS. THE DOCUMENTATION PROVIDED IS NOT ADEQUATE TO JUSTIFY ADDITIONAL INTENSIVE TREATMENT AT THIS TIME.
P785	A LESS THAN SIX-WEEK HEALING PERIOD HAS BEEN SPECIFIED FOR THIS PRIOR AUTHORIZATION. THEREFORE IT IS NOT NECESSARY TO WAIT THE FULL SIX WEEKS AFTER EXTRACTIONS BEFORE TAKING DENTURE IMPRESSIONS.
P818	SIX-WEEK HEALING TIME IS REQUIRED BETWEEN EDENTULATION AND FINAL IMPRESSIONS. PAYMENT FOR DENTURES WILL BE DENIED OR RECOUPED IF HEALING PERIOD IS NOT OBSERVED.
P849	COLORADO MEDICAID HAS DETERMINED THERE WERE (ARE) SEVERAL HOME HEALTH AGENCIES WILLING TO PROVIDE MEDICALLY NECESSARY SKILLED NURSING SERVICES TO THIS CLIENT.
P864	THE DOCUMENTATION YOU HAVE SUBMITTED DOES NOT MEET THE REQUIREMENTS OF COLORADO MEDICAID.
P873	THE MEDICAL NECESSITY FOR THE HOURS REQUESTED IS NOT SUPPORTED BY THE INFORMATION SUBMITTED.
P874	THE DOCUMENTATION SUBMITTED INDICATES THE TASKS SPECIFIED CAN BE COMPLETED DURING THE VISITS APPROVED.
P878	THE DOCUMENTATION SUBMITTED DOES NOT INDICATE THAT MEDICALLY ORIENTED TASKS ARE MEDICALLY NECESSARY; THEREFORE PERSONAL CARE SERVICES HAVE BEEN APPROVED.
P880	THE QUANTITY OF SERVICES AUTHORIZED FOR THIS CLIENTS PERSONAL CARE HAS BEEN AMENDED BASED ON INFORMATION RECEIVED FROM ONE OR MORE OF THESE SOURCES: THE CLIENT, THEIR PHYSICIAN, AND/OR THE IN-HOME VISIT BY STAFF OF THE OIG (OFFICE OF INSPECTOR GENERAL).
P885	THE USE OF THIS DRUG FOR THE INTENDED PURPOSE IS NOT COVERED BY COLORADO MEDICAID, CONSISTENT WITH COLORADO ADMINISTRATIVE CODE AND FEDERAL LAW.
P924	THE MEDICAL RECORDS SUBMITTED WITH THE CURRENT REQUEST CONFLICT OR DISAGREE WITH OUR MEDICAL RECORDS ON THIS CLIENT.
P950	INDEPENDENT NURSES, PLEASE NOTE PAYABLE SERVICES MAY NOT EXCEED 12 HOURS/DAY OR 60 HOURS/WEEK.
P951	SERVICES CAN ONLY BE AUTHORIZED THROUGH ONE YEAR FROM THE PRESCRIPTION DATE.
P952	LEAD INSPECTION IS A COVERED COLORADO MEDICAID SERVICE WHEN THE CHILD HAS BEEN SHOWN TO HAVE LEAD POISONING (E.G., CHILD HAS A BLOOD LEAD LEVEL > 19 UG/DL OR TWO CONSECUTIVE BLOOD LEAD LEVELS OF 15-19 UG/DL DONE AT LEAST 90 DAYS APART). THE INSPECTION MUS
P953	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P954	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P956	THE REQUEST CAN ONLY BE BACKDATED A MAXIMUM OF 14 DAYS FROM FIRST DATE RECEIVED BY COLORADO MEDICAID.

Denial Code	Long Description
P957	COMPLETE PERIODONTAL CHARTING AT TIME OF SERVICE, AND SUBMIT CHARTING, COPY OF OPERATIVE REPORT, TOGETHER WITH A COPY OF THE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF), F-11035, TO PA UNIT ATTENTION DENTAL CONTSULTANT.
P958	NOTE THAT CODE D4341 HAS BEEN CHANGED. REFER TO THE DECISION NOTICE FOR AUTHORIZED QUANTITY.
P960	YOUR PA HAS BEEN APPROVED FOR 90 DAYS. THE 90 DAY APPROVAL DOES NOT IMPLY THE PA REQUEST MEETS PRIOR AUTHORIZATION CRITERIA. AFTER ADDITIONAL INFORMATION IS AVAILABLE IN INTERCHANGE, COLORADO MEDICAID WILL CREATE AN AMENDMENT REQUEST TO EXTEND THE PA FOR
P961	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P962	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
PA10	THE REQUESTED END DATE IS INVALID.
PA12	PLEASE FURNISH A WRITTEN DESCRIPTION OF THE CLIENTS DIAGNOSIS.
PA13	PROVIDE DIAGNOSES WITH DATES OF ONSET.
PA14	IDENTIFY PROBLEMS TO BE TREATED.
PA15	THE AUDIOLOGISTS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1), F-11020, AND PRIOR AUTHORIZATION REQUEST/HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2), F-11021.
PA16	THE PHYSICIANS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION/PHYSICIAN OTOLOGICAL REPORT (PA/POR), F-11019.
PA17	SUBMIT BRIEF HISTORY WITH REFERRAL INFORMATION, LIVING SITUATION, FUNCTIONAL STATUS, AND OTHER PERTINENT INFORMATION. WHAT CHANGE OF STATUS RESULTED IN REFERRAL AT THIS TIME?
PA18	PLEASE FURNISH THE CLIENTS HEIGHT AND WEIGHT.
PA19	PLEASE SUBMIT CLINICAL INFORMATION SUFFICIENT TO VERIFY THE NEED FOR THE REQUESTED SERVICE(S).
PA20	PLEASE RESUBMIT WITH COMPLETE PERIODONTAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PA21	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL EDUCATIONAL PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA22	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL PROGRAM PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA23	REFER TO THE DURABLE MEDICAL EQUIPMENT INDEX FOR APPROPRIATE CODE AND DESCRIPTION. DO NOT USE AN "UNLISTED" CODE.
PA24	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUALIZED FAMILY SERVICE PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA25	INFORMATION ON THE REQUEST FORM IS ILLEGIBLE, AND THE REQUEST CANNOT BE PROCESSED.
PA26	RE-EVALUATE YOUR GOALS. EMPHASIS SHOULD BE ON FUNCTIONAL SELF-CARE. GOALS MUST BE RELATED TO FUNCTIONAL OUTCOME.
PA27	PLEASE CLARIFY THE NUMBER OF HOURS PER WEEK REQUESTED.
PA28	PLEASE CLARIFY THE NUMBER OF HOURS PER DAY REQUESTED.
PA29	PLEASE CLARIFY THE NUMBER OF VISITS PER DAY REQUESTED.
PA30	ATTACH SUPPORTIVE DOCUMENTATION; HOME EXERCISE PROGRAM AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA31	THE DIAGNOSIS CODE INDICATED ON THE REQUEST DOES NOT CORRESPOND TO THE DIAGNOSIS CODE DESCRIPTION.
PA32	PLEASE SUBMIT ADDITIONAL INFORMATION SUFFICIENT TO VERIFY APPROPRIATENESS AND NEED FOR TRANSPLANT.
PA33	PLEASE SUBMIT THE INITIAL AND PROGRESSIVE OBJECTIVE FINDINGS.
PA34	ATTACH SUPPORTIVE DOCUMENTATION, FACILITY PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA35	PLEASE SUBMIT THE CLIENTS ORIGINAL COMPLAINTS AND EXAMINATION FINDINGS.

Denial Code	Long Description
PA36	ATTACH SUPPORTIVE DOCUMENTATION, IN-HOME AUTISM PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA37	PLEASE SUBMIT YOUR TREATMENT PLAN FOR THIS CLIENT.
PA38	ATTACH SUPPORTIVE DOCUMENTATION AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA39	INITIAL EVALUATIONS MUST BE PERFORMED BY AN OCCUPATIONAL THERAPIST REGISTERED (OTR), PER AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA) STANDARDS.
PA41	IDENTIFY THE PLACE OF SERVICE AND ITS EFFECT ON SUPPORTING THE DESIRED TREATMENT OUTCOME.
PA42	PLEASE INDICATE THE HOURS OF USE OF OXYGEN PER 24-HOUR PERIOD.
PA43	PROVIDE BASELINE DOCUMENTATION FOR THIS CLIENTS LIMITATIONS USING UNITS OF MEASUREMENT THAT ARE APPLIED CONSISTENTLY WHEN REPORTING STATUS.
PA44	IDENTIFY FUNCTIONAL LIMITATIONS AS THEY ARE RELATED TO IDENTIFIED CONDITIONS.
PA46	CORRELATE PLAN OF CARE TO REQUESTED PROCEDURE CODES.
PA47	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE FREQUENCY/DURATION REQUESTED.
PA48	PLEASE PROVIDE THE NAME AND CREDENTIALS OF THE RENDERING PROVIDER.
PA50	COLORADO MEDICAID RECORDS INDICATE THE CLIENT OWNS A WHEELCHAIR. DOCUMENT THE REASON AND NEED FOR REPLACEMENT AND COST TO REPAIR CURRENT WHEELCHAIR.
PA51	PLEASE DISTINGUISH PRIMARY AND SUPPORTIVE MODALITIES.
PA52	PLEASE SUBMIT A PROGRESS REPORT.
PA53	MULTIPLE FAMILY CLIENTS TREATMENT BY THE SAME PROVIDER REQUIRES FURTHER INFORMATION DOCUMENTING COORDINATION OF TREATMENT PLAN.
PA54	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE MINUTES REQUESTED.
PA55	MEDICAL NECESSITY OF TREATMENT REQUIRES ADDITIONAL DOCUMENTATION.
PA56	GIVEN AGE, DIAGNOSES, CURRENT LEVEL OF FUNCTION, PAST RESPONSE TO TREATMENT, AND LIVING SITUATION, EXPAND ON POTENTIAL FOR SIGNIFICANT FUNCTIONAL PROGRESS WITHIN THE NEXT SIX MONTHS. EMPHASIZE WHY PROGRESS IS EXPECTED WITH SERVICES AT THIS TIME.
PA57	SUBMIT THE INITIAL FINDINGS. INCLUDE A COMPREHENSIVE EVALUATION.
PA58	SUBMIT PROGRESSIVE, OBJECTIVE FINDINGS. INCLUDE A PERTINENT RE-EVALUATION.
PA59	PLEASE SUPPLY INFORMATION REGARDING THE CLIENTS MEDICATION REQUIREMENTS, IF ANY.
PA60	PLEASE SPECIFY IF THE CLIENT IS IN AN EDUCATIONAL SETTING.
PA61	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA62	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
PA63	THE SKILLS OF A THERAPIST ARE PURPOSEFUL AND SKILLED INTERVENTIONS REQUIRED TO CONTINUALLY DESIGN, IMPLEMENT, REASSESS, MODIFY/GRADE, AND/OR DISCONTINUE A PLAN OF CARE IN A TIMELY MANNER, BASED ON THE COMPLEXITY OF THE CLIENTS MEDICAL CONDITION AND/OR CO
PA64	PLEASE SUBMIT A THERAPY PLAN OF CARE, INCLUDING A CURRENT, DATED EVALUATION.
PA65	A PLAN OF CARE SIGNED AND DATED BY THE PHYSICIAN IS REQUIRED.
PA66	THE SKILLS OF A THERAPIST ARE REQUIRED WHEN ONLY THE THERAPIST CAN SAFELY AND EFFECTIVELY DELIVER THE THERAPEUTIC PROCEDURES BECAUSE OF THEIR UNIQUE KNOWLEDGE, TRAINING, AND EXPERTISE. DESCRIBE THE REASON THAT SOMEONE OTHER THAN A THERAPIST CANNOT SAFELY
PA67	PLEASE SPECIFY IF THE CLIENTS WORK SITE DEMANDS GOOD BINAURAL HEARING.
PA68	DESCRIBE THE REASON, BASED ON THE CLIENTS COGNITIVE, PHYSICAL, COMMUNICATION, OR RESOURCE STATUS, THAT A HOME PROGRAM, EQUIPMENT, OR ENVIRONMENTAL ADAPTATIONS ALONE CANNOT MEET CLIENTS NEEDS.
PA69	PLEASE SPECIFY IF THE CLIENT HAS AN ACCOMPANYING DISABILITY THAT ADDS TO THE HEARING PROBLEM.
PA70	DISTINGUISH REQUESTED PROCEDURES AND GOALS FROM OTHER SERVICES THIS CLIENT RECEIVES. THEY MAY NOT BE DUPLICATIVE.
PA71	PLEASE INDICATE THE NUMBER OF DAYS REQUESTED.
PA73	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).

Denial Code	Long Description
PA74	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA75	PLEASE DOCUMENT CARRYOVER OF THE THERAPY PROGRAM TO NURSING.
PA76	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA79	PROVIDE EVIDENCE OF SIGNIFICANT FUNCTIONAL PROGRESS IN LAST SIX MONTHS.
PA84	THE GRANT DATE OF THIS REQUEST CANNOT BE PRIOR TO THE SIGNATURE DATE OF THE PRESCRIBING PHYSICIAN.
PA86	PROVIDE EVIDENCE OF SKILLS GAINED IN THERAPY CARRYING OVER TO OTHER SETTINGS WITHIN SIX MONTHS.
PA87	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE NUMBER OF SESSIONS REQUESTED.
PA88	THE REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL SCOPE OF PRACTICE.
PA89	PRIOR AUTHORIZATION IS NOT REQUIRED UNTIL LIMITATION OF SERVICE HAS BEEN REACHED.
PA91	PLEASE SUBMIT REQUIRED X-RAYS.
PA92	PLEASE PROVIDE AN EXPLANATION FOR THE MATERIAL SUBMITTED WITH THE REQUEST.
PA95	PLEASE DESCRIBE HOW THE PROVISION OF THIS SERVICE WOULD PREVENT INSTITUTIONALIZATION OF THE CLIENT.
PA96	COULD THE EXISTING DENTURE(S) BE RELINED OR REBASED? IF NOT, PLEASE EXPLAIN WHY NOT.
PA97	REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL STANDARDS OF PRACTICE.
PA98	PLEASE INDICATE IF THE CLIENT IS CURRENTLY BEING TUBE FED.
PB02	PLEASE PROVIDE THE REQUIRED DATED SIGNATURES ON THE ATTACHMENTS.
PB03	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING THE LOSS/DESTRUCTION/THEFT OF THE HEARING AID.
PB04	DESCRIBE THE CLIENTS ABILITY TO STAND OR AMBULATE SUFFICIENTLY TO ACCOMPLISH SELF-CARE ACTIVITIES.
PB07	PLEASE SUBMIT AN ORTHODONTIC STUDY MODEL OR DIAGNOSTIC CASTS.
PB09	PLEASE PROVIDE A PHOTOGRAPH OF THE INVOLVED AREA(S).
PB10	PLEASE PROVIDE AN ESTIMATION (IN GRAMS) OF THE TOTAL AMOUNT OF TISSUE TO BE RESECTED.
PB11	PLEASE SUBMIT THE PLAN OF CARE FOR CO-TREATMENT.
PB12	FURNISH A DETAILED DESCRIPTION FOR THE PROCEDURE CODE REQUESTED.
PB13	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB15	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB18	PLEASE COMPLETE THE ATTACHED OUT-OF-STATE PROVIDER DATA SHEET, F-11001, AND RESUBMIT.
PB20	A SIGNED AND DATED PRESCRIPTION IS REQUIRED WITHIN THREE MONTHS OF RECEIPT BY COLORADO MEDICAID FOR INITIAL REQUESTS AND WITHIN 12 MONTHS OF RECEIPT BY COLORADO MEDICAID FOR SUBSEQUENT REQUESTS.
PB21	PLEASE COMPLETE THE APPROPRIATE PRIOR AUTHORIZATION ATTACHMENT. CONTACT PROVIDER SERVICES OR THE PRIOR AUTHORIZATION UNIT FOR ASSISTANCE.
PB23	PHYSICAL THERAPY ASSISTANT NOTES AND ALL FORMS SUBMITTED MUST BE COSIGNED BY A REGISTERED PHYSICAL THERAPIST.
PB31	ARE YOU REQUESTING A COMPLETE APPLIANCE, OR REPLACEMENT PARTS?
PB32	THE PROCEDURE CODE INDICATED ON THE REQUEST DOES NOT MATCH THE DESCRIPTION OF SERVICE; PLEASE CORRECT AND RESUBMIT.
PB35	THE SERVICE REQUESTED DOES NOT REQUIRE PRIOR AUTHORIZATION.
PB41	PLEASE FURNISH A CURRENT MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT, F-11090 (DATED WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID).
PB45	THE CERTIFICATION PERIOD ON THE PLAN OF CARE (POC) DOES NOT COVER THE REQUESTED GRANT/START DATE. PLEASE RESUBMIT YOUR REQUEST WITH A NEW POC.
PB49	A CERTIFIED OCCUPATIONAL THERAPY ASSISTANTS NOTES MUST BE COSIGNED BY AN OCCUPATIONAL THERAPIST REGISTERED.
PB51	ADDITIONAL INFORMATION IS REQUIRED ON PRIOR AUTHORIZATION TO ENABLE PRICING.
PB54	REQUESTED SERVICES DO NOT MATCH SERVICES ON THE PHYSICIANS ORDERS.

Denial Code	Long Description
PB59	PLEASE PROVIDE AN INDIVIDUAL EDUCATIONAL PLAN (IEP), WHICH HAS BEEN SIGNED BY THE PROVIDER NO EARLIER THAN NINE MONTHS PRIOR TO RECEIPT AT COLORADO MEDICAID; OTHERWISE, DOCUMENT WHY NO IEP EXISTS.
PB65	PLEASE FURNISH THE ANTICIPATED TOTAL CHARGES FOR THIS REQUEST.
PB66	A PHOTOCOPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED; THE DATE MUST BE WITHIN SIX MONTHS OF RECEIPT BY COLORADO MEDICAID.
PB67	THE PRESCRIPTION DATE MUST INCLUDE MONTH, DAY, AND YEAR.
PB68	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID.
PB73	THE SERVICES IDENTIFIED ON THE PLAN OF CARE DO NOT APPEAR APPROPRIATE FOR THE PROCEDURE CODE(S) REQUESTED ON THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018.
PB74	THE CLIENT/PROVIDER DOES NOT HAVE RETROACTIVE ENROLLMENT.
PB75	THE REQUESTED START DATE IS MORE THAN 14 DAYS BEFORE OR 62 DAYS AFTER RECEIPT.
PB82	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
PB83	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A HOME HEALTH AIDE. PLEASE RESUBMIT AS A PERSONAL CARE WORKER OR PROVIDE ADDITIONAL DOCUMENTATION.
PB86	THE SERVICES REQUESTED ARE NOT BEING PROVIDED IN THE CLIENTS RESIDENCE. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL.
PB87	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A NURSE. PLEASE RESUBMIT AS A HOME HEALTH AIDE OR PROVIDE ADDITIONAL DOCUMENTATION.
PB92	PLEASE FURNISH THE CLIENTS COMPLETE ADDRESS.
PB94	IF THE CLIENT IS A RESIDENT OF A NURSING HOME, SUPPLY THE COMPLETE NAME AND ADDRESS OF THE NURSING HOME.
PB99	THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018, MUST BE SIGNED AND DATED.
PC01	PLEASE SUPPLY THE RENDERING PROVIDERS PROVIDER NUMBER.
PC03	THE DRUG ENFORCEMENT ADMINISTRATION NUMBER IS MISSING OR INVALID.
PC06	PLEASE DESCRIBE YOUR PROGRAM; INCLUDE ENTRY DATE, TERMINATION DATE, HOURS PER WEEK, AND NUMBER OF WEEKS OF PRIMARY INTENSIVE SERVICE REQUESTED.
PC07	PLEASE DESCRIBE YOUR "AFTERCARE/FOLLOW-UP" PLANS FOR THIS CLIENT.
PC08	PLEASE SUPPLY DOCUMENTATION OF PREVIOUS SUBSTANCE ABUSE SERVICES WITH DATE(S) AND OUTCOME.
PC09	PLEASE DESCRIBE IN DETAIL THE TREATMENT OBJECTIVES/GOALS FOR THIS CLIENT.
PC10	PLEASE DESCRIBE THE FAMILY SITUATION/DYNAMICS. EXPLAIN HOW THE FAMILY WILL BE INCORPORATED INTO THE CLIENTS PLAN OF CARE.
PC12	PLEASE EXPLAIN IF YOUR SERVICE ENCOURAGES THE CLIENT TO ATTEND SELF-HELP GROUPS.
PC13	PLEASE SUPPLY A SPECIFIC SCHEDULE OF ACTIVITIES, INCLUDING DAY, TIME OF DAY, LENGTH OF SESSION, AND SERVICE TO BE RENDERED DURING THAT TIME.
PC15	PLEASE FURNISH DIAGNOSTIC RATIONALE.
PC17	PLEASE DOCUMENT IF THE CLIENT EVER RECEIVED SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT.
PC19	PLEASE FURNISH MORE EXTENSIVE AND IN-DEPTH HISTORICAL AND PSYCHOSOCIAL DATA.
PC20	PLEASE SUPPLY THE DATE THE CLIENT BECAME TOTALLY ENDENTULOUS.
PC23	PLEASE SUBMIT A PHYSICIANS STATEMENT REGARDING THE MEDICAL NECESSITY OF DENTURES FOR THIS CLIENT. THE PHYSICIANS STATEMENT MUST DOCUMENT THE MEDICAL NEED FOR DENTURES.
PC24	THE SERVICE REQUESTED WAS PREVIOUSLY AUTHORIZED. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT INDICATING THIS FACT IS REQUIRED.
PC25	PLEASE SUPPLY SUFFICIENT MITIGATING CIRCUMSTANCES TO WARRANT THE CONSTRUCTION OF NEW DENTURES(S).
PC26	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
PC28	PLEASE SUBMIT A PHYSICIANS STATEMENT INDICATING DENTURES ARE NECESSARY FOR THIS NURSING HOME CLIENT.
PC29	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING LOSS OR DESTRUCTION OF DENTURE(S). INCLUDE SIGNED STATEMENT FROM CLIENT OR FACILITY DIRECTOR REGARDING HOW, WHEN AND WHERE LOST.

Denial Code	Long Description
PC30	PLEASE PROVIDE COMPLETE INTRAORAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PC31	PLEASE DESCRIBE ANY RELATED DEFORMITIES OF THE FEET.
PC34	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD WITH REQUESTED DME ITEM(S) AND DOCUMENT IF THE CLIENT CAN USE SAFELY AND INDEPENDENTLY.
PC35	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD AND DESCRIBE THE RESULTS AND EFFECTIVENESS OF THE SERVICE REQUESTED.
PC39	PLEASE INDICATE LITER FLOW PER MINUTE, HOURS OF USE PER 24 HOUR PERIOD, AND THE EXPECTED DURATION OF NEED.
PC40	THE ITEM DOES NOT REQUIRE PRIOR AUTHORIZATION UNTIL THE LIFE EXPECTANCY HAS BEEN REACHED.
PC41	PLEASE SUPPLY INFORMATION INDICATING THE NECESSITY OF POSITIONING THE CLIENT'S BODY IN MULTIPLE POSITIONS.
PC42	PLEASE INDICATE IF THE BED HEIGHT MUST BE CHANGED TO ALLOW FOR SAFE TRANSFER OR ADEQUATE BED CARE.
PC43	SUPPLY A PHYSICIANS STATEMENT INDICATING TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR UNIT HAS REDUCED PAIN, IMPROVED/INCREASED THE CLIENTS ACTIVITY LEVEL, AND/OR REDUCED CLIENTS USE OF PAIN MEDICATION.
PC44	A CURRENT AUTHORIZATION FOR THIS SERVICE IS ON FILE FOR ANOTHER PROVIDER. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT OF THAT FACT IS REQUIRED BY THE CLIENT OF FIRST PROVIDER.
PC59	DOCUMENT DECLINE OR PROGRESS IN SPECIFIC, MEASURABLE, OBJECTIVE TERMS.
PC60	DOCUMENT IF CLIENT HAS DEMONSTRATED A GOOD APPOINTMENT COMPLIANCE RECORD.
PC61	THE PHYSICIANS SIGNATURE DATE MUST NOT EXCEED 90 DAYS FROM THE DATE OF RECEIPT BY COLORADO MEDICAID.
PC62	REQUESTS FOR A CONTINUATION OF THERAPY SHOULD NOT BE SUBMITTED MORE THAN FOUR WEEKS PRIOR TO THE EXPIRATION DATE OF THE CURRENT AUTHORIZATION.
PC63	PLEASE FURNISH THE STYLE AND MANUFACTURER OF THE FRAME.
PC64	PLEASE FURNISH THE CLIENTS LENS FORMULA.
PC66	ALL REQUESTS FOR TINTS REQUIRE DOCUMENTATION OF THE VISUAL OR MEDICAL CONDITION RELATED TO PHOTOPHOBIA.
PC67	PLEASE DOCUMENT THE REASON AND JUSTIFICATION FOR REPLACEMENT BEYOND THE FIRST LENS/FRAME.
PC68	DOCUMENT IF ALL REMAINING MAXILLARY AND/OR MANDIBULAR TEETH ARE DECAY-FREE, PROPERLY RESTORED, AND PERIODONTICALLY SOUND.
PC72	SUPPLY MORE DETAIL REGARDING PROGRESS (ATTACHMENT OF GOALS, ETC.). CORRELATE PROGRESS TO PREVIOUS GOALS AND IDENTIFIED LIMITATIONS.
PC77	PLEASE SUBMIT A PLAN OF CARE DESCRIBING THE SERVICES THAT WOULD BE PROVIDED.
PC78	PLEASE DOCUMENT SPECIFIC, MEASURABLE GOALS.
PC82	THE PRIOR AUTHORIZATION (PA) SYSTEM CAN PROCESS ONLY 26 DETAILS PER PA REQUEST. PLEASE RESUBMIT YOUR REQUEST WITH NO MORE THAN 26 DETAILS.
PC83	PLEASE SUPPLY A PHYSICIANS PRESCRIPTION DATED WITHIN ONE MONTH OF REQUESTED SUBSTANCE ABUSE DAY TREATMENT.
PC84	PLEASE PROVIDE INFORMATION INDICATING THIS CLIENT IS APPROPRIATELY DETOXIFIED FROM ALCOHOL AND/OR OTHER DRUGS.
PC85	PLEASE PROVIDE INFORMATION TO INDICATE THE CLIENTS ABILITY TO ABSTAIN FROM ALCOHOL OR DRUGS WHILE IN THE SUBSTANCE ABUSE DAY TREATMENT PROGRAM.
PC86	PLEASE INDICATE IF THIS CLIENT IS WILLING TO PARTICIPATE IN AFTERCARE OR CONTINUING CARE SERVICES.
PC87	PROVIDE MORE INFORMATION ON TREATMENT HISTORY; INCLUDE SERVICE PROVIDED, DATES, AND OUTCOME. PROVIDE DETAIL OF PREVIOUS TREATMENT.
PC88	PLEASE PROVIDE MORE RATIONALE FOR THE APPROPRIATENESS AND MEDICAL NECESSITY OF SUBSTANCE ABUSE DAY TREATMENT.
PC89	PROVIDE A TREATMENT PLAN THAT CONTAINS MEASURABLE GOALS AND OBJECTIVES CORRESPONDING TO THE IDENTIFIED DEFICIT.
PC91	PLEASE PROVIDE MORE INFORMATION ON FAMILY INVOLVEMENT TREATMENT.

Denial Code	Long Description
PC92	PLEASE PROVIDE MORE HISTORY AND EXPLANATION ABOUT THE ISSUE OF ABSTINENCE FOR THIS CLIENT.
PC94	PLEASE PROVIDE THE ANTICIPATED BEGINNING DATE AND/OR THE ESTIMATED SUBSTANCE ABUSE DAY TREATMENT DISCHARGE DATE.
PC95	PLEASE SUPPLY JUSTIFICATION FOR BEGINNING CLIENT IN SERVICE PRIOR TO AUTHORIZATION BEING OBTAINED.
PC96	THE INITIAL THREE HOURS OF SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IN A CALENDAR YEAR DO NOT REQUIRE PRIOR AUTHORIZATION.
PC97	REIMBURSEMENT FOR INITIAL SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IS LIMITED TO THREE HOURS IN A CALENDAR YEAR AND DOES NOT REQUIRE PRIOR AUTHORIZATION.
PC98	THIS DRUG IS CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE BILL USING THE APPROPRIATE NATIONAL DRUG CODE (NDC) OR SUBMIT A COMPLETED DRUG ADDITION REQUEST FORM IF THE NDC IS NOT LISTED IN THE DRUG INDEX.
PC99	THIS DRUG IS NOT CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL, CURRENT ADMINISTRATIVE RULE, OR COLORADO DRUG INDEX FOR COVERAGE LIMITATIONS.
PD01	DOCUMENT THAT CLIENT HAS ACHIEVED GOOD ORAL HYGIENE, PERIODONTAL CASE TYPE 1 OR 2, AND IS MOTIVATED TO MAINTAIN SAME.
PD03	PLEASE PROVIDE AN ARTERIAL BLOOD GAS READING OR PULSE OXIMETRY RESULTS DONE ON ROOM AIR SIGNED AND DATED BY A MEDICAL DOCTOR. THIS SHOULD BE DONE WITHIN 60 DAYS OF REQUESTED SERVICE.
PD04	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 30 DAYS OF RECEIPT BY COLORADO MEDICAID.
PD07	SUBMIT A PHOTOCOPY OF A VALID PRESCRIPTION, ISSUED WITHIN THE PAST YEAR, OR COMPLETE SECTION B OF THE PRIOR AUTHORIZATION/DRUG ATTACHMENT (PA/DGA), F-11049.
PD10	BRAND MEDICALLY NECESSARY MUST BE IN THE PRESCRIBERS OWN HANDWRITING AND WRITTEN DIRECTLY ON THE PRESCRIPTION OR A SEPARATE ORDER ATTACHED TO THE ORIGINAL PRESCRIPTION.
PD12	COMPLETE DENTURES, PARTIAL DENTURES, DENTURE RELINES, AND FIXED PROSTHODONTIC SERVICES ARE NOT COVERED SERVICES FOR ADULTS FOR DATES OF SERVICE ON AND AFTER OCTOBER 1, 1995.
PD22	PLEASE COMPLETE ALL REQUIRED ELEMENTS ON THE PERSONAL CARE SCREENING TOOL (PCST), F-11133.
PD24	THIS PRIOR AUTHORIZATION REQUEST IS UNABLE TO BE PROCESSED. PLEASE RESUBMIT WITH ADDITIONAL REQUIRED FORMS, INCLUDING THE ENTIRE PERSONAL CARE SCREENING TOOL (PCST), F-11133; PERSONAL CARE ADDENDUM, F-11136; AND SUPPORTING DOCUMENTATION, AS DIRECTED.
PD25	THERE IS A PERSONAL CARE SCREENING TOOL (PCST), F-11133, COMPLETED BY ANOTHER AGENCY. CONTACT THE AGENCY TO TRANSFER SCREEN.
PD26	THERE IS A LIMITED TERM CARE FUNCTIONAL SCREEN (LTC-FS) COMPLETED BY ANOTHER AGENCY. THE PERSONAL CARE SCREENING TOOL (PCST), F-11133, INFORMATION IS IN CONFLICT WITH LTC-FS.
PD27	ONLY ONE LEVEL OF FUNCTION MAY BE SELECTED FOR ALL ELEMENTS EXCEPT TOILETING. COLORADO MEDICAID IS UNABLE TO PROCESS THE PRIOR AUTHORIZATION REQUEST.
PD28	NO UNITS MAY BE REQUESTED USING THIS PRIOR AUTHORIZATION PROCESS. PLEASE SUBMIT WITH THE APPROPRIATE ATTACHMENTS FOR REQUESTING SPECIFIC PERSONAL CARE WORKER UNITS.
PD29	CLIENT IS NOT ELIGIBLE FOR THE REQUESTED SERVICE(S) AS OF THE REQUESTED START DATE.
PD30	NO TRAVEL TIME MAY BE AUTHORIZED WHEN NO PERSONAL CARE WORKER SERVICE IS AUTHORIZED.
PD32	PROVIDER NOT CERTIFIED TO RENDER THE SERVICE(S) REQUESTED.
PD34	BASED ON THE DOCUMENTATION SUBMITTED, THIS REQUEST CAN NOT BE PRIOR AUTHORIZED. REFER TO THE PA MESSAGES FROM THE CONSULTANT FOR COMPLETE EXPLANATION.
PD98	PLEASE DOCUMENT HOW AND WHEN EACH PREVIOUSLY AUTHORIZED PRO RE NATA VISIT WAS USED.

Colorado Choice Transitions (CCT)

Denial Code	Long Description
0201	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.

Denial Code	Long Description
0233	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0235	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0237	CLIENT IDENTIFICATION NUMBER DOES NOT MATCH CLIENTS FIRST NAME.
0238	THE CLIENT IDENTIFICATION NUMBER DOES NOT MATCH THE CLIENTS LAST NAME.
0242	SECONDARY DIAGNOSIS CODE IS INVALID.
0248	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0249	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0251	PROCEDURE CODE MODIFIER IN FIRST POSITION IS INVALID.
0252	THE PROCEDURE CODE MODIFIER IN SECOND POSITION IS INVALID FOR REQUESTED START DATE OR DATE OF RECEIPT.
0253	THE PROCEDURE CODE MODIFIER IN THIRD POSITION IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
0258	THE PRIMARY DIAGNOSIS CODE IS REQUIRED.
0272	THE PRIMARY DIAGNSOSIS CODE IS INVALID.
0400	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0853	HCPCS - ANNUAL UPDATE
0885	NEVER EVENTS MODIFIERS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
0886	NEVER EVENTS DIAGNOSIS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
1000	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
1002	RENDERING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1003	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1007	RENDERING PROVIDER ID IS NOT ON FILE.
1047	THE RENDERING PROVIDERS CERTIFICATION HAS BEEN CANCELLED.
1048	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1801	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
1804	A CERTIFIED SUBSTANCE ABUSE DAY TREATMENT PROVIDER MUST SUBMIT A SUBSTANCE ABUSE DAY TREATMENT PROCEDURE CODE.
1806	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
1808	THE BILLING PROVIDER DOES NOT HAVE THE REQUIRED CERTIFICATION ADDENDUM ON FILE.
1900	THE BILLING PROVIDERS TAXONOMY CODE IS INVALID.
1901	THE RENDERING PROVIDERS TAXONOMY CODE IS INVALID.
1927	A NATIONAL PROVIDER IDENTIFIER IS REQUIRED FOR THE BILLING PROVIDER.
1934	A NATIONAL PROVIDER INDENTIFIER IS REQUIRED FOR THE RENDERING PROVIDER.
1936	THE BILLING PROVIDER NUMBER IS INVALID.
1937	THE RENDERING PROVIDER NUMBER IS INVALID.
1960	INTERNAL PROCESSING IS REQUIRED.
1963	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.
1964	THE BILLING PROVIDER INDICATED IS NOT ALLOWABLE AS A BILLING PROVIDER.
1965	RENDERING PROVIDER NUMBER IS MISSING/INVALID FOR THIS PROCEDURE PROVIDER.
1974	PRESCRIBING/REFERRING/ORDERING PROVIDER INDICATED IS NOT CERTIFIED AS A PRESCRIBING/REFERRING/ORDERING PROVIDER.
1975	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
1976	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
2001	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2003	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2017	THE CLIENT IS ENROLLED IN A MEDICAID OR OTHER MANAGED CARE PROGRAM.
2037	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2603	CLIENT LOCKED-IN TO A PROVIDER OR ENROLLED IN A HOSPICE. CONTACT CLIENTS HOSPICE FOR PAYMENT OF SERVICES OR RESUBMIT WITH DOCUMENTATION OF UNRELATED NATURE OF CARE.

Denial Code	Long Description
3324	THE MODIFIER HAS BEEN DISCONTINUED BY THE CENTERS OF MEDICARE AND MEDICAID SERVICES OR THE AMERICAN MEDICAL ASSOCIATION FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
3337	THE PROCEDURE CODE HAS BEEN TERMINATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AMERICAN MEDICAL ASSOCIATION, OR AMERICAN DENTAL ASSOCIATION FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT. RESUBMIT WITH VALID A PROCEDURE CODE.
3339	THE PROCEDURE BILLED IS NOT PAYABLE ACCORDING TO DEFICIT REDUCTION ACT (DEFRA) GUIDELINES.
3351	THE PROCEDURE IS NOT COVERED FOR CLIENTS WITH A NURSING HOME AUTHORIZATION ON THE REQUESTED START DATE OR DATE OF RECEIPT.
3353	THE PROCEDURE IS NOT A COVERED SERVICE FOR HOME AND COMMUNITY-BASED WAIVER CLIENTS.
4021	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4027	THE DIAGNOSIS CODE IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
4031	THE PROCEDURE SUBMITTED IS NOT APPROPRIATE FOR CLIENTS GENDER.
4032	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4034	THE PROCEDURE CODE HAS AN AGE RESTRICTION.
4036	THE PLACE OF SERVICE CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4040	THE PRIMARY DIAGNOSIS CODE IS NOT ON FILE.
4041	THE SECONDARY DIAGNOSIS IS NOT ON FILE.
4046	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4127	INTERNAL PROCESSING IS REQUIRED.
4131	INTERNAL PROCESSING IS REQUIRED.
4141	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4149	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4150	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4236	ETIOLOGY DIAGNOSIS CODE(S) (E-CODES) ARE INVALID AS THE PRIMARY DIAGNOSIS.
4244	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4245	THE FOURTH POSITION MODIFIER IS INVALID FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT.
4256	THE PROCEDURE CODE AND MODIFIER COMBINATION IS NOT PAYABLE FOR THE CLIENTS BENEFIT PLAN.
4257	THE MODIFIERS SUBMITTED ARE EITHER INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT OR THE MODIFIERS ARE MISSING.
4311	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4315	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4316	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4371	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4372	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4711	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR CLIENTS AGE.
4714	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS AGE.
4731	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS DIAGNOSIS.
4742	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4743	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4744	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4745	DIAGNOSIS AND/OR PROCEDURE AND/OR PLACE OF SERVICE (POS) CODE IS NOT COVERED FOR EXPRESS ENROLLMENT CLIENTS.
4746	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4801	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4802	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
4821	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
4871	PLEASE REFER TO PA MESSAGES FOR RETURN INFORMATION.
4963	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS GENDER.
4990	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
7500	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.

Denial Code	Long Description
7509	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
P001	THE BILLING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THE SERVICES.
P002	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P003	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P005	THE PRIOR AUTHORIZATION CAN NOT BE END DATED. THE PRIOR AUTHORIZATION STATUS IS NOT APPROVED OR APPROVED WITH REVISIONS.
P006	PLEASE FURNISH THE PROCEDURE CODE AND CORRESPONDING DESCRIPTION.
P008	THE BILLING PROVIDER NUMBER IS INVALID.
P009	THE BILLING PROVIDER NUMBER IS INVALID.
P010	THE REQUESTED END DATE IS INVALID.
P011	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P012	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P013	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P014	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P015	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P016	THE REQUESTED START DATE IS MISSING OR INVALID.
P019	THE REQUESTED START DATE IS MISSING OR INVALID.
P020	THE RENDERING PROVIDER NUMBER IS INVALID.
P021	THE RENDERING PROVIDER NUMBER IS INVALID.
P022	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P023	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P024	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P026	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P027	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P030	FIRST MODIFIER IS INVALID.
P031	FIRST MODIFIER IS INVALID.
P032	SECOND MODIFIER IS INVALID.
P033	SECOND MODIFIER IS INVALID.
P034	THIRD MODIFIER IS INVALID.
P035	THIRD MODIFIER IS INVALID.
P036	FOURTH MODIFIER IS INVALID.
P037	FOURTH MODIFIER IS INVALID.
P038	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P039	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P040	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P041	CLIENTS FIRST NAME IS MISSING.
P042	CLIENTS LAST NAME IS MISSING.
P043	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P044	BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES REQUESTED.
P045	FIRST MODIFIER IS INVALID.
P046	SECOND MODIFIER IS INVALID.
P047	THIRD MODIFIER IS INVALID.
P048	FOURTH MODIFIER IS INVALID.
P052	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P053	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.

Denial Code	Long Description
P054	RENDERING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES FOR THE BENEFIT PLAN.
P055	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P061	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P062	THE CLIENT ID AND/OR NAME INDICATED ON THE PA REQUEST IS INCORRECT. THE CLIENT ID AND/OR NAME HAS BEEN UPDATED. PLEASE VERIFY THE ID AND/OR NAME IS CORRECT.
P064	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
P067	THE FREQUENCY OF HOURS REQUESTED ARE NOT APPROPRIATE FOR THIS CLIENT AND HAVE BEEN MODIFIED ACCORDINGLY.
P079	BILLING PROVIDER IS ON PAYMENT SUSPENSION DUE TO CREDIBLE ALLEGATION OF FRAUD.
P120	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAS BEEN REDUCED.
P121	THE SERVICE/ PROCEDURE REQUESTED IS NOT SUPPORTED BY SUBMITTED DOCUMENTATION.
P126	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
P128	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.
P138	SERVICE(S) DO NOT MEET COLORADO MEDICAID GUIDELINES.
P167	REQUESTED DOCUMENTATION HAS NOT BEEN SUBMITTED.
P178	THE SERVICE REQUESTED IS NOT MEDICALLY NECESSARY.
P179	THE MEDICAL NECESSITY FOR THIS SERVICE IS NOT SUPPORTED BY THE SUBMITTED DOCUMENTATION.
P233	THE DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE ADDITIONAL CARE.
P257	THIS CLIENTS FUNCTIONAL ASSESSMENT SCORES PLACE THIS CLIENT OUTSIDE ELIGIBILITY FOR DAY TREATMENT.
P274	OUR RECORDS INDICATE THIS CLIENT IS INVOLVED IN EFFECTIVE AND APPROPRIATE SERVICE ELSEWHERE.
P292	INTENSIVE REHABILITATION HOURS ARE NO LONGER APPROPRIATE AS INDICATED BY HISTORY, DIAGNOSIS, AND/ OR FUNCTIONAL ASSESSMENT SCORES.
P328	THE SERVICES REQUESTED INCLUDE NON-COVERED SERVICES, AND HOURS ARE REDUCED ACCORDINGLY.
P339	THE CLIENTS PAST HISTORY INDICATES REDUCED TREATMENT HOURS ARE WARRANTED.
P342	THE REQUEST DOES NOT MEET GENERALLY ACCEPTED CONDITIONS REQUIRING FLUORIDE TREATMENTS.
P346	SERVICES EXCEED COLORADO MEDICAID LIMITATION AND DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE MEDICAL NECESSITY OF THE SERVICE.
P349	THE SERVICE REQUESTED WAS PERFORMED LESS THAN FIVE YEARS AGO.
P353	THE EXISTING APPLIANCE HAS NOT BEEN WORN FOR THREE YEARS.
P367	THE CLIENT HAS BEEN TOTALLY WITHOUT TEETH AND AN APPLIANCE FOR FIVE YEARS.
P392	THE CLIENT IS MISSING AN ANTERIOR TOOTH AND/OR HAS TWO OR MORE POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P405	THE SERVICE(S) REQUESTED COULD ADEQUATELY BE PERFORMED IN THE DENTAL OFFICE.
P406	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE OF GOOD PERIODONTAL HEALTH (AMERICAN ACADEMY OF PERIODONTOLOGY PERIODONTAL CLASSIFICATION OF TYPE I OR II).
P407	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE VISIBLE ON RADIOGRAPHS THAT AT LEAST 50 PERCENT OF THE CLINICAL CROWN IS INTACT.
P409	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING SIX OR MORE TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED, INCLUDING THIRD MOLARS.
P410	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING ONE OR MORE ANTERIOR TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED.
P411	DOCUMENTATION DOES NOT SUPPORT THE NEED FOR PERIODONTIC SERVICES. POCKETS ARE LESS THAN 4MM AND/OR GREATER THAN 6MM FOR CLIENT AND/OR THE CLIENT IS UNDER THE AGE OF 13.
P412	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA.
P413	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA. THIS PA HAS BEEN GRANTED AS APPROVED NOT APPROVED WITH REVISIONS. THE DURATION REQUESTED MAY HAVE BEEN REDUCED TO REFLECT COVERAGE LIMITATIONS, PRESCRIBER ORDERS, CONFLICTI
P417	THE SERVICE(S) REQUESTED COULD BE ADEQUATELY PERFORMED WITH LOCAL ANESTHESIA.
P437	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO POOR ORAL HYGIENE.

Denial Code	Long Description
P444	THIS LINE ITEM IS A DUPLICATE OF ANOTHER LINE ITEM ON THIS PRIOR AUTHORIZATION (PA) REQUEST. PLEASE CORRECT.
P446	THIS IS A DUPLICATE OF AN EXISTING PRIOR AUTHORIZATION (PA) REQUEST. YOU MAY CONTACT PROVIDER SERVICES IF YOU REQUIRE ASSISTANCE. DUPLICATE PA REQUEST
P448	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO DECAY HISTORY.
P449	QUESTIONABLE LONG TERM PROGNOSIS DUE TO GUM AND BONE DISEASE.
P456	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO APPARENT ROOT INFECTION.
P457	OUR RECORDS INDICATE THIS CLIENT HAS EXCEEDED ESTABLISHED PROGRAM LIMITATIONS. COLORADO MEDICAID WILL NOT AUTHORIZE NEW DENTURES.
P458	DOCUMENTATION PROVIDED INDICATES A LESS ELABORATE PROCEDURE SHOULD BE CONSIDERED.
P502	RENTAL ONLY ALLOWED; MEDICAL NEED FOR PURCHASE HAS NOT BEEN DOCUMENTED.
P503	PURCHASE ONLY ALLOWED; MEDICAL NEED FOR RENTAL HAS NOT BEEN DOCUMENTED.
P504	OCCUPATIONAL THERAPY GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P505	THE SERVICE REQUESTED IS INCLUDED IN THE NURSING HOME RATE STRUCTURE.
P511	THIS NATIONAL DRUG CODE IS ONLY BILLABLE AS PART OF A COMPOUND DRUG.
P515	THE PRESENCE OF A HANDICAPPING MALOCCLUSION OR HANDICAPPING DENTOFACIAL DEFORMITY IS NOT SUPPORTED BY THE DOCUMENTATION SUBMITTED.
P521	THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVERED BY COLORADO MEDICAID.
P522	GASTRO-INTESTINAL SURGERY FOR THE PURPOSE OF WEIGHT CONTROL IS COVERED ONLY AS A LIFE THREATENING PROCEDURE.
P523	THE TREATMENT REQUEST IS NOT CONSISTENT WITH THE CLIENT'S DIAGNOSIS.
P524	PSYCHOTHERAPY PROVIDED IN THE CLIENTS HOME IS NOT A COVERED BENEFIT OF COLORADO MEDICAID.
P525	THE INFORMATION PROVIDED IS NOT CONSISTENT WITH THE INTENSITY OF SERVICES REQUESTED.
P526	INTENSIVE MULTIPLE MODALITY TREATMENT IS NOT CONSISTENT WITH THE INFORMATION PROVIDED.
P527	MULTIPLE PROVIDERS OF TREATMENT ARE NOT INDICATED FOR THIS CLIENT.
P528	THE DURATION OF TREATMENT SESSIONS EXCEED CURRENT COLORADO MEDICAID GUIDELINES.
P534	DOCUMENTATION OF POOR PHYSICAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P535	OTHER PHYSICAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P536	THE PHYSICAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P537	USE OF PHYSICAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P538	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF A PHYSICAL THERAPIST.
P539	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS AND LIVING ARRANGEMENT.
P540	GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P541	THE PROCEDURE(S) REQUESTED ARE NOT MEDICAL IN NATURE.
P542	DOCUMENTATION OF POOR OCCUPATIONAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P543	DOCUMENTATION OF POOR SPEECH THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P544	OTHER OCCUPATIONAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P546	THE OCCUPATIONAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P547	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF PHYSICAL THERAPY.
P548	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.

Denial Code	Long Description
P549	ACTIVITIES TO PROMOTE DIVERSION OR GENERAL MOTIVATION ARE NONCOVERED COLORADO MEDICAID SERVICES.
P550	REVISIONS OF THE REQUEST IS NECESSITATED BY THE CLIENTS MINIMAL PROGRESS.
P551	RESTORATIVE NURSING INVOLVEMENT COULD BE INCREASED.
P552	CLIENTS DEMONSTRATED RESPONSE TO CURRENT THERAPY DOES NOT WARRANT THE INTENSE FREQUENCY REQUESTED.
P553	MAINTENANCE IS TWO TIMES PER WEEK OR LESS.
P554	THE SPEECH THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P555	USE OF OCCUPATIONAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P556	USE OF SPEECH THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P557	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF AN OCCUPATIONAL THERAPIST.
P558	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
P559	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P560	THE MATERIALS/ SERVICES REQUESTED ARE PRINCIPALLY COSMETIC IN NATURE.
P561	THE LENS FORMULA DOES NOT JUSTIFY REPLACEMENT.
P562	THE CHANGE IN THE LENS FORMULA DOES NOT WARRANT MULTIPLE REPLACEMENTS.
P563	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P564	LENSES ONLY ARE APPROVED; PLEASE DISPENSE A CONTRACTED FRAME. THE NON-CONTRACTED FRAME IS NOT MEDICALLY JUSTIFIED.
P565	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P566	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P567	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF OCCUPATIONAL THERAPY.
P568	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF SPEECH THERAPY.
P569	LEVEL, INTENSITY, OR EXTENT OF SERVICE(S) REQUESTED HAS BEEN MODIFIED CONSISTENT WITH MEDICAL NEED AS DEFINED IN THE PLAN OF CARE.
P570	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P571	THE SERVICE ASKED FOR IS NOT COVERED BY COLORADO MEDICAID AS THESE TASKS CAN BE DONE BY NURSES OR ACTIVITY STAFF.
P572	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P573	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.
P574	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P575	MEDICAL NEED FOR EQUIPMENT/ SUPPLY REQUESTED IS NOT SUPPORTED BY DOCUMENTATION SUBMITTED.
P576	OTHER SPEECH THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P577	DOCUMENTATION SUBMITTED IDENTIFIES THAT THE CLIENT HAS FEWER THAN TWO POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P582	LESS EXPENSIVE ALTERNATIVE SERVICES ARE AVAILABLE FOR THIS CLIENT.
P634	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P711	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING PERIODONTAL SCALING AND ROOT PLANNING.
P712	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING GINGIVECTOMY.
P754	AN APPROVED SUBSTANCE ABUSE DAY TREATMENT PROGRAM CANNOT EXCEED A SIX WEEK PERIOD.
P761	THE CLIENT DOES NOT APPEAR TO BE ABLE OR WILLING TO ABSTAIN FROM ALCOHOL/DRUG USAGE WHILE IN TREATMENT. THEREFORE, SUBSTANCE ABUSE DAY TREATMENT SERVICES ARE NOT APPROVED.
P764	THIS CLIENT HAS COMPLETED INTENSIVE SUBSTANCE ABUSE TREATMENT WITHIN THE PAST 12 MONTHS. THE DOCUMENTATION PROVIDED IS NOT ADEQUATE TO JUSTIFY ADDITIONAL INTENSIVE TREATMENT AT THIS TIME.

Denial Code	Long Description
P785	A LESS THAN SIX-WEEK HEALING PERIOD HAS BEEN SPECIFIED FOR THIS PRIOR AUTHORIZATION. THEREFORE IT IS NOT NECESSARY TO WAIT THE FULL SIX WEEKS AFTER EXTRACTIONS BEFORE TAKING DENTURE IMPRESSIONS.
P818	SIX-WEEK HEALING TIME IS REQUIRED BETWEEN EDENTULATION AND FINAL IMPRESSIONS. PAYMENT FOR DENTURES WILL BE DENIED OR RECOUPED IF HEALING PERIOD IS NOT OBSERVED.
P849	COLORADO MEDICAID HAS DETERMINED THERE WERE (ARE) SEVERAL HOME HEALTH AGENCIES WILLING TO PROVIDE MEDICALLY NECESSARY SKILLED NURSING SERVICES TO THIS CLIENT.
P864	THE DOCUMENTATION YOU HAVE SUBMITTED DOES NOT MEET THE REQUIREMENTS OF COLORADO MEDICAID.
P873	THE MEDICAL NECESSITY FOR THE HOURS REQUESTED IS NOT SUPPORTED BY THE INFORMATION SUBMITTED.
P874	THE DOCUMENTATION SUBMITTED INDICATES THE TASKS SPECIFIED CAN BE COMPLETED DURING THE VISITS APPROVED.
P878	THE DOCUMENTATION SUBMITTED DOES NOT INDICATE THAT MEDICALLY ORIENTED TASKS ARE MEDICALLY NECESSARY; THEREFORE PERSONAL CARE SERVICES HAVE BEEN APPROVED.
P880	THE QUANTITY OF SERVICES AUTHORIZED FOR THIS CLIENTS PERSONAL CARE HAS BEEN AMENDED BASED ON INFORMATION RECEIVED FROM ONE OR MORE OF THESE SOURCES: THE CLIENT, THEIR PHYSICIAN, AND/OR THE IN-HOME VISIT BY STAFF OF THE OIG (OFFICE OF INSPECTOR GENERAL).
P885	THE USE OF THIS DRUG FOR THE INTENDED PURPOSE IS NOT COVERED BY COLORADO MEDICAID, CONSISTENT WITH COLORADO ADMINISTRATIVE CODE AND FEDERAL LAW.
P924	THE MEDICAL RECORDS SUBMITTED WITH THE CURRENT REQUEST CONFLICT OR DISAGREE WITH OUR MEDICAL RECORDS ON THIS CLIENT.
P950	INDEPENDENT NURSES, PLEASE NOTE PAYABLE SERVICES MAY NOT EXCEED 12 HOURS/DAY OR 60 HOURS/WEEK.
P951	SERVICES CAN ONLY BE AUTHORIZED THROUGH ONE YEAR FROM THE PRESCRIPTION DATE.
P952	LEAD INSPECTION IS A COVERED COLORADO MEDICAID SERVICE WHEN THE CHILD HAS BEEN SHOWN TO HAVE LEAD POISONING (E.G., CHILD HAS A BLOOD LEAD LEVEL > 19 UG/DL OR TWO CONSECUTIVE BLOOD LEAD LEVELS OF 15-19 UG/DL DONE AT LEAST 90 DAYS APART). THE INSPECTION MUS
P953	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P954	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P956	THE REQUEST CAN ONLY BE BACKDATED A MAXIMUM OF 14 DAYS FROM FIRST DATE RECEIVED BY COLORADO MEDICAID.
P957	COMPLETE PERIODONTAL CHARTING AT TIME OF SERVICE, AND SUBMIT CHARTING, COPY OF OPERATIVE REPORT, TOGETHER WITH A COPY OF THE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF), F-11035, TO PA UNIT ATTENTION DENTAL CONTSULTANT.
P958	NOTE THAT CODE D4341 HAS BEEN CHANGED. REFER TO THE DECISION NOTICE FOR AUTHORIZED QUANTITY.
P960	YOUR PA HAS BEEN APPROVED FOR 90 DAYS. THE 90 DAY APPROVAL DOES NOT IMPLY THE PA REQUEST MEETS PRIOR AUTHORIZATION CRITERIA. AFTER ADDITIONAL INFORMATION IS AVAILABLE IN INTERCHANGE, COLORADO MEDICAID WILL CREATE AN AMENDMENT REQUEST TO EXTEND THE PA FOR
P961	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P962	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
PA10	THE REQUESTED END DATE IS INVALID.
PA12	PLEASE FURNISH A WRITTEN DESCRIPTION OF THE CLIENTS DIAGNOSIS.
PA13	PROVIDE DIAGNOSES WITH DATES OF ONSET.
PA14	IDENTIFY PROBLEMS TO BE TREATED.
PA15	THE AUDIOLOGISTS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1), F-11020, AND PRIOR AUTHORIZATION REQUEST/HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2), F-11021.

Denial Code	Long Description
PA16	THE PHYSICIANS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION/PHYSICIAN OTOLOGICAL REPORT (PA/POR), F-11019.
PA17	SUBMIT BRIEF HISTORY WITH REFERRAL INFORMATION, LIVING SITUATION, FUNCTIONAL STATUS, AND OTHER PERTINENT INFORMATION. WHAT CHANGE OF STATUS RESULTED IN REFERRAL AT THIS TIME?
PA18	PLEASE FURNISH THE CLIENTS HEIGHT AND WEIGHT.
PA19	PLEASE SUBMIT CLINICAL INFORMATION SUFFICIENT TO VERIFY THE NEED FOR THE REQUESTED SERVICE(S).
PA20	PLEASE RESUBMIT WITH COMPLETE PERIODONTAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PA21	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL EDUCATIONAL PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA22	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL PROGRAM PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA23	REFER TO THE DURABLE MEDICAL EQUIPMENT INDEX FOR APPROPRIATE CODE AND DESCRIPTION. DO NOT USE AN "UNLISTED" CODE.
PA24	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUALIZED FAMILY SERVICE PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA25	INFORMATION ON THE REQUEST FORM IS ILLEGIBLE, AND THE REQUEST CANNOT BE PROCESSED.
PA26	RE-EVALUATE YOUR GOALS. EMPHASIS SHOULD BE ON FUNCTIONAL SELF-CARE. GOALS MUST BE RELATED TO FUNCTIONAL OUTCOME.
PA27	PLEASE CLARIFY THE NUMBER OF HOURS PER WEEK REQUESTED.
PA28	PLEASE CLARIFY THE NUMBER OF HOURS PER DAY REQUESTED.
PA29	PLEASE CLARIFY THE NUMBER OF VISITS PER DAY REQUESTED.
PA30	ATTACH SUPPORTIVE DOCUMENTATION; HOME EXERCISE PROGRAM AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA31	THE DIAGNOSIS CODE INDICATED ON THE REQUEST DOES NOT CORRESPOND TO THE DIAGNOSIS CODE DESCRIPTION.
PA32	PLEASE SUBMIT ADDITIONAL INFORMATION SUFFICIENT TO VERIFY APPROPRIATENESS AND NEED FOR TRANSPLANT.
PA33	PLEASE SUBMIT THE INITIAL AND PROGRESSIVE OBJECTIVE FINDINGS.
PA34	ATTACH SUPPORTIVE DOCUMENTATION, FACILITY PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA35	PLEASE SUBMIT THE CLIENTS ORIGINAL COMPLAINTS AND EXAMINATION FINDINGS.
PA36	ATTACH SUPPORTIVE DOCUMENTATION, IN-HOME AUTISM PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA37	PLEASE SUBMIT YOUR TREATMENT PLAN FOR THIS CLIENT.
PA38	ATTACH SUPPORTIVE DOCUMENTATION AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA39	INITIAL EVALUATIONS MUST BE PERFORMED BY AN OCCUPATIONAL THERAPIST REGISTERED (OTR), PER AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA) STANDARDS.
PA41	IDENTIFY THE PLACE OF SERVICE AND ITS EFFECT ON SUPPORTING THE DESIRED TREATMENT OUTCOME.
PA42	PLEASE INDICATE THE HOURS OF USE OF OXYGEN PER 24-HOUR PERIOD.
PA43	PROVIDE BASELINE DOCUMENTATION FOR THIS CLIENTS LIMITATIONS USING UNITS OF MEASUREMENT THAT ARE APPLIED CONSISTENTLY WHEN REPORTING STATUS.
PA44	IDENTIFY FUNCTIONAL LIMITATIONS AS THEY ARE RELATED TO IDENTIFIED CONDITIONS.
PA46	CORRELATE PLAN OF CARE TO REQUESTED PROCEDURE CODES.
PA47	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE FREQUENCY/DURATION REQUESTED.
PA48	PLEASE PROVIDE THE NAME AND CREDENTIALS OF THE RENDERING PROVIDER.
PA50	COLORADO MEDICAID RECORDS INDICATE THE CLIENT OWNS A WHEELCHAIR. DOCUMENT THE REASON AND NEED FOR REPLACEMENT AND COST TO REPAIR CURRENT WHEELCHAIR.
PA51	PLEASE DISTINGUISH PRIMARY AND SUPPORTIVE MODALITIES.
PA52	PLEASE SUBMIT A PROGRESS REPORT.

Denial Code	Long Description
PA53	MULTIPLE FAMILY CLIENTS TREATMENT BY THE SAME PROVIDER REQUIRES FURTHER INFORMATION DOCUMENTING COORDINATION OF TREATMENT PLAN.
PA54	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE MINUTES REQUESTED.
PA55	MEDICAL NECESSITY OF TREATMENT REQUIRES ADDITIONAL DOCUMENTATION.
PA56	GIVEN AGE, DIAGNOSES, CURRENT LEVEL OF FUNCTION, PAST RESPONSE TO TREATMENT, AND LIVING SITUATION, EXPAND ON POTENTIAL FOR SIGNIFICANT FUNCTIONAL PROGRESS WITHIN THE NEXT SIX MONTHS. EMPHASIZE WHY PROGRESS IS EXPECTED WITH SERVICES AT THIS TIME.
PA57	SUBMIT THE INITIAL FINDINGS. INCLUDE A COMPREHENSIVE EVALUATION.
PA58	SUBMIT PROGRESSIVE, OBJECTIVE FINDINGS. INCLUDE A PERTINENT RE-EVALUATION.
PA59	PLEASE SUPPLY INFORMATION REGARDING THE CLIENTS MEDICATION REQUIREMENTS, IF ANY.
PA60	PLEASE SPECIFY IF THE CLIENT IS IN AN EDUCATIONAL SETTING.
PA61	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA62	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
PA63	THE SKILLS OF A THERAPIST ARE PURPOSEFUL AND SKILLED INTERVENTIONS REQUIRED TO CONTINUALLY DESIGN, IMPLEMENT, REASSESS, MODIFY/GRADE, AND/OR DISCONTINUE A PLAN OF CARE IN A TIMELY MANNER, BASED ON THE COMPLEXITY OF THE CLIENTS MEDICAL CONDITION AND/OR CO
PA64	PLEASE SUBMIT A THERAPY PLAN OF CARE, INCLUDING A CURRENT, DATED EVALUATION.
PA65	A PLAN OF CARE SIGNED AND DATED BY THE PHYSICIAN IS REQUIRED.
PA66	THE SKILLS OF A THERAPIST ARE REQUIRED WHEN ONLY THE THERAPIST CAN SAFELY AND EFFECTIVELY DELIVER THE THERAPEUTIC PROCEDURES BECAUSE OF THEIR UNIQUE KNOWLEDGE, TRAINING, AND EXPERTISE. DESCRIBE THE REASON THAT SOMEONE OTHER THAN A THERAPIST CANNOT SAFELY
PA67	PLEASE SPECIFY IF THE CLIENTS WORK SITE DEMANDS GOOD BINAURAL HEARING.
PA68	DESCRIBE THE REASON, BASED ON THE CLIENTS COGNITIVE, PHYSICAL, COMMUNICATION, OR RESOURCE STATUS, THAT A HOME PROGRAM, EQUIPMENT, OR ENVIRONMENTAL ADAPTATIONS ALONE CANNOT MEET CLIENTS NEEDS.
PA69	PLEASE SPECIFY IF THE CLIENT HAS AN ACCOMPANYING DISABILITY THAT ADDS TO THE HEARING PROBLEM.
PA70	DISTINGUISH REQUESTED PROCEDURES AND GOALS FROM OTHER SERVICES THIS CLIENT RECEIVES. THEY MAY NOT BE DUPLICATIVE.
PA71	PLEASE INDICATE THE NUMBER OF DAYS REQUESTED.
PA73	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA74	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA75	PLEASE DOCUMENT CARRYOVER OF THE THERAPY PROGRAM TO NURSING.
PA76	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA79	PROVIDE EVIDENCE OF SIGNIFICANT FUNCTIONAL PROGRESS IN LAST SIX MONTHS.
PA84	THE GRANT DATE OF THIS REQUEST CANNOT BE PRIOR TO THE SIGNATURE DATE OF THE PRESCRIBING PHYSICIAN.
PA86	PROVIDE EVIDENCE OF SKILLS GAINED IN THERAPY CARRYING OVER TO OTHER SETTINGS WITHIN SIX MONTHS.
PA87	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE NUMBER OF SESSIONS REQUESTED.
PA88	THE REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL SCOPE OF PRACTICE.
PA89	PRIOR AUTHORIZATION IS NOT REQUIRED UNTIL LIMITATION OF SERVICE HAS BEEN REACHED.
PA91	PLEASE SUBMIT REQUIRED X-RAYS.
PA92	PLEASE PROVIDE AN EXPLANATION FOR THE MATERIAL SUBMITTED WITH THE REQUEST.
PA95	PLEASE DESCRIBE HOW THE PROVISION OF THIS SERVICE WOULD PREVENT INSTITUTIONALIZATION OF THE CLIENT.
PA96	COULD THE EXISTING DENTURE(S) BE RELINED OR REBASED? IF NOT, PLEASE EXPLAIN WHY NOT.
PA97	REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL STANDARDS OF PRACTICE.

Denial Code	Long Description
PA98	PLEASE INDICATE IF THE CLIENT IS CURRENTLY BEING TUBE FED.
PB02	PLEASE PROVIDE THE REQUIRED DATED SIGNATURES ON THE ATTACHMENTS.
PB03	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING THE LOSS/DESTRUCTION/THEFT OF THE HEARING AID.
PB04	DESCRIBE THE CLIENTS ABILITY TO STAND OR AMBULATE SUFFICIENTLY TO ACCOMPLISH SELF-CARE ACTIVITIES.
PB07	PLEASE SUBMIT AN ORTHODONTIC STUDY MODEL OR DIAGNOSTIC CASTS.
PB09	PLEASE PROVIDE A PHOTOGRAPH OF THE INVOLVED AREA(S).
PB10	PLEASE PROVIDE AN ESTIMATION (IN GRAMS) OF THE TOTAL AMOUNT OF TISSUE TO BE RESECTED.
PB11	PLEASE SUBMIT THE PLAN OF CARE FOR CO-TREATMENT.
PB12	FURNISH A DETAILED DESCRIPTION FOR THE PROCEDURE CODE REQUESTED.
PB13	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB15	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB18	PLEASE COMPLETE THE ATTACHED OUT-OF-STATE PROVIDER DATA SHEET, F-11001, AND RESUBMIT.
PB20	A SIGNED AND DATED PRESCRIPTION IS REQUIRED WITHIN THREE MONTHS OF RECEIPT BY COLORADO MEDICAID FOR INITIAL REQUESTS AND WITHIN 12 MONTHS OF RECEIPT BY COLORADO MEDICAID FOR SUBSEQUENT REQUESTS.
PB21	PLEASE COMPLETE THE APPROPRIATE PRIOR AUTHORIZATION ATTACHMENT. CONTACT PROVIDER SERVICES OR THE PRIOR AUTHORIZATION UNIT FOR ASSISTANCE.
PB23	PHYSICAL THERAPY ASSISTANT NOTES AND ALL FORMS SUBMITTED MUST BE COSIGNED BY A REGISTERED PHYSICAL THERAPIST.
PB31	ARE YOU REQUESTING A COMPLETE APPLIANCE, OR REPLACEMENT PARTS?
PB32	THE PROCEDURE CODE INDICATED ON THE REQUEST DOES NOT MATCH THE DESCRIPTION OF SERVICE; PLEASE CORRECT AND RESUBMIT.
PB35	THE SERVICE REQUESTED DOES NOT REQUIRE PRIOR AUTHORIZATION.
PB41	PLEASE FURNISH A CURRENT MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT, F-11090 (DATED WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID).
PB45	THE CERTIFICATION PERIOD ON THE PLAN OF CARE (POC) DOES NOT COVER THE REQUESTED GRANT/START DATE. PLEASE RESUBMIT YOUR REQUEST WITH A NEW POC.
PB49	A CERTIFIED OCCUPATIONAL THERAPY ASSISTANTS NOTES MUST BE COSIGNED BY AN OCCUPATIONAL THERAPIST REGISTERED.
PB51	ADDITIONAL INFORMATION IS REQUIRED ON PRIOR AUTHORIZATION TO ENABLE PRICING.
PB54	REQUESTED SERVICES DO NOT MATCH SERVICES ON THE PHYSICIANS ORDERS.
PB59	PLEASE PROVIDE AN INDIVIDUAL EDUCATIONAL PLAN (IEP), WHICH HAS BEEN SIGNED BY THE PROVIDER NO EARLIER THAN NINE MONTHS PRIOR TO RECEIPT AT COLORADO MEDICAID; OTHERWISE, DOCUMENT WHY NO IEP EXISTS.
PB65	PLEASE FURNISH THE ANTICIPATED TOTAL CHARGES FOR THIS REQUEST.
PB66	A PHOTOCOPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED; THE DATE MUST BE WITHIN SIX MONTHS OF RECEIPT BY COLORADO MEDICAID.
PB67	THE PRESCRIPTION DATE MUST INCLUDE MONTH, DAY, AND YEAR.
PB68	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID.
PB73	THE SERVICES IDENTIFIED ON THE PLAN OF CARE DO NOT APPEAR APPROPRIATE FOR THE PROCEDURE CODE(S) REQUESTED ON THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018.
PB74	THE CLIENT/PROVIDER DOES NOT HAVE RETROACTIVE ENROLLMENT.
PB75	THE REQUESTED START DATE IS MORE THAN 14 DAYS BEFORE OR 62 DAYS AFTER RECEIPT.
PB82	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
PB83	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A HOME HEALTH AIDE. PLEASE RESUBMIT AS A PERSONAL CARE WORKER OR PROVIDE ADDITIONAL DOCUMENTATION.
PB86	THE SERVICES REQUESTED ARE NOT BEING PROVIDED IN THE CLIENTS RESIDENCE. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL.
PB87	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A NURSE. PLEASE RESUBMIT AS A HOME HEALTH AIDE OR PROVIDE ADDITIONAL DOCUMENTATION.
PB92	PLEASE FURNISH THE CLIENTS COMPLETE ADDRESS.

Denial Code	Long Description
PB94	IF THE CLIENT IS A RESIDENT OF A NURSING HOME, SUPPLY THE COMPLETE NAME AND ADDRESS OF THE NURSING HOME.
PB99	THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018, MUST BE SIGNED AND DATED.
PC01	PLEASE SUPPLY THE RENDERING PROVIDERS PROVIDER NUMBER.
PC03	THE DRUG ENFORCEMENT ADMINISTRATION NUMBER IS MISSING OR INVALID.
PC06	PLEASE DESCRIBE YOUR PROGRAM; INCLUDE ENTRY DATE, TERMINATION DATE, HOURS PER WEEK, AND NUMBER OF WEEKS OF PRIMARY INTENSIVE SERVICE REQUESTED.
PC07	PLEASE DESCRIBE YOUR "AFTERCARE/FOLLOW-UP" PLANS FOR THIS CLIENT.
PC08	PLEASE SUPPLY DOCUMENTATION OF PREVIOUS SUBSTANCE ABUSE SERVICES WITH DATE(S) AND OUTCOME.
PC09	PLEASE DESCRIBE IN DETAIL THE TREATMENT OBJECTIVES/GOALS FOR THIS CLIENT.
PC10	PLEASE DESCRIBE THE FAMILY SITUATION/DYNAMICS. EXPLAIN HOW THE FAMILY WILL BE INCORPORATED INTO THE CLIENTS PLAN OF CARE.
PC12	PLEASE EXPLAIN IF YOUR SERVICE ENCOURAGES THE CLIENT TO ATTEND SELF-HELP GROUPS.
PC13	PLEASE SUPPLY A SPECIFIC SCHEDULE OF ACTIVITIES, INCLUDING DAY, TIME OF DAY, LENGTH OF SESSION, AND SERVICE TO BE RENDERED DURING THAT TIME.
PC15	PLEASE FURNISH DIAGNOSTIC RATIONALE.
PC17	PLEASE DOCUMENT IF THE CLIENT EVER RECEIVED SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT.
PC19	PLEASE FURNISH MORE EXTENSIVE AND IN-DEPTH HISTORICAL AND PSYCHOSOCIAL DATA.
PC20	PLEASE SUPPLY THE DATE THE CLIENT BECAME TOTALLY ENDENTULOUS.
PC23	PLEASE SUBMIT A PHYSICIANS STATEMENT REGARDING THE MEDICAL NECESSITY OF DENTURES FOR THIS CLIENT. THE PHYSICIANS STATEMENT MUST DOCUMENT THE MEDICAL NEED FOR DENTURES.
PC24	THE SERVICE REQUESTED WAS PREVIOUSLY AUTHORIZED. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT INDICATING THIS FACT IS REQUIRED.
PC25	PLEASE SUPPLY SUFFICIENT MITIGATING CIRCUMSTANCES TO WARRANT THE CONSTRUCTION OF NEW DENTURES(S).
PC26	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
PC28	PLEASE SUBMIT A PHYSICIANS STATEMENT INDICATING DENTURES ARE NECESSARY FOR THIS NURSING HOME CLIENT.
PC29	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING LOSS OR DESTRUCTION OF DENTURE(S). INCLUDE SIGNED STATEMENT FROM CLIENT OR FACILITY DIRECTOR REGARDING HOW, WHEN AND WHERE LOST.
PC30	PLEASE PROVIDE COMPLETE INTRAORAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PC31	PLEASE DESCRIBE ANY RELATED DEFORMITIES OF THE FEET.
PC34	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD WITH REQUESTED DME ITEM(S) AND DOCUMENT IF THE CLIENT CAN USE SAFELY AND INDEPENDENTLY.
PC35	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD AND DESCRIBE THE RESULTS AND EFFECTIVENESS OF THE SERVICE REQUESTED.
PC39	PLEASE INDICATE LITER FLOW PER MINUTE, HOURS OF USE PER 24 HOUR PERIOD, AND THE EXPECTED DURATION OF NEED.
PC40	THE ITEM DOES NOT REQUIRE PRIOR AUTHORIZATION UNTIL THE LIFE EXPECTANCY HAS BEEN REACHED.
PC41	PLEASE SUPPLY INFORMATION INDICATING THE NECESSITY OF POSITIONING THE CLIENT'S BODY IN MULTIPLE POSITIONS.
PC42	PLEASE INDICATE IF THE BED HEIGHT MUST BE CHANGED TO ALLOW FOR SAFE TRANSFER OR ADEQUATE BED CARE.
PC43	SUPPLY A PHYSICIANS STATEMENT INDICATING TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR UNIT HAS REDUCED PAIN, IMPROVED/INCREASED THE CLIENTS ACTIVITY LEVEL, AND/OR REDUCED CLIENTS USE OF PAIN MEDICATION.
PC44	A CURRENT AUTHORIZATION FOR THIS SERVICE IS ON FILE FOR ANOTHER PROVIDER. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT OF THAT FACT IS REQUIRED BY THE CLIENT OF FIRST PROVIDER.
PC59	DOCUMENT DECLINE OR PROGRESS IN SPECIFIC, MEASURABLE, OBJECTIVE TERMS.
PC60	DOCUMENT IF CLIENT HAS DEMONSTRATED A GOOD APPOINTMENT COMPLIANCE RECORD.

Denial Code	Long Description
PC61	THE PHYSICIANS SIGNATURE DATE MUST NOT EXCEED 90 DAYS FROM THE DATE OF RECEIPT BY COLORADO MEDICAID.
PC62	REQUESTS FOR A CONTINUATION OF THERAPY SHOULD NOT BE SUBMITTED MORE THAN FOUR WEEKS PRIOR TO THE EXPIRATION DATE OF THE CURRENT AUTHORIZATION.
PC63	PLEASE FURNISH THE STYLE AND MANUFACTURER OF THE FRAME.
PC64	PLEASE FURNISH THE CLIENTS LENS FORMULA.
PC66	ALL REQUESTS FOR TINTS REQUIRE DOCUMENTATION OF THE VISUAL OR MEDICAL CONDITION RELATED TO PHOTOPHOBIA.
PC67	PLEASE DOCUMENT THE REASON AND JUSTIFICATION FOR REPLACEMENT BEYOND THE FIRST LENS/FRAME.
PC68	DOCUMENT IF ALL REMAINING MAXILLARY AND/OR MANDIBULAR TEETH ARE DECAY-FREE, PROPERLY RESTORED, AND PERIODONTICALLY SOUND.
PC72	SUPPLY MORE DETAIL REGARDING PROGRESS (ATTACHMENT OF GOALS, ETC.). CORRELATE PROGRESS TO PREVIOUS GOALS AND IDENTIFIED LIMITATIONS.
PC77	PLEASE SUBMIT A PLAN OF CARE DESCRIBING THE SERVICES THAT WOULD BE PROVIDED.
PC78	PLEASE DOCUMENT SPECIFIC, MEASURABLE GOALS.
PC82	THE PRIOR AUTHORIZATION (PA) SYSTEM CAN PROCESS ONLY 26 DETAILS PER PA REQUEST. PLEASE RESUBMIT YOUR REQUEST WITH NO MORE THAN 26 DETAILS.
PC83	PLEASE SUPPLY A PHYSICIANS PRESCRIPTION DATED WITHIN ONE MONTH OF REQUESTED SUBSTANCE ABUSE DAY TREATMENT.
PC84	PLEASE PROVIDE INFORMATION INDICATING THIS CLIENT IS APPROPRIATELY DETOXIFIED FROM ALCOHOL AND/OR OTHER DRUGS.
PC85	PLEASE PROVIDE INFORMATION TO INDICATE THE CLIENTS ABILITY TO ABSTAIN FROM ALCOHOL OR DRUGS WHILE IN THE SUBSTANCE ABUSE DAY TREATMENT PROGRAM.
PC86	PLEASE INDICATE IF THIS CLIENT IS WILLING TO PARTICIPATE IN AFTERCARE OR CONTINUING CARE SERVICES.
PC87	PROVIDE MORE INFORMATION ON TREATMENT HISTORY; INCLUDE SERVICE PROVIDED, DATES, AND OUTCOME. PROVIDE DETAIL OF PREVIOUS TREATMENT.
PC88	PLEASE PROVIDE MORE RATIONALE FOR THE APPROPRIATENESS AND MEDICAL NECESSITY OF SUBSTANCE ABUSE DAY TREATMENT.
PC89	PROVIDE A TREATMENT PLAN THAT CONTAINS MEASURABLE GOALS AND OBJECTIVES CORRESPONDING TO THE IDENTIFIED DEFICIT.
PC91	PLEASE PROVIDE MORE INFORMATION ON FAMILY INVOLVEMENT TREATMENT.
PC92	PLEASE PROVIDE MORE HISTORY AND EXPLANATION ABOUT THE ISSUE OF ABSTINENCE FOR THIS CLIENT.
PC94	PLEASE PROVIDE THE ANTICIPATED BEGINNING DATE AND/OR THE ESTIMATED SUBSTANCE ABUSE DAY TREATMENT DISCHARGE DATE.
PC95	PLEASE SUPPLY JUSTIFICATION FOR BEGINNING CLIENT IN SERVICE PRIOR TO AUTHORIZATION BEING OBTAINED.
PC96	THE INITIAL THREE HOURS OF SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IN A CALENDAR YEAR DO NOT REQUIRE PRIOR AUTHORIZATION.
PC97	REIMBURSEMENT FOR INITIAL SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IS LIMITED TO THREE HOURS IN A CALENDAR YEAR AND DOES NOT REQUIRE PRIOR AUTHORIZATION.
PC98	THIS DRUG IS CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE BILL USING THE APPROPRIATE NATIONAL DRUG CODE (NDC) OR SUBMIT A COMPLETED DRUG ADDITION REQUEST FORM IF THE NDC IS NOT LISTED IN THE DRUG INDEX.
PC99	THIS DRUG IS NOT CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL, CURRENT ADMINISTRATIVE RULE, OR COLORADO DRUG INDEX FOR COVERAGE LIMITATIONS.
PD01	DOCUMENT THAT CLIENT HAS ACHIEVED GOOD ORAL HYGIENE, PERIODONTAL CASE TYPE 1 OR 2, AND IS MOTIVATED TO MAINTAIN SAME.
PD03	PLEASE PROVIDE AN ARTERIAL BLOOD GAS READING OR PULSE OXIMETRY RESULTS DONE ON ROOM AIR SIGNED AND DATED BY A MEDICAL DOCTOR. THIS SHOULD BE DONE WITHIN 60 DAYS OF REQUESTED SERVICE.

Denial Code	Long Description
PD04	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 30 DAYS OF RECEIPT BY COLORADO MEDICAID.
PD07	SUBMIT A PHOTOCOPY OF A VALID PRESCRIPTION, ISSUED WITHIN THE PAST YEAR, OR COMPLETE SECTION B OF THE PRIOR AUTHORIZATION/DRUG ATTACHMENT (PA/DGA), F-11049.
PD10	BRAND MEDICALLY NECESSARY MUST BE IN THE PRESCRIBERS OWN HANDWRITING AND WRITTEN DIRECTLY ON THE PRESCRIPTION OR A SEPARATE ORDER ATTACHED TO THE ORIGINAL PRESCRIPTION.
PD12	COMPLETE DENTURES, PARTIAL DENTURES, DENTURE RELINES, AND FIXED PROSTHODONTIC SERVICES ARE NOT COVERED SERVICES FOR ADULTS FOR DATES OF SERVICE ON AND AFTER OCTOBER 1, 1995.
PD22	PLEASE COMPLETE ALL REQUIRED ELEMENTS ON THE PERSONAL CARE SCREENING TOOL (PCST), F-11133.
PD24	THIS PRIOR AUTHORIZATION REQUEST IS UNABLE TO BE PROCESSED. PLEASE RESUBMIT WITH ADDITIONAL REQUIRED FORMS, INCLUDING THE ENTIRE PERSONAL CARE SCREENING TOOL (PCST), F-11133; PERSONAL CARE ADDENDUM, F-11136; AND SUPPORTING DOCUMENTATION, AS DIRECTED.
PD25	THERE IS A PERSONAL CARE SCREENING TOOL (PCST), F-11133, COMPLETED BY ANOTHER AGENCY. CONTACT THE AGENCY TO TRANSFER SCREEN.
PD26	THERE IS A LIMITED TERM CARE FUNCTIONAL SCREEN (LTC-FS) COMPLETED BY ANOTHER AGENCY. THE PERSONAL CARE SCREENING TOOL (PCST), F-11133, INFORMATION IS IN CONFLICT WITH LTC-FS.
PD27	ONLY ONE LEVEL OF FUNCTION MAY BE SELECTED FOR ALL ELEMENTS EXCEPT TOILETING. COLORADO MEDICAID IS UNABLE TO PROCESS THE PRIOR AUTHORIZATION REQUEST.
PD28	NO UNITS MAY BE REQUESTED USING THIS PRIOR AUTHORIZATION PROCESS. PLEASE SUBMIT WITH THE APPROPRIATE ATTACHMENTS FOR REQUESTING SPECIFIC PERSONAL CARE WORKER UNITS.
PD29	CLIENT IS NOT ELIGIBLE FOR THE REQUESTED SERVICE(S) AS OF THE REQUESTED START DATE.
PD30	NO TRAVEL TIME MAY BE AUTHORIZED WHEN NO PERSONAL CARE WORKER SERVICE IS AUTHORIZED.
PD32	PROVIDER NOT CERTIFIED TO RENDER THE SERVICE(S) REQUESTED.
PD34	BASED ON THE DOCUMENTATION SUBMITTED, THIS REQUEST CAN NOT BE PRIOR AUTHORIZED. REFER TO THE PA MESSAGES FROM THE CONSULTANT FOR COMPLETE EXPLANATION.
PD98	PLEASE DOCUMENT HOW AND WHEN EACH PREVIOUSLY AUTHORIZED PRO RE NATA VISIT WAS USED.

Community Mental Health Supports Waiver (CMHS)

Denial Code	Long Description
0201	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
0233	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0235	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0237	CLIENT IDENTIFICATION NUMBER DOES NOT MATCH CLIENTS FIRST NAME.
0238	THE CLIENT IDENTIFICATION NUMBER DOES NOT MATCH THE CLIENTS LAST NAME.
0242	SECONDARY DIAGNOSIS CODE IS INVALID.
0248	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0249	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0251	PROCEDURE CODE MODIFIER IN FIRST POSITION IS INVALID.
0252	THE PROCEDURE CODE MODIFIER IN SECOND POSITION IS INVALID FOR REQUESTED START DATE OR DATE OF RECEIPT.
0253	THE PROCEDURE CODE MODIFIER IN THIRD POSITION IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
0258	THE PRIMARY DIAGNOSIS CODE IS REQUIRED.
0272	THE PRIMARY DIAGNSOSIS CODE IS INVALID.
0400	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0853	HCPCS - ANNUAL UPDATE
0885	NEVER EVENTS MODIFIERS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
0886	NEVER EVENTS DIAGNOSIS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.

Denial Code	Long Description
1000	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
1002	RENDERING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1003	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1007	RENDERING PROVIDER ID IS NOT ON FILE.
1047	THE RENDERING PROVIDERS CERTIFICATION HAS BEEN CANCELLED.
1048	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1801	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
1804	A CERTIFIED SUBSTANCE ABUSE DAY TREATMENT PROVIDER MUST SUBMIT A SUBSTANCE ABUSE DAY TREATMENT PROCEDURE CODE.
1806	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
1808	THE BILLING PROVIDER DOES NOT HAVE THE REQUIRED CERTIFICATION ADDENDUM ON FILE.
1900	THE BILLING PROVIDERS TAXONOMY CODE IS INVALID.
1901	THE RENDERING PROVIDERS TAXONOMY CODE IS INVALID.
1927	A NATIONAL PROVIDER IDENTIFIER IS REQUIRED FOR THE BILLING PROVIDER.
1934	A NATIONAL PROVIDER INDENTIFIER IS REQUIRED FOR THE RENDERING PROVIDER.
1936	THE BILLING PROVIDER NUMBER IS INVALID.
1937	THE RENDERING PROVIDER NUMBER IS INVALID.
1960	INTERNAL PROCESSING IS REQUIRED.
1963	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.
1964	THE BILLING PROVIDER INDICATED IS NOT ALLOWABLE AS A BILLING PROVIDER.
1965	RENDERING PROVIDER NUMBER IS MISSING/INVALID FOR THIS PROCEDURE PROVIDER.
1974	PRESCRIBING/REFERRING/ORDERING PROVIDER INDICATED IS NOT CERTIFIED AS A PRESCRIBING/REFERRING/ORDERING PROVIDER.
1975	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
1976	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
2001	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2003	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2017	THE CLIENT IS ENROLLED IN A MEDICAID OR OTHER MANAGED CARE PROGRAM.
2037	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2603	CLIENT LOCKED-IN TO A PROVIDER OR ENROLLED IN A HOSPICE. CONTACT CLIENTS HOSPICE FOR PAYMENT OF SERVICES OR RESUBMIT WITH DOCUMENTATION OF UNRELATED NATURE OF CARE.
3324	THE MODIFIER HAS BEEN DISCONTINUED BY THE CENTERS OF MEDICARE AND MEDICAID SERVICES OR THE AMERICAN MEDICAL ASSOCIATION FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
3337	THE PROCEDURE CODE HAS BEEN TERMINATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AMERICAN MEDICAL ASSOCIATION, OR AMERICAN DENTAL ASSOCIATION FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT. RESUBMIT WITH VALID A PROCEDURE CODE.
3339	THE PROCEDURE BILLED IS NOT PAYABLE ACCORDING TO DEFICIT REDUCTION ACT (DEFRA) GUIDELINES.
3351	THE PROCEDURE IS NOT COVERED FOR CLIENTS WITH A NURSING HOME AUTHORIZATION ON THE REQUESTED START DATE OR DATE OF RECEIPT.
3353	THE PROCEDURE IS NOT A COVERED SERVICE FOR HOME AND COMMUNITY-BASED WAIVER CLIENTS.
4021	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4027	THE DIAGNOSIS CODE IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
4031	THE PROCEDURE SUBMITTED IS NOT APPROPRIATE FOR CLIENTS GENDER.
4032	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4034	THE PROCEDURE CODE HAS AN AGE RESTRICTION.
4036	THE PLACE OF SERVICE CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4040	THE PRIMARY DIAGNOSIS CODE IS NOT ON FILE.
4041	THE SECONDARY DIAGNOSIS IS NOT ON FILE.
4046	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4127	INTERNAL PROCESSING IS REQUIRED.
4131	INTERNAL PROCESSING IS REQUIRED.
4141	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.

Denial Code	Long Description
4149	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4150	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4236	ETIOLOGY DIAGNOSIS CODE(S) (E-CODES) ARE INVALID AS THE PRIMARY DIAGNOSIS.
4244	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4245	THE FOURTH POSITION MODIFIER IS INVALID FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT.
4256	THE PROCEDURE CODE AND MODIFIER COMBINATION IS NOT PAYABLE FOR THE CLIENTS BENEFIT PLAN.
4257	THE MODIFIERS SUBMITTED ARE EITHER INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT OR THE MODIFIERS ARE MISSING.
4311	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4315	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4316	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4371	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4372	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4711	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR CLIENTS AGE.
4714	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS AGE.
4731	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS DIAGNOSIS.
4742	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4743	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4744	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4745	DIAGNOSIS AND/OR PROCEDURE AND/OR PLACE OF SERVICE (POS) CODE IS NOT COVERED FOR EXPRESS ENROLLMENT CLIENTS.
4746	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4801	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4802	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
4821	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
4871	PLEASE REFER TO PA MESSAGES FOR RETURN INFORMATION.
4963	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS GENDER.
4990	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
7500	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
7509	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
P001	THE BILLING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THE SERVICES.
P002	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P003	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P005	THE PRIOR AUTHORIZATION CAN NOT BE END DATED. THE PRIOR AUTHORIZATION STATUS IS NOT APPROVED OR APPROVED WITH REVISIONS.
P006	PLEASE FURNISH THE PROCEDURE CODE AND CORRESPONDING DESCRIPTION.
P008	THE BILLING PROVIDER NUMBER IS INVALID.
P009	THE BILLING PROVIDER NUMBER IS INVALID.
P010	THE REQUESTED END DATE IS INVALID.
P011	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P012	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P013	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P014	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P015	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P016	THE REQUESTED START DATE IS MISSING OR INVALID.

Denial Code	Long Description
P019	THE REQUESTED START DATE IS MISSING OR INVALID.
P020	THE RENDERING PROVIDER NUMBER IS INVALID.
P021	THE RENDERING PROVIDER NUMBER IS INVALID.
P022	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P023	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P024	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P026	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P027	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P030	FIRST MODIFIER IS INVALID.
P031	FIRST MODIFIER IS INVALID.
P032	SECOND MODIFIER IS INVALID.
P033	SECOND MODIFIER IS INVALID.
P034	THIRD MODIFIER IS INVALID.
P035	THIRD MODIFIER IS INVALID.
P036	FOURTH MODIFIER IS INVALID.
P037	FOURTH MODIFIER IS INVALID.
P038	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P039	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P040	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P041	CLIENTS FIRST NAME IS MISSING.
P042	CLIENTS LAST NAME IS MISSING.
P043	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P044	BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES REQUESTED.
P045	FIRST MODIFIER IS INVALID.
P046	SECOND MODIFIER IS INVALID.
P047	THIRD MODIFIER IS INVALID.
P048	FOURTH MODIFIER IS INVALID.
P052	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P053	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P054	RENDERING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES FOR THE BENEFIT PLAN.
P055	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P061	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P062	THE CLIENT ID AND/OR NAME INDICATED ON THE PA REQUEST IS INCORRECT. THE CLIENT ID AND/OR NAME HAS BEEN UPDATED. PLEASE VERIFY THE ID AND/OR NAME IS CORRECT.
P064	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
P067	THE FREQUENCY OF HOURS REQUESTED ARE NOT APPROPRIATE FOR THIS CLIENT AND HAVE BEEN MODIFIED ACCORDINGLY.
P079	BILLING PROVIDER IS ON PAYMENT SUSPENSION DUE TO CREDIBLE ALLEGATION OF FRAUD.
P120	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAS BEEN REDUCED.
P121	THE SERVICE/ PROCEDURE REQUESTED IS NOT SUPPORTED BY SUBMITTED DOCUMENTATION.
P126	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
P128	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.
P138	SERVICE(S) DO NOT MEET COLORADO MEDICAID GUIDELINES.
P167	REQUESTED DOCUMENTATION HAS NOT BEEN SUBMITTED.
P178	THE SERVICE REQUESTED IS NOT MEDICALLY NECESSARY.
P179	THE MEDICAL NECESSITY FOR THIS SERVICE IS NOT SUPPORTED BY THE SUBMITTED DOCUMENTATION.
P233	THE DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE ADDITIONAL CARE.

Denial Code	Long Description
P257	THIS CLIENTS FUNCTIONAL ASSESSMENT SCORES PLACE THIS CLIENT OUTSIDE ELIGIBILITY FOR DAY TREATMENT.
P274	OUR RECORDS INDICATE THIS CLIENT IS INVOLVED IN EFFECTIVE AND APPROPRIATE SERVICE ELSEWHERE.
P292	INTENSIVE REHABILITATION HOURS ARE NO LONGER APPROPRIATE AS INDICATED BY HISTORY, DIAGNOSIS, AND/ OR FUNCTIONAL ASSESSMENT SCORES.
P328	THE SERVICES REQUESTED INCLUDE NON-COVERED SERVICES, AND HOURS ARE REDUCED ACCORDINGLY.
P339	THE CLIENTS PAST HISTORY INDICATES REDUCED TREATMENT HOURS ARE WARRANTED.
P342	THE REQUEST DOES NOT MEET GENERALLY ACCEPTED CONDITIONS REQUIRING FLUORIDE TREATMENTS.
P346	SERVICES EXCEED COLORADO MEDICAID LIMITATION AND DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE MEDICAL NECESSITY OF THE SERVICE.
P349	THE SERVICE REQUESTED WAS PERFORMED LESS THAN FIVE YEARS AGO.
P353	THE EXISTING APPLIANCE HAS NOT BEEN WORN FOR THREE YEARS.
P367	THE CLIENT HAS BEEN TOTALLY WITHOUT TEETH AND AN APPLIANCE FOR FIVE YEARS.
P392	THE CLIENT IS MISSING AN ANTERIOR TOOTH AND/OR HAS TWO OR MORE POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P405	THE SERVICE(S) REQUESTED COULD ADEQUATELY BE PERFORMED IN THE DENTAL OFFICE.
P406	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE OF GOOD PERIODONTAL HEALTH (AMERICAN ACADEMY OF PERIODONTOLOGY PERIODONTAL CLASSIFICATION OF TYPE I OR II).
P407	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE VISIBLE ON RADIOGRAPHS THAT AT LEAST 50 PERCENT OF THE CLINICAL CROWN IS INTACT.
P409	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING SIX OR MORE TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED, INCLUDING THIRD MOLARS.
P410	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING ONE OR MORE ANTERIOR TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED.
P411	DOCUMENTATION DOES NOT SUPPORT THE NEED FOR PERIODONTIC SERVICES. POCKETS ARE LESS THAN 4MM AND/OR GREATER THAN 6MM FOR CLIENT AND/OR THE CLIENT IS UNDER THE AGE OF 13.
P412	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA.
P413	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA. THIS PA HAS BEEN GRANTED AS APPROVED NOT APPROVED WITH REVISIONS. THE DURATION REQUESTED MAY HAVE BEEN REDUCED TO REFLECT COVERAGE LIMITATIONS, PRESCRIBER ORDERS, CONFLICTI
P417	THE SERVICE(S) REQUESTED COULD BE ADEQUATELY PERFORMED WITH LOCAL ANESTHESIA.
P437	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO POOR ORAL HYGIENE.
P444	THIS LINE ITEM IS A DUPLICATE OF ANOTHER LINE ITEM ON THIS PRIOR AUTHORIZATION (PA) REQUEST. PLEASE CORRECT.
P446	THIS IS A DUPLICATE OF AN EXISTING PRIOR AUTHORIZATION (PA) REQUEST. YOU MAY CONTACT PROVIDER SERVICES IF YOU REQUIRE ASSISTANCE. DUPLICATE PA REQUEST
P448	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO DECAY HISTORY.
P449	QUESTIONABLE LONG TERM PROGNOSIS DUE TO GUM AND BONE DISEASE.
P456	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO APPARENT ROOT INFECTION.
P457	OUR RECORDS INDICATE THIS CLIENT HAS EXCEEDED ESTABLISHED PROGRAM LIMITATIONS. COLORADO MEDICAID WILL NOT AUTHORIZE NEW DENTURES.
P458	DOCUMENTATION PROVIDED INDICATES A LESS ELABORATE PROCEDURE SHOULD BE CONSIDERED.
P502	RENTAL ONLY ALLOWED; MEDICAL NEED FOR PURCHASE HAS NOT BEEN DOCUMENTED.
P503	PURCHASE ONLY ALLOWED; MEDICAL NEED FOR RENTAL HAS NOT BEEN DOCUMENTED.
P504	OCCUPATIONAL THERAPY GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P505	THE SERVICE REQUESTED IS INCLUDED IN THE NURSING HOME RATE STRUCTURE.
P511	THIS NATIONAL DRUG CODE IS ONLY BILLABLE AS PART OF A COMPOUND DRUG.
P515	THE PRESENCE OF A HANDICAPPING MALOCCLUSION OR HANDICAPPING DENTOFACIAL DEFORMITY IS NOT SUPPORTED BY THE DOCUMENTATION SUBMITTED.
P521	THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVERED BY COLORADO MEDICAID.

Denial Code	Long Description
P522	GASTRO-INTESTINAL SURGERY FOR THE PURPOSE OF WEIGHT CONTROL IS COVERED ONLY AS A LIFE THREATENING PROCEDURE.
P523	THE TREATMENT REQUEST IS NOT CONSISTENT WITH THE CLIENT'S DIAGNOSIS.
P524	PSYCHOTHERAPY PROVIDED IN THE CLIENTS HOME IS NOT A COVERED BENEFIT OF COLORADO MEDICAID.
P525	THE INFORMATION PROVIDED IS NOT CONSISTENT WITH THE INTENSITY OF SERVICES REQUESTED.
P526	INTENSIVE MULTIPLE MODALITY TREATMENT IS NOT CONSISTENT WITH THE INFORMATION PROVIDED.
P527	MULTIPLE PROVIDERS OF TREATMENT ARE NOT INDICATED FOR THIS CLIENT.
P528	THE DURATION OF TREATMENT SESSIONS EXCEED CURRENT COLORADO MEDICAID GUIDELINES.
P534	DOCUMENTATION OF POOR PHYSICAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P535	OTHER PHYSICAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P536	THE PHYSICAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P537	USE OF PHYSICAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P538	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF A PHYSICAL THERAPIST.
P539	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS AND LIVING ARRANGEMENT.
P540	GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P541	THE PROCEDURE(S) REQUESTED ARE NOT MEDICAL IN NATURE.
P542	DOCUMENTATION OF POOR OCCUPATIONAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P543	DOCUMENTATION OF POOR SPEECH THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P544	OTHER OCCUPATIONAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P546	THE OCCUPATIONAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P547	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF PHYSICAL THERAPY.
P548	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P549	ACTIVITIES TO PROMOTE DIVERSION OR GENERAL MOTIVATION ARE NONCOVERED COLORADO MEDICAID SERVICES.
P550	REVISIONS OF THE REQUEST IS NECESSITATED BY THE CLIENTS MINIMAL PROGRESS.
P551	RESTORATIVE NURSING INVOLVEMENT COULD BE INCREASED.
P552	CLIENTS DEMONSTRATED RESPONSE TO CURRENT THERAPY DOES NOT WARRANT THE INTENSE FREQUENCY REQUESTED.
P553	MAINTENANCE IS TWO TIMES PER WEEK OR LESS.
P554	THE SPEECH THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P555	USE OF OCCUPATIONAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P556	USE OF SPEECH THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P557	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF AN OCCUPATIONAL THERAPIST.
P558	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
P559	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P560	THE MATERIALS/ SERVICES REQUESTED ARE PRINCIPALLY COSMETIC IN NATURE.
P561	THE LENS FORMULA DOES NOT JUSTIFY REPLACEMENT.
P562	THE CHANGE IN THE LENS FORMULA DOES NOT WARRANT MULTIPLE REPLACEMENTS.
P563	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P564	LENSES ONLY ARE APPROVED; PLEASE DISPENSE A CONTRACTED FRAME. THE NON-CONTRACTED FRAME IS NOT MEDICALLY JUSTIFIED.
P565	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.

Denial Code	Long Description
P566	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P567	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF OCCUPATIONAL THERAPY.
P568	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF SPEECH THERAPY.
P569	LEVEL, INTENSITY, OR EXTENT OF SERVICE(S) REQUESTED HAS BEEN MODIFIED CONSISTENT WITH MEDICAL NEED AS DEFINED IN THE PLAN OF CARE.
P570	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P571	THE SERVICE ASKED FOR IS NOT COVERED BY COLORADO MEDICAID AS THESE TASKS CAN BE DONE BY NURSES OR ACTIVITY STAFF.
P572	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P573	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.
P574	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P575	MEDICAL NEED FOR EQUIPMENT/ SUPPLY REQUESTED IS NOT SUPPORTED BY DOCUMENTATION SUBMITTED.
P576	OTHER SPEECH THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P577	DOCUMENTATION SUBMITTED IDENTIFIES THAT THE CLIENT HAS FEWER THAN TWO POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P582	LESS EXPENSIVE ALTERNATIVE SERVICES ARE AVAILABLE FOR THIS CLIENT.
P634	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P711	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING PERIODONTAL SCALING AND ROOT PLANNING.
P712	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING GINGIVECTOMY.
P754	AN APPROVED SUBSTANCE ABUSE DAY TREATMENT PROGRAM CANNOT EXCEED A SIX WEEK PERIOD.
P761	THE CLIENT DOES NOT APPEAR TO BE ABLE OR WILLING TO ABSTAIN FROM ALCOHOL/DRUG USAGE WHILE IN TREATMENT. THEREFORE, SUBSTANCE ABUSE DAY TREATMENT SERVICES ARE NOT APPROVED.
P764	THIS CLIENT HAS COMPLETED INTENSIVE SUBSTANCE ABUSE TREATMENT WITHIN THE PAST 12 MONTHS. THE DOCUMENTATION PROVIDED IS NOT ADEQUATE TO JUSTIFY ADDITIONAL INTENSIVE TREATMENT AT THIS TIME.
P785	A LESS THAN SIX-WEEK HEALING PERIOD HAS BEEN SPECIFIED FOR THIS PRIOR AUTHORIZATION. THEREFORE IT IS NOT NECESSARY TO WAIT THE FULL SIX WEEKS AFTER EXTRACTIONS BEFORE TAKING DENTURE IMPRESSIONS.
P818	SIX-WEEK HEALING TIME IS REQUIRED BETWEEN EDENTULATION AND FINAL IMPRESSIONS. PAYMENT FOR DENTURES WILL BE DENIED OR RECOUPED IF HEALING PERIOD IS NOT OBSERVED.
P849	COLORADO MEDICAID HAS DETERMINED THERE WERE (ARE) SEVERAL HOME HEALTH AGENCIES WILLING TO PROVIDE MEDICALLY NECESSARY SKILLED NURSING SERVICES TO THIS CLIENT.
P864	THE DOCUMENTATION YOU HAVE SUBMITTED DOES NOT MEET THE REQUIREMENTS OF COLORADO MEDICAID.
P873	THE MEDICAL NECESSITY FOR THE HOURS REQUESTED IS NOT SUPPORTED BY THE INFORMATION SUBMITTED.
P874	THE DOCUMENTATION SUBMITTED INDICATES THE TASKS SPECIFIED CAN BE COMPLETED DURING THE VISITS APPROVED.
P878	THE DOCUMENTATION SUBMITTED DOES NOT INDICATE THAT MEDICALLY ORIENTED TASKS ARE MEDICALLY NECESSARY; THEREFORE PERSONAL CARE SERVICES HAVE BEEN APPROVED.
P880	THE QUANTITY OF SERVICES AUTHORIZED FOR THIS CLIENTS PERSONAL CARE HAS BEEN AMENDED BASED ON INFORMATION RECEIVED FROM ONE OR MORE OF THESE SOURCES: THE CLIENT, THEIR PHYSICIAN, AND/OR THE IN-HOME VISIT BY STAFF OF THE OIG (OFFICE OF INSPECTOR GENERAL).
P885	THE USE OF THIS DRUG FOR THE INTENDED PURPOSE IS NOT COVERED BY COLORADO MEDICAID, CONSISTENT WITH COLORADO ADMINISTRATIVE CODE AND FEDERAL LAW.

Denial Code	Long Description
P924	THE MEDICAL RECORDS SUBMITTED WITH THE CURRENT REQUEST CONFLICT OR DISAGREE WITH OUR MEDICAL RECORDS ON THIS CLIENT.
P950	INDEPENDENT NURSES, PLEASE NOTE PAYABLE SERVICES MAY NOT EXCEED 12 HOURS/DAY OR 60 HOURS/WEEK.
P951	SERVICES CAN ONLY BE AUTHORIZED THROUGH ONE YEAR FROM THE PRESCRIPTION DATE.
P952	LEAD INSPECTION IS A COVERED COLORADO MEDICAID SERVICE WHEN THE CHILD HAS BEEN SHOWN TO HAVE LEAD POISONING (E.G., CHILD HAS A BLOOD LEAD LEVEL > 19 UG/DL OR TWO CONSECUTIVE BLOOD LEAD LEVELS OF 15-19 UG/DL DONE AT LEAST 90 DAYS APART). THE INSPECTION MUS
P953	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P954	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P956	THE REQUEST CAN ONLY BE BACKDATED A MAXIMUM OF 14 DAYS FROM FIRST DATE RECEIVED BY COLORADO MEDICAID.
P957	COMPLETE PERIODONTAL CHARTING AT TIME OF SERVICE, AND SUBMIT CHARTING, COPY OF OPERATIVE REPORT, TOGETHER WITH A COPY OF THE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF), F-11035, TO PA UNIT ATTENTION DENTAL CONTSULTANT.
P958	NOTE THAT CODE D4341 HAS BEEN CHANGED. REFER TO THE DECISION NOTICE FOR AUTHORIZED QUANTITY.
P960	YOUR PA HAS BEEN APPROVED FOR 90 DAYS. THE 90 DAY APPROVAL DOES NOT IMPLY THE PA REQUEST MEETS PRIOR AUTHORIZATION CRITERIA. AFTER ADDITIONAL INFORMATION IS AVAILABLE IN INTERCHANGE, COLORADO MEDICAID WILL CREATE AN AMENDMENT REQUEST TO EXTEND THE PA FOR
P961	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P962	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
PA10	THE REQUESTED END DATE IS INVALID.
PA12	PLEASE FURNISH A WRITTEN DESCRIPTION OF THE CLIENTS DIAGNOSIS.
PA13	PROVIDE DIAGNOSES WITH DATES OF ONSET.
PA14	IDENTIFY PROBLEMS TO BE TREATED.
PA15	THE AUDIOLOGISTS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1), F-11020, AND PRIOR AUTHORIZATION REQUEST/HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2), F-11021.
PA16	THE PHYSICIANS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION/PHYSICIAN OTOLOGICAL REPORT (PA/POR), F-11019.
PA17	SUBMIT BRIEF HISTORY WITH REFERRAL INFORMATION, LIVING SITUATION, FUNCTIONAL STATUS, AND OTHER PERTINENT INFORMATION. WHAT CHANGE OF STATUS RESULTED IN REFERRAL AT THIS TIME?
PA18	PLEASE FURNISH THE CLIENTS HEIGHT AND WEIGHT.
PA19	PLEASE SUBMIT CLINICAL INFORMATION SUFFICIENT TO VERIFY THE NEED FOR THE REQUESTED SERVICE(S).
PA20	PLEASE RESUBMIT WITH COMPLETE PERIODONTAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PA21	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL EDUCATIONAL PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA22	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL PROGRAM PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA23	REFER TO THE DURABLE MEDICAL EQUIPMENT INDEX FOR APPROPRIATE CODE AND DESCRIPTION. DO NOT USE AN "UNLISTED" CODE.
PA24	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUALIZED FAMILY SERVICE PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA25	INFORMATION ON THE REQUEST FORM IS ILLEGIBLE, AND THE REQUEST CANNOT BE PROCESSED.
PA26	RE-EVALUATE YOUR GOALS. EMPHASIS SHOULD BE ON FUNCTIONAL SELF-CARE. GOALS MUST BE RELATED TO FUNCTIONAL OUTCOME.

Denial Code	Long Description
PA27	PLEASE CLARIFY THE NUMBER OF HOURS PER WEEK REQUESTED.
PA28	PLEASE CLARIFY THE NUMBER OF HOURS PER DAY REQUESTED.
PA29	PLEASE CLARIFY THE NUMBER OF VISITS PER DAY REQUESTED.
PA30	ATTACH SUPPORTIVE DOCUMENTATION; HOME EXERCISE PROGRAM AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA31	THE DIAGNOSIS CODE INDICATED ON THE REQUEST DOES NOT CORRESPOND TO THE DIAGNOSIS CODE DESCRIPTION.
PA32	PLEASE SUBMIT ADDITIONAL INFORMATION SUFFICIENT TO VERIFY APPROPRIATENESS AND NEED FOR TRANSPLANT.
PA33	PLEASE SUBMIT THE INITIAL AND PROGRESSIVE OBJECTIVE FINDINGS.
PA34	ATTACH SUPPORTIVE DOCUMENTATION, FACILITY PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA35	PLEASE SUBMIT THE CLIENTS ORIGINAL COMPLAINTS AND EXAMINATION FINDINGS.
PA36	ATTACH SUPPORTIVE DOCUMENTATION, IN-HOME AUTISM PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA37	PLEASE SUBMIT YOUR TREATMENT PLAN FOR THIS CLIENT.
PA38	ATTACH SUPPORTIVE DOCUMENTATION AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA39	INITIAL EVALUATIONS MUST BE PERFORMED BY AN OCCUPATIONAL THERAPIST REGISTERED (OTR), PER AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA) STANDARDS.
PA41	IDENTIFY THE PLACE OF SERVICE AND ITS EFFECT ON SUPPORTING THE DESIRED TREATMENT OUTCOME.
PA42	PLEASE INDICATE THE HOURS OF USE OF OXYGEN PER 24-HOUR PERIOD.
PA43	PROVIDE BASELINE DOCUMENTATION FOR THIS CLIENTS LIMITATIONS USING UNITS OF MEASUREMENT THAT ARE APPLIED CONSISTENTLY WHEN REPORTING STATUS.
PA44	IDENTIFY FUNCTIONAL LIMITATIONS AS THEY ARE RELATED TO IDENTIFIED CONDITIONS.
PA46	CORRELATE PLAN OF CARE TO REQUESTED PROCEDURE CODES.
PA47	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE FREQUENCY/DURATION REQUESTED.
PA48	PLEASE PROVIDE THE NAME AND CREDENTIALS OF THE RENDERING PROVIDER.
PA50	COLORADO MEDICAID RECORDS INDICATE THE CLIENT OWNS A WHEELCHAIR. DOCUMENT THE REASON AND NEED FOR REPLACEMENT AND COST TO REPAIR CURRENT WHEELCHAIR.
PA51	PLEASE DISTINGUISH PRIMARY AND SUPPORTIVE MODALITIES.
PA52	PLEASE SUBMIT A PROGRESS REPORT.
PA53	MULTIPLE FAMILY CLIENTS TREATMENT BY THE SAME PROVIDER REQUIRES FURTHER INFORMATION DOCUMENTING COORDINATION OF TREATMENT PLAN.
PA54	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE MINUTES REQUESTED.
PA55	MEDICAL NECESSITY OF TREATMENT REQUIRES ADDITIONAL DOCUMENTATION.
PA56	GIVEN AGE, DIAGNOSES, CURRENT LEVEL OF FUNCTION, PAST RESPONSE TO TREATMENT, AND LIVING SITUATION, EXPAND ON POTENTIAL FOR SIGNIFICANT FUNCTIONAL PROGRESS WITHIN THE NEXT SIX MONTHS. EMPHASIZE WHY PROGRESS IS EXPECTED WITH SERVICES AT THIS TIME.
PA57	SUBMIT THE INITIAL FINDINGS. INCLUDE A COMPREHENSIVE EVALUATION.
PA58	SUBMIT PROGRESSIVE, OBJECTIVE FINDINGS. INCLUDE A PERTINENT RE-EVALUATION.
PA59	PLEASE SUPPLY INFORMATION REGARDING THE CLIENTS MEDICATION REQUIREMENTS, IF ANY.
PA60	PLEASE SPECIFY IF THE CLIENT IS IN AN EDUCATIONAL SETTING.
PA61	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA62	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
PA63	THE SKILLS OF A THERAPIST ARE PURPOSEFUL AND SKILLED INTERVENTIONS REQUIRED TO CONTINUALLY DESIGN, IMPLEMENT, REASSESS, MODIFY/GRADE, AND/OR DISCONTINUE A PLAN OF CARE IN A TIMELY MANNER, BASED ON THE COMPLEXITY OF THE CLIENTS MEDICAL CONDITION AND/OR CO
PA64	PLEASE SUBMIT A THERAPY PLAN OF CARE, INCLUDING A CURRENT, DATED EVALUATION.
PA65	A PLAN OF CARE SIGNED AND DATED BY THE PHYSICIAN IS REQUIRED.

Denial Code	Long Description
PA66	THE SKILLS OF A THERAPIST ARE REQUIRED WHEN ONLY THE THERAPIST CAN SAFELY AND EFFECTIVELY DELIVER THE THERAPEUTIC PROCEDURES BECAUSE OF THEIR UNIQUE KNOWLEDGE, TRAINING, AND EXPERTISE. DESCRIBE THE REASON THAT SOMEONE OTHER THAN A THERAPIST CANNOT SAFELY
PA67	PLEASE SPECIFY IF THE CLIENTS WORK SITE DEMANDS GOOD BINAURAL HEARING.
PA68	DESCRIBE THE REASON, BASED ON THE CLIENTS COGNITIVE, PHYSICAL, COMMUNICATION, OR RESOURCE STATUS, THAT A HOME PROGRAM, EQUIPMENT, OR ENVIRONMENTAL ADAPTATIONS ALONE CANNOT MEET CLIENTS NEEDS.
PA69	PLEASE SPECIFY IF THE CLIENT HAS AN ACCOMPANYING DISABILITY THAT ADDS TO THE HEARING PROBLEM.
PA70	DISTINGUISH REQUESTED PROCEDURES AND GOALS FROM OTHER SERVICES THIS CLIENT RECEIVES. THEY MAY NOT BE DUPLICATIVE.
PA71	PLEASE INDICATE THE NUMBER OF DAYS REQUESTED.
PA73	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA74	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA75	PLEASE DOCUMENT CARRYOVER OF THE THERAPY PROGRAM TO NURSING.
PA76	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA79	PROVIDE EVIDENCE OF SIGNIFICANT FUNCTIONAL PROGRESS IN LAST SIX MONTHS.
PA84	THE GRANT DATE OF THIS REQUEST CANNOT BE PRIOR TO THE SIGNATURE DATE OF THE PRESCRIBING PHYSICIAN.
PA86	PROVIDE EVIDENCE OF SKILLS GAINED IN THERAPY CARRYING OVER TO OTHER SETTINGS WITHIN SIX MONTHS.
PA87	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE NUMBER OF SESSIONS REQUESTED.
PA88	THE REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL SCOPE OF PRACTICE.
PA89	PRIOR AUTHORIZATION IS NOT REQUIRED UNTIL LIMITATION OF SERVICE HAS BEEN REACHED.
PA91	PLEASE SUBMIT REQUIRED X-RAYS.
PA92	PLEASE PROVIDE AN EXPLANATION FOR THE MATERIAL SUBMITTED WITH THE REQUEST.
PA95	PLEASE DESCRIBE HOW THE PROVISION OF THIS SERVICE WOULD PREVENT INSTITUTIONALIZATION OF THE CLIENT.
PA96	COULD THE EXISTING DENTURE(S) BE RELINED OR REBASED? IF NOT, PLEASE EXPLAIN WHY NOT.
PA97	REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL STANDARDS OF PRACTICE.
PA98	PLEASE INDICATE IF THE CLIENT IS CURRENTLY BEING TUBE FED.
PB02	PLEASE PROVIDE THE REQUIRED DATED SIGNATURES ON THE ATTACHMENTS.
PB03	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING THE LOSS/DESTRUCTION/THEFT OF THE HEARING AID.
PB04	DESCRIBE THE CLIENTS ABILITY TO STAND OR AMBULATE SUFFICIENTLY TO ACCOMPLISH SELF-CARE ACTIVITIES.
PB07	PLEASE SUBMIT AN ORTHODONTIC STUDY MODEL OR DIAGNOSTIC CASTS.
PB09	PLEASE PROVIDE A PHOTOGRAPH OF THE INVOLVED AREA(S).
PB10	PLEASE PROVIDE AN ESTIMATION (IN GRAMS) OF THE TOTAL AMOUNT OF TISSUE TO BE RESECTED.
PB11	PLEASE SUBMIT THE PLAN OF CARE FOR CO-TREATMENT.
PB12	FURNISH A DETAILED DESCRIPTION FOR THE PROCEDURE CODE REQUESTED.
PB13	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB15	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB18	PLEASE COMPLETE THE ATTACHED OUT-OF-STATE PROVIDER DATA SHEET, F-11001, AND RESUBMIT.
PB20	A SIGNED AND DATED PRESCRIPTION IS REQUIRED WITHIN THREE MONTHS OF RECEIPT BY COLORADO MEDICAID FOR INITIAL REQUESTS AND WITHIN 12 MONTHS OF RECEIPT BY COLORADO MEDICAID FOR SUBSEQUENT REQUESTS.
PB21	PLEASE COMPLETE THE APPROPRIATE PRIOR AUTHORIZATION ATTACHMENT. CONTACT PROVIDER SERVICES OR THE PRIOR AUTHORIZATION UNIT FOR ASSISTANCE.
PB23	PHYSICAL THERAPY ASSISTANT NOTES AND ALL FORMS SUBMITTED MUST BE COSIGNED BY A REGISTERED PHYSICAL THERAPIST.

Denial Code	Long Description
PB31	ARE YOU REQUESTING A COMPLETE APPLIANCE, OR REPLACEMENT PARTS?
PB32	THE PROCEDURE CODE INDICATED ON THE REQUEST DOES NOT MATCH THE DESCRIPTION OF SERVICE; PLEASE CORRECT AND RESUBMIT.
PB35	THE SERVICE REQUESTED DOES NOT REQUIRE PRIOR AUTHORIZATION.
PB41	PLEASE FURNISH A CURRENT MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT, F-11090 (DATED WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID).
PB45	THE CERTIFICATION PERIOD ON THE PLAN OF CARE (POC) DOES NOT COVER THE REQUESTED GRANT/START DATE. PLEASE RESUBMIT YOUR REQUEST WITH A NEW POC.
PB49	A CERTIFIED OCCUPATIONAL THERAPY ASSISTANTS NOTES MUST BE COSIGNED BY AN OCCUPATIONAL THERAPIST REGISTERED.
PB51	ADDITIONAL INFORMATION IS REQUIRED ON PRIOR AUTHORIZATION TO ENABLE PRICING.
PB54	REQUESTED SERVICES DO NOT MATCH SERVICES ON THE PHYSICIANS ORDERS.
PB59	PLEASE PROVIDE AN INDIVIDUAL EDUCATIONAL PLAN (IEP), WHICH HAS BEEN SIGNED BY THE PROVIDER NO EARLIER THAN NINE MONTHS PRIOR TO RECEIPT AT COLORADO MEDICAID; OTHERWISE, DOCUMENT WHY NO IEP EXISTS.
PB65	PLEASE FURNISH THE ANTICIPATED TOTAL CHARGES FOR THIS REQUEST.
PB66	A PHOTOCOPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED; THE DATE MUST BE WITHIN SIX MONTHS OF RECEIPT BY COLORADO MEDICAID.
PB67	THE PRESCRIPTION DATE MUST INCLUDE MONTH, DAY, AND YEAR.
PB68	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID.
PB73	THE SERVICES IDENTIFIED ON THE PLAN OF CARE DO NOT APPEAR APPROPRIATE FOR THE PROCEDURE CODE(S) REQUESTED ON THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018.
PB74	THE CLIENT/PROVIDER DOES NOT HAVE RETROACTIVE ENROLLMENT.
PB75	THE REQUESTED START DATE IS MORE THAN 14 DAYS BEFORE OR 62 DAYS AFTER RECEIPT.
PB82	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
PB83	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A HOME HEALTH AIDE. PLEASE RESUBMIT AS A PERSONAL CARE WORKER OR PROVIDE ADDITIONAL DOCUMENTATION.
PB86	THE SERVICES REQUESTED ARE NOT BEING PROVIDED IN THE CLIENTS RESIDENCE. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL.
PB87	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A NURSE. PLEASE RESUBMIT AS A HOME HEALTH AIDE OR PROVIDE ADDITIONAL DOCUMENTATION.
PB92	PLEASE FURNISH THE CLIENTS COMPLETE ADDRESS.
PB94	IF THE CLIENT IS A RESIDENT OF A NURSING HOME, SUPPLY THE COMPLETE NAME AND ADDRESS OF THE NURSING HOME.
PB99	THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018, MUST BE SIGNED AND DATED.
PC01	PLEASE SUPPLY THE RENDERING PROVIDERS PROVIDER NUMBER.
PC03	THE DRUG ENFORCEMENT ADMINISTRATION NUMBER IS MISSING OR INVALID.
PC06	PLEASE DESCRIBE YOUR PROGRAM; INCLUDE ENTRY DATE, TERMINATION DATE, HOURS PER WEEK, AND NUMBER OF WEEKS OF PRIMARY INTENSIVE SERVICE REQUESTED.
PC07	PLEASE DESCRIBE YOUR "AFTERCARE/FOLLOW-UP" PLANS FOR THIS CLIENT.
PC08	PLEASE SUPPLY DOCUMENTATION OF PREVIOUS SUBSTANCE ABUSE SERVICES WITH DATE(S) AND OUTCOME.
PC09	PLEASE DESCRIBE IN DETAIL THE TREATMENT OBJECTIVES/GOALS FOR THIS CLIENT.
PC10	PLEASE DESCRIBE THE FAMILY SITUATION/DYNAMICS. EXPLAIN HOW THE FAMILY WILL BE INCORPORATED INTO THE CLIENTS PLAN OF CARE.
PC12	PLEASE EXPLAIN IF YOUR SERVICE ENCOURAGES THE CLIENT TO ATTEND SELF-HELP GROUPS.
PC13	PLEASE SUPPLY A SPECIFIC SCHEDULE OF ACTIVITIES, INCLUDING DAY, TIME OF DAY, LENGTH OF SESSION, AND SERVICE TO BE RENDERED DURING THAT TIME.
PC15	PLEASE FURNISH DIAGNOSTIC RATIONALE.
PC17	PLEASE DOCUMENT IF THE CLIENT EVER RECEIVED SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT.
PC19	PLEASE FURNISH MORE EXTENSIVE AND IN-DEPTH HISTORICAL AND PSYCHOSOCIAL DATA.
PC20	PLEASE SUPPLY THE DATE THE CLIENT BECAME TOTALLY ENDENTULOUS.

Denial Code	Long Description
PC23	PLEASE SUBMIT A PHYSICIANS STATEMENT REGARDING THE MEDICAL NECESSITY OF DENTURES FOR THIS CLIENT. THE PHYSICIANS STATEMENT MUST DOCUMENT THE MEDICAL NEED FOR DENTURES.
PC24	THE SERVICE REQUESTED WAS PREVIOUSLY AUTHORIZED. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT INDICATING THIS FACT IS REQUIRED.
PC25	PLEASE SUPPLY SUFFICIENT MITIGATING CIRCUMSTANCES TO WARRANT THE CONSTRUCTION OF NEW DENTURES(S).
PC26	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
PC28	PLEASE SUBMIT A PHYSICIANS STATEMENT INDICATING DENTURES ARE NECESSARY FOR THIS NURSING HOME CLIENT.
PC29	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING LOSS OR DESTRUCTION OF DENTURE(S). INCLUDE SIGNED STATEMENT FROM CLIENT OR FACILITY DIRECTOR REGARDING HOW, WHEN AND WHERE LOST.
PC30	PLEASE PROVIDE COMPLETE INTRAORAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PC31	PLEASE DESCRIBE ANY RELATED DEFORMITIES OF THE FEET.
PC34	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD WITH REQUESTED DME ITEM(S) AND DOCUMENT IF THE CLIENT CAN USE SAFELY AND INDEPENDENTLY.
PC35	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD AND DESCRIBE THE RESULTS AND EFFECTIVENESS OF THE SERVICE REQUESTED.
PC39	PLEASE INDICATE LITER FLOW PER MINUTE, HOURS OF USE PER 24 HOUR PERIOD, AND THE EXPECTED DURATION OF NEED.
PC40	THE ITEM DOES NOT REQUIRE PRIOR AUTHORIZATION UNTIL THE LIFE EXPECTANCY HAS BEEN REACHED.
PC41	PLEASE SUPPLY INFORMATION INDICATING THE NECESSITY OF POSITIONING THE CLIENT'S BODY IN MULTIPLE POSITIONS.
PC42	PLEASE INDICATE IF THE BED HEIGHT MUST BE CHANGED TO ALLOW FOR SAFE TRANSFER OR ADEQUATE BED CARE.
PC43	SUPPLY A PHYSICIANS STATEMENT INDICATING TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR UNIT HAS REDUCED PAIN, IMPROVED/INCREASED THE CLIENTS ACTIVITY LEVEL, AND/OR REDUCED CLIENTS USE OF PAIN MEDICATION.
PC44	A CURRENT AUTHORIZATION FOR THIS SERVICE IS ON FILE FOR ANOTHER PROVIDER. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT OF THAT FACT IS REQUIRED BY THE CLIENT OF FIRST PROVIDER.
PC59	DOCUMENT DECLINE OR PROGRESS IN SPECIFIC, MEASURABLE, OBJECTIVE TERMS.
PC60	DOCUMENT IF CLIENT HAS DEMONSTRATED A GOOD APPOINTMENT COMPLIANCE RECORD.
PC61	THE PHYSICIANS SIGNATURE DATE MUST NOT EXCEED 90 DAYS FROM THE DATE OF RECEIPT BY COLORADO MEDICAID.
PC62	REQUESTS FOR A CONTINUATION OF THERAPY SHOULD NOT BE SUBMITTED MORE THAN FOUR WEEKS PRIOR TO THE EXPIRATION DATE OF THE CURRENT AUTHORIZATION.
PC63	PLEASE FURNISH THE STYLE AND MANUFACTURER OF THE FRAME.
PC64	PLEASE FURNISH THE CLIENTS LENS FORMULA.
PC66	ALL REQUESTS FOR TINTS REQUIRE DOCUMENTATION OF THE VISUAL OR MEDICAL CONDITION RELATED TO PHOTOPHOBIA.
PC67	PLEASE DOCUMENT THE REASON AND JUSTIFICATION FOR REPLACEMENT BEYOND THE FIRST LENS/FRAME.
PC68	DOCUMENT IF ALL REMAINING MAXILLARY AND/OR MANDIBULAR TEETH ARE DECAY-FREE, PROPERLY RESTORED, AND PERIODONTICALLY SOUND.
PC72	SUPPLY MORE DETAIL REGARDING PROGRESS (ATTACHMENT OF GOALS, ETC.). CORRELATE PROGRESS TO PREVIOUS GOALS AND IDENTIFIED LIMITATIONS.
PC77	PLEASE SUBMIT A PLAN OF CARE DESCRIBING THE SERVICES THAT WOULD BE PROVIDED.
PC78	PLEASE DOCUMENT SPECIFIC, MEASURABLE GOALS.
PC82	THE PRIOR AUTHORIZATION (PA) SYSTEM CAN PROCESS ONLY 26 DETAILS PER PA REQUEST. PLEASE RESUBMIT YOUR REQUEST WITH NO MORE THAN 26 DETAILS.
PC83	PLEASE SUPPLY A PHYSICIANS PRESCRIPTION DATED WITHIN ONE MONTH OF REQUESTED SUBSTANCE ABUSE DAY TREATMENT.

Denial Code	Long Description
PC84	PLEASE PROVIDE INFORMATION INDICATING THIS CLIENT IS APPROPRIATELY DETOXIFIED FROM ALCOHOL AND/OR OTHER DRUGS.
PC85	PLEASE PROVIDE INFORMATION TO INDICATE THE CLIENTS ABILITY TO ABSTAIN FROM ALCOHOL OR DRUGS WHILE IN THE SUBSTANCE ABUSE DAY TREATMENT PROGRAM.
PC86	PLEASE INDICATE IF THIS CLIENT IS WILLING TO PARTICIPATE IN AFTERCARE OR CONTINUING CARE SERVICES.
PC87	PROVIDE MORE INFORMATION ON TREATMENT HISTORY; INCLUDE SERVICE PROVIDED, DATES, AND OUTCOME. PROVIDE DETAIL OF PREVIOUS TREATMENT.
PC88	PLEASE PROVIDE MORE RATIONALE FOR THE APPROPRIATENESS AND MEDICAL NECESSITY OF SUBSTANCE ABUSE DAY TREATMENT.
PC89	PROVIDE A TREATMENT PLAN THAT CONTAINS MEASURABLE GOALS AND OBJECTIVES CORRESPONDING TO THE IDENTIFIED DEFICIT.
PC91	PLEASE PROVIDE MORE INFORMATION ON FAMILY INVOLVEMENT TREATMENT.
PC92	PLEASE PROVIDE MORE HISTORY AND EXPLANATION ABOUT THE ISSUE OF ABSTINENCE FOR THIS CLIENT.
PC94	PLEASE PROVIDE THE ANTICIPATED BEGINNING DATE AND/OR THE ESTIMATED SUBSTANCE ABUSE DAY TREATMENT DISCHARGE DATE.
PC95	PLEASE SUPPLY JUSTIFICATION FOR BEGINNING CLIENT IN SERVICE PRIOR TO AUTHORIZATION BEING OBTAINED.
PC96	THE INITIAL THREE HOURS OF SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IN A CALENDAR YEAR DO NOT REQUIRE PRIOR AUTHORIZATION.
PC97	REIMBURSEMENT FOR INITIAL SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IS LIMITED TO THREE HOURS IN A CALENDAR YEAR AND DOES NOT REQUIRE PRIOR AUTHORIZATION.
PC98	THIS DRUG IS CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE BILL USING THE APPROPRIATE NATIONAL DRUG CODE (NDC) OR SUBMIT A COMPLETED DRUG ADDITION REQUEST FORM IF THE NDC IS NOT LISTED IN THE DRUG INDEX.
PC99	THIS DRUG IS NOT CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL, CURRENT ADMINISTRATIVE RULE, OR COLORADO DRUG INDEX FOR COVERAGE LIMITATIONS.
PD01	DOCUMENT THAT CLIENT HAS ACHIEVED GOOD ORAL HYGIENE, PERIODONTAL CASE TYPE 1 OR 2, AND IS MOTIVATED TO MAINTAIN SAME.
PD03	PLEASE PROVIDE AN ARTERIAL BLOOD GAS READING OR PULSE OXIMETRY RESULTS DONE ON ROOM AIR SIGNED AND DATED BY A MEDICAL DOCTOR. THIS SHOULD BE DONE WITHIN 60 DAYS OF REQUESTED SERVICE.
PD04	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 30 DAYS OF RECEIPT BY COLORADO MEDICAID.
PD07	SUBMIT A PHOTOCOPY OF A VALID PRESCRIPTION, ISSUED WITHIN THE PAST YEAR, OR COMPLETE SECTION B OF THE PRIOR AUTHORIZATION/DRUG ATTACHMENT (PA/DGA), F-11049.
PD10	BRAND MEDICALLY NECESSARY MUST BE IN THE PRESCRIBERS OWN HANDWRITING AND WRITTEN DIRECTLY ON THE PRESCRIPTION OR A SEPARATE ORDER ATTACHED TO THE ORIGINAL PRESCRIPTION.
PD12	COMPLETE DENTURES, PARTIAL DENTURES, DENTURE RELINES, AND FIXED PROSTHODONTIC SERVICES ARE NOT COVERED SERVICES FOR ADULTS FOR DATES OF SERVICE ON AND AFTER OCTOBER 1, 1995.
PD22	PLEASE COMPLETE ALL REQUIRED ELEMENTS ON THE PERSONAL CARE SCREENING TOOL (PCST), F-11133.
PD24	THIS PRIOR AUTHORIZATION REQUEST IS UNABLE TO BE PROCESSED. PLEASE RESUBMIT WITH ADDITIONAL REQUIRED FORMS, INCLUDING THE ENTIRE PERSONAL CARE SCREENING TOOL (PCST), F-11133; PERSONAL CARE ADDENDUM, F-11136; AND SUPPORTING DOCUMENTATION, AS DIRECTED.
PD25	THERE IS A PERSONAL CARE SCREENING TOOL (PCST), F-11133, COMPLETED BY ANOTHER AGENCY. CONTACT THE AGENCY TO TRANSFER SCREEN.
PD26	THERE IS A LIMITED TERM CARE FUNCTIONAL SCREEN (LTC-FS) COMPLETED BY ANOTHER AGENCY. THE PERSONAL CARE SCREENING TOOL (PCST), F-11133, INFORMATION IS IN CONFLICT WITH LTC-FS.
PD27	ONLY ONE LEVEL OF FUNCTION MAY BE SELECTED FOR ALL ELEMENTS EXCEPT TOILETING. COLORADO MEDICAID IS UNABLE TO PROCESS THE PRIOR AUTHORIZATION REQUEST.
PD28	NO UNITS MAY BE REQUESTED USING THIS PRIOR AUTHORIZATION PROCESS. PLEASE SUBMIT WITH THE APPROPRIATE ATTACHMENTS FOR REQUESTING SPECIFIC PERSONAL CARE WORKER UNITS.

Denial Code	Long Description
PD29	CLIENT IS NOT ELIGIBLE FOR THE REQUESTED SERVICE(S) AS OF THE REQUESTED START DATE.
PD30	NO TRAVEL TIME MAY BE AUTHORIZED WHEN NO PERSONAL CARE WORKER SERVICE IS AUTHORIZED.
PD32	PROVIDER NOT CERTIFIED TO RENDER THE SERVICE(S) REQUESTED.
PD34	BASED ON THE DOCUMENTATION SUBMITTED, THIS REQUEST CAN NOT BE PRIOR AUTHORIZED. REFER TO THE PA MESSAGES FROM THE CONSULTANT FOR COMPLETE EXPLANATION.
PD98	PLEASE DOCUMENT HOW AND WHEN EACH PREVIOUSLY AUTHORIZED PRO RE NATA VISIT WAS USED.

Dental

Denial Code	Long Description
0201	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
0233	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0235	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0237	CLIENT IDENTIFICATION NUMBER DOES NOT MATCH CLIENTS FIRST NAME.
0238	THE CLIENT IDENTIFICATION NUMBER DOES NOT MATCH THE CLIENTS LAST NAME.
0248	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0249	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0251	PROCEDURE CODE MODIFIER IN FIRST POSITION IS INVALID.
0252	THE PROCEDURE CODE MODIFIER IN SECOND POSITION IS INVALID FOR REQUESTED START DATE OR DATE OF RECEIPT.
0253	THE PROCEDURE CODE MODIFIER IN THIRD POSITION IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
0261	THE TOOTH NUMBER OR LETTER IS INVALID.
0262	THE TOOTH NUMBER OR LETTER IS INVALID.
0400	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0450	THE AREA OF THE ORAL CAVITY INVALID.
0853	HCPCS - ANNUAL UPDATE
0885	NEVER EVENTS MODIFIERS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
0886	NEVER EVENTS DIAGNOSIS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
1000	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
1002	RENDERING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1003	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1007	RENDERING PROVIDER ID IS NOT ON FILE.
1047	THE RENDERING PROVIDERS CERTIFICATION HAS BEEN CANCELLED.
1048	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1801	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
1804	A CERTIFIED SUBSTANCE ABUSE DAY TREATMENT PROVIDER MUST SUBMIT A SUBSTANCE ABUSE DAY TREATMENT PROCEDURE CODE.
1806	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
1808	THE BILLING PROVIDER DOES NOT HAVE THE REQUIRED CERTIFICATION ADDENDUM ON FILE.
1900	THE BILLING PROVIDERS TAXONOMY CODE IS INVALID.
1901	THE RENDERING PROVIDERS TAXONOMY CODE IS INVALID.
1927	A NATIONAL PROVIDER IDENTIFIER IS REQUIRED FOR THE BILLING PROVIDER.
1934	A NATIONAL PROVIDER INDENTIFIER IS REQUIRED FOR THE RENDERING PROVIDER.
1936	THE BILLING PROVIDER NUMBER IS INVALID.
1937	THE RENDERING PROVIDER NUMBER IS INVALID.
1960	INTERNAL PROCESSING IS REQUIRED.
1963	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.

Denial Code	Long Description
1964	THE BILLING PROVIDER INDICATED IS NOT ALLOWABLE AS A BILLING PROVIDER.
1965	RENDERING PROVIDER NUMBER IS MISSING/INVALID FOR THIS PROCEDURE PROVIDER.
1974	PRESCRIBING/REFERRING/ORDERING PROVIDER INDICATED IS NOT CERTIFIED AS A PRESCRIBING/REFERRING/ORDERING PROVIDER.
1975	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
1976	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
2001	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2003	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2004	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2017	THE CLIENT IS ENROLLED IN A MEDICAID OR OTHER MANAGED CARE PROGRAM.
2037	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2603	CLIENT LOCKED-IN TO A PROVIDER OR ENROLLED IN A HOSPICE. CONTACT CLIENTS HOSPICE FOR PAYMENT OF SERVICES OR RESUBMIT WITH DOCUMENTATION OF UNRELATED NATURE OF CARE.
3324	THE MODIFIER HAS BEEN DISCONTINUED BY THE CENTERS OF MEDICARE AND MEDICAID SERVICES OR THE AMERICAN MEDICAL ASSOCIATION FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
3337	THE PROCEDURE CODE HAS BEEN TERMINATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AMERICAN MEDICAL ASSOCIATION, OR AMERICAN DENTAL ASSOCIATION FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT. RESUBMIT WITH VALID A PROCEDURE CODE.
3339	THE PROCEDURE BILLED IS NOT PAYABLE ACCORDING TO DEFICIT REDUCTION ACT (DEFRA) GUIDELINES.
3351	THE PROCEDURE IS NOT COVERED FOR CLIENTS WITH A NURSING HOME AUTHORIZATION ON THE REQUESTED START DATE OR DATE OF RECEIPT.
3353	THE PROCEDURE IS NOT A COVERED SERVICE FOR HOME AND COMMUNITY-BASED WAIVER CLIENTS.
4021	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4031	THE PROCEDURE SUBMITTED IS NOT APPROPRIATE FOR CLIENTS GENDER.
4032	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4034	THE PROCEDURE CODE HAS AN AGE RESTRICTION.
4036	THE PLACE OF SERVICE CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4046	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4120	THE AREA OF ORAL CAVITY IS REQUIRED FOR THE PROCEDURE CODE.
4127	INTERNAL PROCESSING IS REQUIRED.
4131	INTERNAL PROCESSING IS REQUIRED.
4141	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4149	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4150	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4211	TOOTH NUMBER/LETTER NOT APPROPRIATE FOR PROCEDURE CODE.
4236	ETIOLOGY DIAGNOSIS CODE(S) (E-CODES) ARE INVALID AS THE PRIMARY DIAGNOSIS.
4244	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4245	THE FOURTH POSITION MODIFIER IS INVALID FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT.
4256	THE PROCEDURE CODE AND MODIFIER COMBINATION IS NOT PAYABLE FOR THE CLIENTS BENEFIT PLAN.
4257	THE MODIFIERS SUBMITTED ARE EITHER INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT OR THE MODIFIERS ARE MISSING.
4371	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4711	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR CLIENTS AGE.
4714	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS AGE.
4731	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS DIAGNOSIS.
4801	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4802	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
4821	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
4871	PLEASE REFER TO PA MESSAGES FOR RETURN INFORMATION.
4963	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS GENDER.
4990	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.

Denial Code	Long Description
7500	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
7509	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
P001	THE BILLING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THE SERVICES.
P003	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P005	THE PRIOR AUTHORIZATION CAN NOT BE END DATED. THE PRIOR AUTHORIZATION STATUS IS NOT APPROVED OR APPROVED WITH REVISIONS.
P006	PLEASE FURNISH THE PROCEDURE CODE AND CORRESPONDING DESCRIPTION.
P008	THE BILLING PROVIDER NUMBER IS INVALID.
P009	THE BILLING PROVIDER NUMBER IS INVALID.
P010	THE REQUESTED END DATE IS INVALID.
P011	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P012	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P013	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P014	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P015	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P016	THE REQUESTED START DATE IS MISSING OR INVALID.
P019	THE REQUESTED START DATE IS MISSING OR INVALID.
P020	THE RENDERING PROVIDER NUMBER IS INVALID.
P021	THE RENDERING PROVIDER NUMBER IS INVALID.
P022	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P023	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P024	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P028	THE AREA OF THE ORAL CAVITY IS MISSING OR INVALID.
P029	THE AREA OF THE ORAL CAVITY IS MISSING OR INVALID.
P030	FIRST MODIFIER IS INVALID.
P031	FIRST MODIFIER IS INVALID.
P032	SECOND MODIFIER IS INVALID.
P033	SECOND MODIFIER IS INVALID.
P034	THIRD MODIFIER IS INVALID.
P035	THIRD MODIFIER IS INVALID.
P036	FOURTH MODIFIER IS INVALID.
P037	FOURTH MODIFIER IS INVALID.
P038	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P039	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P040	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P041	CLIENTS FIRST NAME IS MISSING.
P042	CLIENTS LAST NAME IS MISSING.
P043	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P044	BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES REQUESTED.
P045	FIRST MODIFIER IS INVALID.
P046	SECOND MODIFIER IS INVALID.
P047	THIRD MODIFIER IS INVALID.
P048	FOURTH MODIFIER IS INVALID.
P049	THE TOOTH IS MISSING OR INVALID.
P052	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.

Denial Code	Long Description
P053	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P054	RENDERING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES FOR THE BENEFIT PLAN.
P055	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P059	THE TOOTH IS MISSING OR INVALID.
P061	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P062	THE CLIENT ID AND/OR NAME INDICATED ON THE PA REQUEST IS INCORRECT. THE CLIENT ID AND/OR NAME HAS BEEN UPDATED. PLEASE VERIFY THE ID AND/OR NAME IS CORRECT.
P064	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
P067	THE FREQUENCY OF HOURS REQUESTED ARE NOT APPROPRIATE FOR THIS CLIENT AND HAVE BEEN MODIFIED ACCORDINGLY.
P079	BILLING PROVIDER IS ON PAYMENT SUSPENSION DUE TO CREDIBLE ALLEGATION OF FRAUD.
P120	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAS BEEN REDUCED.
P121	THE SERVICE/ PROCEDURE REQUESTED IS NOT SUPPORTED BY SUBMITTED DOCUMENTATION.
P126	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
P128	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.
P138	SERVICE(S) DO NOT MEET COLORADO MEDICAID GUIDELINES.
P167	REQUESTED DOCUMENTATION HAS NOT BEEN SUBMITTED.
P178	THE SERVICE REQUESTED IS NOT MEDICALLY NECESSARY.
P179	THE MEDICAL NECESSITY FOR THIS SERVICE IS NOT SUPPORTED BY THE SUBMITTED DOCUMENTATION.
P233	THE DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE ADDITIONAL CARE.
P257	THIS CLIENTS FUNCTIONAL ASSESSMENT SCORES PLACE THIS CLIENT OUTSIDE ELIGIBILITY FOR DAY TREATMENT.
P274	OUR RECORDS INDICATE THIS CLIENT IS INVOLVED IN EFFECTIVE AND APPROPRIATE SERVICE ELSEWHERE.
P292	INTENSIVE REHABILITATION HOURS ARE NO LONGER APPROPRIATE AS INDICATED BY HISTORY, DIAGNOSIS, AND/ OR FUNCTIONAL ASSESSMENT SCORES.
P328	THE SERVICES REQUESTED INCLUDE NON-COVERED SERVICES, AND HOURS ARE REDUCED ACCORDINGLY.
P339	THE CLIENTS PAST HISTORY INDICATES REDUCED TREATMENT HOURS ARE WARRANTED.
P342	THE REQUEST DOES NOT MEET GENERALLY ACCEPTED CONDITIONS REQUIRING FLUORIDE TREATMENTS.
P346	SERVICES EXCEED COLORADO MEDICAID LIMITATION AND DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE MEDICAL NECESSITY OF THE SERVICE.
P349	THE SERVICE REQUESTED WAS PERFORMED LESS THAN FIVE YEARS AGO.
P353	THE EXISTING APPLIANCE HAS NOT BEEN WORN FOR THREE YEARS.
P367	THE CLIENT HAS BEEN TOTALLY WITHOUT TEETH AND AN APPLIANCE FOR FIVE YEARS.
P392	THE CLIENT IS MISSING AN ANTERIOR TOOTH AND/OR HAS TWO OR MORE POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P405	THE SERVICE(S) REQUESTED COULD ADEQUATELY BE PERFORMED IN THE DENTAL OFFICE.
P406	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE OF GOOD PERIODONTAL HEALTH (AMERICAN ACADEMY OF PERIODONTOLOGY PERIODONTAL CLASSIFICATION OF TYPE I OR II).
P407	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE VISIBLE ON RADIOGRAPHS THAT AT LEAST 50 PERCENT OF THE CLINICAL CROWN IS INTACT.
P409	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING SIX OR MORE TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED, INCLUDING THIRD MOLARS.
P410	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING ONE OR MORE ANTERIOR TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED.
P411	DOCUMENTATION DOES NOT SUPPORT THE NEED FOR PERIODONTIC SERVICES. POCKETS ARE LESS THAN 4MM AND/OR GREATER THAN 6MM FOR CLIENT AND/OR THE CLIENT IS UNDER THE AGE OF 13.
P412	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA.

Denial Code	Long Description
P413	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA. THIS PA HAS BEEN GRANTED AS APPROVED NOT APPROVED WITH REVISIONS. THE DURATION REQUESTED MAY HAVE BEEN REDUCED TO REFLECT COVERAGE LIMITATIONS, PRESCRIBER ORDERS, CONFLICTI
P417	THE SERVICE(S) REQUESTED COULD BE ADEQUATELY PERFORMED WITH LOCAL ANESTHESIA.
P437	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO POOR ORAL HYGIENE.
P444	THIS LINE ITEM IS A DUPLICATE OF ANOTHER LINE ITEM ON THIS PRIOR AUTHORIZATION (PA) REQUEST. PLEASE CORRECT.
P446	THIS IS A DUPLICATE OF AN EXISTING PRIOR AUTHORIZATION (PA) REQUEST. YOU MAY CONTACT PROVIDER SERVICES IF YOU REQUIRE ASSISTANCE. DUPLICATE PA REQUEST
P448	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO DECAY HISTORY.
P449	QUESTIONABLE LONG TERM PROGNOSIS DUE TO GUM AND BONE DISEASE.
P456	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO APPARENT ROOT INFECTION.
P457	OUR RECORDS INDICATE THIS CLIENT HAS EXCEEDED ESTABLISHED PROGRAM LIMITATIONS. COLORADO MEDICAID WILL NOT AUTHORIZE NEW DENTURES.
P458	DOCUMENTATION PROVIDED INDICATES A LESS ELABORATE PROCEDURE SHOULD BE CONSIDERED.
P502	RENTAL ONLY ALLOWED; MEDICAL NEED FOR PURCHASE HAS NOT BEEN DOCUMENTED.
P503	PURCHASE ONLY ALLOWED; MEDICAL NEED FOR RENTAL HAS NOT BEEN DOCUMENTED.
P504	OCCUPATIONAL THERAPY GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P505	THE SERVICE REQUESTED IS INCLUDED IN THE NURSING HOME RATE STRUCTURE.
P511	THIS NATIONAL DRUG CODE IS ONLY BILLABLE AS PART OF A COMPOUND DRUG.
P515	THE PRESENCE OF A HANDICAPPING MALOCCLUSION OR HANDICAPPING DENTOFACIAL DEFORMITY IS NOT SUPPORTED BY THE DOCUMENTATION SUBMITTED.
P521	THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVERED BY COLORADO MEDICAID.
P522	GASTRO-INTESTINAL SURGERY FOR THE PURPOSE OF WEIGHT CONTROL IS COVERED ONLY AS A LIFE THREATENING PROCEDURE.
P523	THE TREATMENT REQUEST IS NOT CONSISTENT WITH THE CLIENT'S DIAGNOSIS.
P524	PSYCHOTHERAPY PROVIDED IN THE CLIENTS HOME IS NOT A COVERED BENEFIT OF COLORADO MEDICAID.
P525	THE INFORMATION PROVIDED IS NOT CONSISTENT WITH THE INTENSITY OF SERVICES REQUESTED.
P526	INTENSIVE MULTIPLE MODALITY TREATMENT IS NOT CONSISTENT WITH THE INFORMATION PROVIDED.
P527	MULTIPLE PROVIDERS OF TREATMENT ARE NOT INDICATED FOR THIS CLIENT.
P528	THE DURATION OF TREATMENT SESSIONS EXCEED CURRENT COLORADO MEDICAID GUIDELINES.
P534	DOCUMENTATION OF POOR PHYSICAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P535	OTHER PHYSICAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P536	THE PHYSICAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P537	USE OF PHYSICAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P538	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF A PHYSICAL THERAPIST.
P539	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS AND LIVING ARRANGEMENT.
P540	GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P541	THE PROCEDURE(S) REQUESTED ARE NOT MEDICAL IN NATURE.
P542	DOCUMENTATION OF POOR OCCUPATIONAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P543	DOCUMENTATION OF POOR SPEECH THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P544	OTHER OCCUPATIONAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P546	THE OCCUPATIONAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.

Denial Code	Long Description
P547	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF PHYSICAL THERAPY.
P548	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P549	ACTIVITIES TO PROMOTE DIVERSION OR GENERAL MOTIVATION ARE NONCOVERED COLORADO MEDICAID SERVICES.
P550	REVISIONS OF THE REQUEST IS NECESSITATED BY THE CLIENTS MINIMAL PROGRESS.
P551	RESTORATIVE NURSING INVOLVEMENT COULD BE INCREASED.
P552	CLIENTS DEMONSTRATED RESPONSE TO CURRENT THERAPY DOES NOT WARRANT THE INTENSE FREQUENCY REQUESTED.
P553	MAINTENANCE IS TWO TIMES PER WEEK OR LESS.
P554	THE SPEECH THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P555	USE OF OCCUPATIONAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P556	USE OF SPEECH THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P557	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF AN OCCUPATIONAL THERAPIST.
P558	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
P559	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P560	THE MATERIALS/ SERVICES REQUESTED ARE PRINCIPALLY COSMETIC IN NATURE.
P561	THE LENS FORMULA DOES NOT JUSTIFY REPLACEMENT.
P562	THE CHANGE IN THE LENS FORMULA DOES NOT WARRANT MULTIPLE REPLACEMENTS.
P563	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P564	LENSES ONLY ARE APPROVED; PLEASE DISPENSE A CONTRACTED FRAME. THE NON-CONTRACTED FRAME IS NOT MEDICALLY JUSTIFIED.
P565	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P566	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P567	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF OCCUPATIONAL THERAPY.
P568	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF SPEECH THERAPY.
P569	LEVEL, INTENSITY, OR EXTENT OF SERVICE(S) REQUESTED HAS BEEN MODIFIED CONSISTENT WITH MEDICAL NEED AS DEFINED IN THE PLAN OF CARE.
P570	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P571	THE SERVICE ASKED FOR IS NOT COVERED BY COLORADO MEDICAID AS THESE TASKS CAN BE DONE BY NURSES OR ACTIVITY STAFF.
P572	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P573	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.
P574	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P575	MEDICAL NEED FOR EQUIPMENT/ SUPPLY REQUESTED IS NOT SUPPORTED BY DOCUMENTATION SUBMITTED.
P576	OTHER SPEECH THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P577	DOCUMENTATION SUBMITTED IDENTIFIES THAT THE CLIENT HAS FEWER THAN TWO POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P582	LESS EXPENSIVE ALTERNATIVE SERVICES ARE AVAILABLE FOR THIS CLIENT.
P634	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P711	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING PERIODONTAL SCALING AND ROOT PLANNING.
P712	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING GINGIVECTOMY.
P754	AN APPROVED SUBSTANCE ABUSE DAY TREATMENT PROGRAM CANNOT EXCEED A SIX WEEK PERIOD.

Denial Code	Long Description
P761	THE CLIENT DOES NOT APPEAR TO BE ABLE OR WILLING TO ABSTAIN FROM ALCOHOL/DRUG USAGE WHILE IN TREATMENT. THEREFORE, SUBSTANCE ABUSE DAY TREATMENT SERVICES ARE NOT APPROVED.
P764	THIS CLIENT HAS COMPLETED INTENSIVE SUBSTANCE ABUSE TREATMENT WITHIN THE PAST 12 MONTHS. THE DOCUMENTATION PROVIDED IS NOT ADEQUATE TO JUSTIFY ADDITIONAL INTENSIVE TREATMENT AT THIS TIME.
P785	A LESS THAN SIX-WEEK HEALING PERIOD HAS BEEN SPECIFIED FOR THIS PRIOR AUTHORIZATION. THEREFORE IT IS NOT NECESSARY TO WAIT THE FULL SIX WEEKS AFTER EXTRACTIONS BEFORE TAKING DENTURE IMPRESSIONS.
P818	SIX-WEEK HEALING TIME IS REQUIRED BETWEEN EDENTULATION AND FINAL IMPRESSIONS. PAYMENT FOR DENTURES WILL BE DENIED OR RECOUPED IF HEALING PERIOD IS NOT OBSERVED.
P849	COLORADO MEDICAID HAS DETERMINED THERE WERE (ARE) SEVERAL HOME HEALTH AGENCIES WILLING TO PROVIDE MEDICALLY NECESSARY SKILLED NURSING SERVICES TO THIS CLIENT.
P864	THE DOCUMENTATION YOU HAVE SUBMITTED DOES NOT MEET THE REQUIREMENTS OF COLORADO MEDICAID.
P873	THE MEDICAL NECESSITY FOR THE HOURS REQUESTED IS NOT SUPPORTED BY THE INFORMATION SUBMITTED.
P874	THE DOCUMENTATION SUBMITTED INDICATES THE TASKS SPECIFIED CAN BE COMPLETED DURING THE VISITS APPROVED.
P878	THE DOCUMENTATION SUBMITTED DOES NOT INDICATE THAT MEDICALLY ORIENTED TASKS ARE MEDICALLY NECESSARY; THEREFORE PERSONAL CARE SERVICES HAVE BEEN APPROVED.
P880	THE QUANTITY OF SERVICES AUTHORIZED FOR THIS CLIENTS PERSONAL CARE HAS BEEN AMENDED BASED ON INFORMATION RECEIVED FROM ONE OR MORE OF THESE SOURCES: THE CLIENT, THEIR PHYSICIAN, AND/OR THE IN-HOME VISIT BY STAFF OF THE OIG (OFFICE OF INSPECTOR GENERAL).
P885	THE USE OF THIS DRUG FOR THE INTENDED PURPOSE IS NOT COVERED BY COLORADO MEDICAID, CONSISTENT WITH COLORADO ADMINISTRATIVE CODE AND FEDERAL LAW.
P924	THE MEDICAL RECORDS SUBMITTED WITH THE CURRENT REQUEST CONFLICT OR DISAGREE WITH OUR MEDICAL RECORDS ON THIS CLIENT.
P950	INDEPENDENT NURSES, PLEASE NOTE PAYABLE SERVICES MAY NOT EXCEED 12 HOURS/DAY OR 60 HOURS/WEEK.
P951	SERVICES CAN ONLY BE AUTHORIZED THROUGH ONE YEAR FROM THE PRESCRIPTION DATE.
P952	LEAD INSPECTION IS A COVERED COLORADO MEDICAID SERVICE WHEN THE CHILD HAS BEEN SHOWN TO HAVE LEAD POISONING (E.G., CHILD HAS A BLOOD LEAD LEVEL > 19 UG/DL OR TWO CONSECUTIVE BLOOD LEAD LEVELS OF 15-19 UG/DL DONE AT LEAST 90 DAYS APART). THE INSPECTION MUS
P953	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P954	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P956	THE REQUEST CAN ONLY BE BACKDATED A MAXIMUM OF 14 DAYS FROM FIRST DATE RECEIVED BY COLORADO MEDICAID.
P957	COMPLETE PERIODONTAL CHARTING AT TIME OF SERVICE, AND SUBMIT CHARTING, COPY OF OPERATIVE REPORT, TOGETHER WITH A COPY OF THE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF), F-11035, TO PA UNIT ATTENTION DENTAL CONTSULTANT.
P958	NOTE THAT CODE D4341 HAS BEEN CHANGED. REFER TO THE DECISION NOTICE FOR AUTHORIZED QUANTITY.
P960	YOUR PA HAS BEEN APPROVED FOR 90 DAYS. THE 90 DAY APPROVAL DOES NOT IMPLY THE PA REQUEST MEETS PRIOR AUTHORIZATION CRITERIA. AFTER ADDITIONAL INFORMATION IS AVAILABLE IN INTERCHANGE, COLORADO MEDICAID WILL CREATE AN AMENDMENT REQUEST TO EXTEND THE PA FOR
P961	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P962	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
PA10	THE REQUESTED END DATE IS INVALID.
PA12	PLEASE FURNISH A WRITTEN DESCRIPTION OF THE CLIENTS DIAGNOSIS.

Denial Code	Long Description
PA13	PROVIDE DIAGNOSES WITH DATES OF ONSET.
PA14	IDENTIFY PROBLEMS TO BE TREATED.
PA15	THE AUDIOLOGISTS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1), F-11020, AND PRIOR AUTHORIZATION REQUEST/HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2), F-11021.
PA16	THE PHYSICIANS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION/PHYSICIAN OTOLOGICAL REPORT (PA/POR), F-11019.
PA17	SUBMIT BRIEF HISTORY WITH REFERRAL INFORMATION, LIVING SITUATION, FUNCTIONAL STATUS, AND OTHER PERTINENT INFORMATION. WHAT CHANGE OF STATUS RESULTED IN REFERRAL AT THIS TIME?
PA18	PLEASE FURNISH THE CLIENTS HEIGHT AND WEIGHT.
PA19	PLEASE SUBMIT CLINICAL INFORMATION SUFFICIENT TO VERIFY THE NEED FOR THE REQUESTED SERVICE(S).
PA20	PLEASE RESUBMIT WITH COMPLETE PERIODONTAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PA21	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL EDUCATIONAL PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA22	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL PROGRAM PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA23	REFER TO THE DURABLE MEDICAL EQUIPMENT INDEX FOR APPROPRIATE CODE AND DESCRIPTION. DO NOT USE AN "UNLISTED" CODE.
PA24	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUALIZED FAMILY SERVICE PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA25	INFORMATION ON THE REQUEST FORM IS ILLEGIBLE, AND THE REQUEST CANNOT BE PROCESSED.
PA26	RE-EVALUATE YOUR GOALS. EMPHASIS SHOULD BE ON FUNCTIONAL SELF-CARE. GOALS MUST BE RELATED TO FUNCTIONAL OUTCOME.
PA27	PLEASE CLARIFY THE NUMBER OF HOURS PER WEEK REQUESTED.
PA28	PLEASE CLARIFY THE NUMBER OF HOURS PER DAY REQUESTED.
PA29	PLEASE CLARIFY THE NUMBER OF VISITS PER DAY REQUESTED.
PA30	ATTACH SUPPORTIVE DOCUMENTATION; HOME EXERCISE PROGRAM AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA31	THE DIAGNOSIS CODE INDICATED ON THE REQUEST DOES NOT CORRESPOND TO THE DIAGNOSIS CODE DESCRIPTION.
PA32	PLEASE SUBMIT ADDITIONAL INFORMATION SUFFICIENT TO VERIFY APPROPRIATENESS AND NEED FOR TRANSPLANT.
PA33	PLEASE SUBMIT THE INITIAL AND PROGRESSIVE OBJECTIVE FINDINGS.
PA34	ATTACH SUPPORTIVE DOCUMENTATION, FACILITY PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA35	PLEASE SUBMIT THE CLIENTS ORIGINAL COMPLAINTS AND EXAMINATION FINDINGS.
PA36	ATTACH SUPPORTIVE DOCUMENTATION, IN-HOME AUTISM PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA37	PLEASE SUBMIT YOUR TREATMENT PLAN FOR THIS CLIENT.
PA38	ATTACH SUPPORTIVE DOCUMENTATION AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA39	INITIAL EVALUATIONS MUST BE PERFORMED BY AN OCCUPATIONAL THERAPIST REGISTERED (OTR), PER AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA) STANDARDS.
PA41	IDENTIFY THE PLACE OF SERVICE AND ITS EFFECT ON SUPPORTING THE DESIRED TREATMENT OUTCOME.
PA42	PLEASE INDICATE THE HOURS OF USE OF OXYGEN PER 24-HOUR PERIOD.
PA43	PROVIDE BASELINE DOCUMENTATION FOR THIS CLIENTS LIMITATIONS USING UNITS OF MEASUREMENT THAT ARE APPLIED CONSISTENTLY WHEN REPORTING STATUS.
PA44	IDENTIFY FUNCTIONAL LIMITATIONS AS THEY ARE RELATED TO IDENTIFIED CONDITIONS.
PA46	CORRELATE PLAN OF CARE TO REQUESTED PROCEDURE CODES.
PA47	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE FREQUENCY/DURATION REQUESTED.

Denial Code	Long Description
PA48	PLEASE PROVIDE THE NAME AND CREDENTIALS OF THE RENDERING PROVIDER.
PA50	COLORADO MEDICAID RECORDS INDICATE THE CLIENT OWNS A WHEELCHAIR. DOCUMENT THE REASON AND NEED FOR REPLACEMENT AND COST TO REPAIR CURRENT WHEELCHAIR.
PA51	PLEASE DISTINGUISH PRIMARY AND SUPPORTIVE MODALITIES.
PA52	PLEASE SUBMIT A PROGRESS REPORT.
PA53	MULTIPLE FAMILY CLIENTS TREATMENT BY THE SAME PROVIDER REQUIRES FURTHER INFORMATION DOCUMENTING COORDINATION OF TREATMENT PLAN.
PA54	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE MINUTES REQUESTED.
PA55	MEDICAL NECESSITY OF TREATMENT REQUIRES ADDITIONAL DOCUMENTATION.
PA56	GIVEN AGE, DIAGNOSES, CURRENT LEVEL OF FUNCTION, PAST RESPONSE TO TREATMENT, AND LIVING SITUATION, EXPAND ON POTENTIAL FOR SIGNIFICANT FUNCTIONAL PROGRESS WITHIN THE NEXT SIX MONTHS. EMPHASIZE WHY PROGRESS IS EXPECTED WITH SERVICES AT THIS TIME.
PA57	SUBMIT THE INITIAL FINDINGS. INCLUDE A COMPREHENSIVE EVALUATION.
PA58	SUBMIT PROGRESSIVE, OBJECTIVE FINDINGS. INCLUDE A PERTINENT RE-EVALUATION.
PA59	PLEASE SUPPLY INFORMATION REGARDING THE CLIENTS MEDICATION REQUIREMENTS, IF ANY.
PA60	PLEASE SPECIFY IF THE CLIENT IS IN AN EDUCATIONAL SETTING.
PA61	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA62	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
PA63	THE SKILLS OF A THERAPIST ARE PURPOSEFUL AND SKILLED INTERVENTIONS REQUIRED TO CONTINUALLY DESIGN, IMPLEMENT, REASSESS, MODIFY/GRADE, AND/OR DISCONTINUE A PLAN OF CARE IN A TIMELY MANNER, BASED ON THE COMPLEXITY OF THE CLIENTS MEDICAL CONDITION AND/OR CO
PA64	PLEASE SUBMIT A THERAPY PLAN OF CARE, INCLUDING A CURRENT, DATED EVALUATION.
PA65	A PLAN OF CARE SIGNED AND DATED BY THE PHYSICIAN IS REQUIRED.
PA66	THE SKILLS OF A THERAPIST ARE REQUIRED WHEN ONLY THE THERAPIST CAN SAFELY AND EFFECTIVELY DELIVER THE THERAPEUTIC PROCEDURES BECAUSE OF THEIR UNIQUE KNOWLEDGE, TRAINING, AND EXPERTISE. DESCRIBE THE REASON THAT SOMEONE OTHER THAN A THERAPIST CANNOT SAFELY
PA67	PLEASE SPECIFY IF THE CLIENTS WORK SITE DEMANDS GOOD BINAURAL HEARING.
PA68	DESCRIBE THE REASON, BASED ON THE CLIENTS COGNITIVE, PHYSICAL, COMMUNICATION, OR RESOURCE STATUS, THAT A HOME PROGRAM, EQUIPMENT, OR ENVIRONMENTAL ADAPTATIONS ALONE CANNOT MEET CLIENTS NEEDS.
PA69	PLEASE SPECIFY IF THE CLIENT HAS AN ACCOMPANYING DISABILITY THAT ADDS TO THE HEARING PROBLEM.
PA70	DISTINGUISH REQUESTED PROCEDURES AND GOALS FROM OTHER SERVICES THIS CLIENT RECEIVES. THEY MAY NOT BE DUPLICATIVE.
PA71	PLEASE INDICATE THE NUMBER OF DAYS REQUESTED.
PA73	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA74	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA75	PLEASE DOCUMENT CARRYOVER OF THE THERAPY PROGRAM TO NURSING.
PA76	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA79	PROVIDE EVIDENCE OF SIGNIFICANT FUNCTIONAL PROGRESS IN LAST SIX MONTHS.
PA84	THE GRANT DATE OF THIS REQUEST CANNOT BE PRIOR TO THE SIGNATURE DATE OF THE PRESCRIBING PHYSICIAN.
PA86	PROVIDE EVIDENCE OF SKILLS GAINED IN THERAPY CARRYING OVER TO OTHER SETTINGS WITHIN SIX MONTHS.
PA87	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE NUMBER OF SESSIONS REQUESTED.
PA88	THE REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL SCOPE OF PRACTICE.
PA89	PRIOR AUTHORIZATION IS NOT REQUIRED UNTIL LIMITATION OF SERVICE HAS BEEN REACHED.
PA91	PLEASE SUBMIT REQUIRED X-RAYS.

Denial Code	Long Description
PA92	PLEASE PROVIDE AN EXPLANATION FOR THE MATERIAL SUBMITTED WITH THE REQUEST.
PA95	PLEASE DESCRIBE HOW THE PROVISION OF THIS SERVICE WOULD PREVENT INSTITUTIONALIZATION OF THE CLIENT.
PA96	COULD THE EXISTING DENTURE(S) BE RELINED OR REBASED? IF NOT, PLEASE EXPLAIN WHY NOT.
PA97	REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL STANDARDS OF PRACTICE.
PA98	PLEASE INDICATE IF THE CLIENT IS CURRENTLY BEING TUBE FED.
PB02	PLEASE PROVIDE THE REQUIRED DATED SIGNATURES ON THE ATTACHMENTS.
PB03	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING THE LOSS/DESTRUCTION/THEFT OF THE HEARING AID.
PB04	DESCRIBE THE CLIENTS ABILITY TO STAND OR AMBULATE SUFFICIENTLY TO ACCOMPLISH SELF-CARE ACTIVITIES.
PB07	PLEASE SUBMIT AN ORTHODONTIC STUDY MODEL OR DIAGNOSTIC CASTS.
PB09	PLEASE PROVIDE A PHOTOGRAPH OF THE INVOLVED AREA(S).
PB10	PLEASE PROVIDE AN ESTIMATION (IN GRAMS) OF THE TOTAL AMOUNT OF TISSUE TO BE RESECTED.
PB11	PLEASE SUBMIT THE PLAN OF CARE FOR CO-TREATMENT.
PB12	FURNISH A DETAILED DESCRIPTION FOR THE PROCEDURE CODE REQUESTED.
PB13	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB15	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB18	PLEASE COMPLETE THE ATTACHED OUT-OF-STATE PROVIDER DATA SHEET, F-11001, AND RESUBMIT.
PB20	A SIGNED AND DATED PRESCRIPTION IS REQUIRED WITHIN THREE MONTHS OF RECEIPT BY COLORADO MEDICAID FOR INITIAL REQUESTS AND WITHIN 12 MONTHS OF RECEIPT BY COLORADO MEDICAID FOR SUBSEQUENT REQUESTS.
PB21	PLEASE COMPLETE THE APPROPRIATE PRIOR AUTHORIZATION ATTACHMENT. CONTACT PROVIDER SERVICES OR THE PRIOR AUTHORIZATION UNIT FOR ASSISTANCE.
PB23	PHYSICAL THERAPY ASSISTANT NOTES AND ALL FORMS SUBMITTED MUST BE COSIGNED BY A REGISTERED PHYSICAL THERAPIST.
PB31	ARE YOU REQUESTING A COMPLETE APPLIANCE, OR REPLACEMENT PARTS?
PB32	THE PROCEDURE CODE INDICATED ON THE REQUEST DOES NOT MATCH THE DESCRIPTION OF SERVICE; PLEASE CORRECT AND RESUBMIT.
PB35	THE SERVICE REQUESTED DOES NOT REQUIRE PRIOR AUTHORIZATION.
PB41	PLEASE FURNISH A CURRENT MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT, F-11090 (DATED WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID).
PB45	THE CERTIFICATION PERIOD ON THE PLAN OF CARE (POC) DOES NOT COVER THE REQUESTED GRANT/START DATE. PLEASE RESUBMIT YOUR REQUEST WITH A NEW POC.
PB49	A CERTIFIED OCCUPATIONAL THERAPY ASSISTANTS NOTES MUST BE COSIGNED BY AN OCCUPATIONAL THERAPIST REGISTERED.
PB51	ADDITIONAL INFORMATION IS REQUIRED ON PRIOR AUTHORIZATION TO ENABLE PRICING.
PB54	REQUESTED SERVICES DO NOT MATCH SERVICES ON THE PHYSICIANS ORDERS.
PB59	PLEASE PROVIDE AN INDIVIDUAL EDUCATIONAL PLAN (IEP), WHICH HAS BEEN SIGNED BY THE PROVIDER NO EARLIER THAN NINE MONTHS PRIOR TO RECEIPT AT COLORADO MEDICAID; OTHERWISE, DOCUMENT WHY NO IEP EXISTS.
PB65	PLEASE FURNISH THE ANTICIPATED TOTAL CHARGES FOR THIS REQUEST.
PB66	A PHOTOCOPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED; THE DATE MUST BE WITHIN SIX MONTHS OF RECEIPT BY COLORADO MEDICAID.
PB67	THE PRESCRIPTION DATE MUST INCLUDE MONTH, DAY, AND YEAR.
PB68	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID.
PB73	THE SERVICES IDENTIFIED ON THE PLAN OF CARE DO NOT APPEAR APPROPRIATE FOR THE PROCEDURE CODE(S) REQUESTED ON THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018.
PB74	THE CLIENT/PROVIDER DOES NOT HAVE RETROACTIVE ENROLLMENT.
PB75	THE REQUESTED START DATE IS MORE THAN 14 DAYS BEFORE OR 62 DAYS AFTER RECEIPT.
PB82	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
PB83	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A HOME HEALTH AIDE. PLEASE RESUBMIT AS A PERSONAL CARE WORKER OR PROVIDE ADDITIONAL DOCUMENTATION.

Denial Code	Long Description
PB86	THE SERVICES REQUESTED ARE NOT BEING PROVIDED IN THE CLIENTS RESIDENCE. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL.
PB87	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A NURSE. PLEASE RESUBMIT AS A HOME HEALTH AIDE OR PROVIDE ADDITIONAL DOCUMENTATION.
PB92	PLEASE FURNISH THE CLIENTS COMPLETE ADDRESS.
PB94	IF THE CLIENT IS A RESIDENT OF A NURSING HOME, SUPPLY THE COMPLETE NAME AND ADDRESS OF THE NURSING HOME.
PB99	THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018, MUST BE SIGNED AND DATED.
PC01	PLEASE SUPPLY THE RENDERING PROVIDERS PROVIDER NUMBER.
PC03	THE DRUG ENFORCEMENT ADMINISTRATION NUMBER IS MISSING OR INVALID.
PC06	PLEASE DESCRIBE YOUR PROGRAM; INCLUDE ENTRY DATE, TERMINATION DATE, HOURS PER WEEK, AND NUMBER OF WEEKS OF PRIMARY INTENSIVE SERVICE REQUESTED.
PC07	PLEASE DESCRIBE YOUR "AFTERCARE/FOLLOW-UP" PLANS FOR THIS CLIENT.
PC08	PLEASE SUPPLY DOCUMENTATION OF PREVIOUS SUBSTANCE ABUSE SERVICES WITH DATE(S) AND OUTCOME.
PC09	PLEASE DESCRIBE IN DETAIL THE TREATMENT OBJECTIVES/GOALS FOR THIS CLIENT.
PC10	PLEASE DESCRIBE THE FAMILY SITUATION/DYNAMICS. EXPLAIN HOW THE FAMILY WILL BE INCORPORATED INTO THE CLIENTS PLAN OF CARE.
PC12	PLEASE EXPLAIN IF YOUR SERVICE ENCOURAGES THE CLIENT TO ATTEND SELF-HELP GROUPS.
PC13	PLEASE SUPPLY A SPECIFIC SCHEDULE OF ACTIVITIES, INCLUDING DAY, TIME OF DAY, LENGTH OF SESSION, AND SERVICE TO BE RENDERED DURING THAT TIME.
PC15	PLEASE FURNISH DIAGNOSTIC RATIONALE.
PC17	PLEASE DOCUMENT IF THE CLIENT EVER RECEIVED SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT.
PC19	PLEASE FURNISH MORE EXTENSIVE AND IN-DEPTH HISTORICAL AND PSYCHOSOCIAL DATA.
PC20	PLEASE SUPPLY THE DATE THE CLIENT BECAME TOTALLY ENDENTULOUS.
PC23	PLEASE SUBMIT A PHYSICIANS STATEMENT REGARDING THE MEDICAL NECESSITY OF DENTURES FOR THIS CLIENT. THE PHYSICIANS STATEMENT MUST DOCUMENT THE MEDICAL NEED FOR DENTURES.
PC24	THE SERVICE REQUESTED WAS PREVIOUSLY AUTHORIZED. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT INDICATING THIS FACT IS REQUIRED.
PC25	PLEASE SUPPLY SUFFICIENT MITIGATING CIRCUMSTANCES TO WARRANT THE CONSTRUCTION OF NEW DENTURES(S).
PC26	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
PC28	PLEASE SUBMIT A PHYSICIANS STATEMENT INDICATING DENTURES ARE NECESSARY FOR THIS NURSING HOME CLIENT.
PC29	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING LOSS OR DESTRUCTION OF DENTURE(S). INCLUDE SIGNED STATEMENT FROM CLIENT OR FACILITY DIRECTOR REGARDING HOW, WHEN AND WHERE LOST.
PC30	PLEASE PROVIDE COMPLETE INTRAORAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PC31	PLEASE DESCRIBE ANY RELATED DEFORMITIES OF THE FEET.
PC34	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD WITH REQUESTED DME ITEM(S) AND DOCUMENT IF THE CLIENT CAN USE SAFELY AND INDEPENDENTLY.
PC35	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD AND DESCRIBE THE RESULTS AND EFFECTIVENESS OF THE SERVICE REQUESTED.
PC39	PLEASE INDICATE LITER FLOW PER MINUTE, HOURS OF USE PER 24 HOUR PERIOD, AND THE EXPECTED DURATION OF NEED.
PC40	THE ITEM DOES NOT REQUIRE PRIOR AUTHORIZATION UNTIL THE LIFE EXPECTANCY HAS BEEN REACHED.
PC41	PLEASE SUPPLY INFORMATION INDICATING THE NECESSITY OF POSITIONING THE CLIENT'S BODY IN MULTIPLE POSITIONS.
PC42	PLEASE INDICATE IF THE BED HEIGHT MUST BE CHANGED TO ALLOW FOR SAFE TRANSFER OR ADEQUATE BED CARE.
PC43	SUPPLY A PHYSICIANS STATEMENT INDICATING TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR UNIT HAS REDUCED PAIN, IMPROVED/INCREASED THE CLIENTS ACTIVITY LEVEL, AND/OR REDUCED CLIENTS USE OF PAIN MEDICATION.

Denial Code	Long Description
PC44	A CURRENT AUTHORIZATION FOR THIS SERVICE IS ON FILE FOR ANOTHER PROVIDER. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT OF THAT FACT IS REQUIRED BY THE CLIENT OF FIRST PROVIDER.
PC59	DOCUMENT DECLINE OR PROGRESS IN SPECIFIC, MEASURABLE, OBJECTIVE TERMS.
PC60	DOCUMENT IF CLIENT HAS DEMONSTRATED A GOOD APPOINTMENT COMPLIANCE RECORD.
PC61	THE PHYSICIANS SIGNATURE DATE MUST NOT EXCEED 90 DAYS FROM THE DATE OF RECEIPT BY COLORADO MEDICAID.
PC62	REQUESTS FOR A CONTINUATION OF THERAPY SHOULD NOT BE SUBMITTED MORE THAN FOUR WEEKS PRIOR TO THE EXPIRATION DATE OF THE CURRENT AUTHORIZATION.
PC63	PLEASE FURNISH THE STYLE AND MANUFACTURER OF THE FRAME.
PC64	PLEASE FURNISH THE CLIENTS LENS FORMULA.
PC66	ALL REQUESTS FOR TINTS REQUIRE DOCUMENTATION OF THE VISUAL OR MEDICAL CONDITION RELATED TO PHOTOPHOBIA.
PC67	PLEASE DOCUMENT THE REASON AND JUSTIFICATION FOR REPLACEMENT BEYOND THE FIRST LENS/FRAME.
PC68	DOCUMENT IF ALL REMAINING MAXILLARY AND/OR MANDIBULAR TEETH ARE DECAY-FREE, PROPERLY RESTORED, AND PERIODONTICALLY SOUND.
PC72	SUPPLY MORE DETAIL REGARDING PROGRESS (ATTACHMENT OF GOALS, ETC.). CORRELATE PROGRESS TO PREVIOUS GOALS AND IDENTIFIED LIMITATIONS.
PC77	PLEASE SUBMIT A PLAN OF CARE DESCRIBING THE SERVICES THAT WOULD BE PROVIDED.
PC78	PLEASE DOCUMENT SPECIFIC, MEASURABLE GOALS.
PC82	THE PRIOR AUTHORIZATION (PA) SYSTEM CAN PROCESS ONLY 26 DETAILS PER PA REQUEST. PLEASE RESUBMIT YOUR REQUEST WITH NO MORE THAN 26 DETAILS.
PC83	PLEASE SUPPLY A PHYSICIANS PRESCRIPTION DATED WITHIN ONE MONTH OF REQUESTED SUBSTANCE ABUSE DAY TREATMENT.
PC84	PLEASE PROVIDE INFORMATION INDICATING THIS CLIENT IS APPROPRIATELY DETOXIFIED FROM ALCOHOL AND/OR OTHER DRUGS.
PC85	PLEASE PROVIDE INFORMATION TO INDICATE THE CLIENTS ABILITY TO ABSTAIN FROM ALCOHOL OR DRUGS WHILE IN THE SUBSTANCE ABUSE DAY TREATMENT PROGRAM.
PC86	PLEASE INDICATE IF THIS CLIENT IS WILLING TO PARTICIPATE IN AFTERCARE OR CONTINUING CARE SERVICES.
PC87	PROVIDE MORE INFORMATION ON TREATMENT HISTORY; INCLUDE SERVICE PROVIDED, DATES, AND OUTCOME. PROVIDE DETAIL OF PREVIOUS TREATMENT.
PC88	PLEASE PROVIDE MORE RATIONALE FOR THE APPROPRIATENESS AND MEDICAL NECESSITY OF SUBSTANCE ABUSE DAY TREATMENT.
PC89	PROVIDE A TREATMENT PLAN THAT CONTAINS MEASURABLE GOALS AND OBJECTIVES CORRESPONDING TO THE IDENTIFIED DEFICIT.
PC91	PLEASE PROVIDE MORE INFORMATION ON FAMILY INVOLVEMENT TREATMENT.
PC92	PLEASE PROVIDE MORE HISTORY AND EXPLANATION ABOUT THE ISSUE OF ABSTINENCE FOR THIS CLIENT.
PC94	PLEASE PROVIDE THE ANTICIPATED BEGINNING DATE AND/OR THE ESTIMATED SUBSTANCE ABUSE DAY TREATMENT DISCHARGE DATE.
PC95	PLEASE SUPPLY JUSTIFICATION FOR BEGINNING CLIENT IN SERVICE PRIOR TO AUTHORIZATION BEING OBTAINED.
PC96	THE INITIAL THREE HOURS OF SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IN A CALENDAR YEAR DO NOT REQUIRE PRIOR AUTHORIZATION.
PC97	REIMBURSEMENT FOR INITIAL SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IS LIMITED TO THREE HOURS IN A CALENDAR YEAR AND DOES NOT REQUIRE PRIOR AUTHORIZATION.
PC98	THIS DRUG IS CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE BILL USING THE APPROPRIATE NATIONAL DRUG CODE (NDC) OR SUBMIT A COMPLETED DRUG ADDITION REQUEST FORM IF THE NDC IS NOT LISTED IN THE DRUG INDEX.
PC99	THIS DRUG IS NOT CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL, CURRENT ADMINISTRATIVE RULE, OR COLORADO DRUG INDEX FOR COVERAGE LIMITATIONS.
PD01	DOCUMENT THAT CLIENT HAS ACHIEVED GOOD ORAL HYGIENE, PERIODONTAL CASE TYPE 1 OR 2, AND IS MOTIVATED TO MAINTAIN SAME.

Denial Code	Long Description
PD03	PLEASE PROVIDE AN ARTERIAL BLOOD GAS READING OR PULSE OXIMETRY RESULTS DONE ON ROOM AIR SIGNED AND DATED BY A MEDICAL DOCTOR. THIS SHOULD BE DONE WITHIN 60 DAYS OF REQUESTED SERVICE.
PD04	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 30 DAYS OF RECEIPT BY COLORADO MEDICAID.
PD07	SUBMIT A PHOTOCOPY OF A VALID PRESCRIPTION, ISSUED WITHIN THE PAST YEAR, OR COMPLETE SECTION B OF THE PRIOR AUTHORIZATION/DRUG ATTACHMENT (PA/DGA), F-11049.
PD10	BRAND MEDICALLY NECESSARY MUST BE IN THE PRESCRIBERS OWN HANDWRITING AND WRITTEN DIRECTLY ON THE PRESCRIPTION OR A SEPARATE ORDER ATTACHED TO THE ORIGINAL PRESCRIPTION.
PD12	COMPLETE DENTURES, PARTIAL DENTURES, DENTURE RELINES, AND FIXED PROSTHODONTIC SERVICES ARE NOT COVERED SERVICES FOR ADULTS FOR DATES OF SERVICE ON AND AFTER OCTOBER 1, 1995.
PD22	PLEASE COMPLETE ALL REQUIRED ELEMENTS ON THE PERSONAL CARE SCREENING TOOL (PCST), F-11133.
PD24	THIS PRIOR AUTHORIZATION REQUEST IS UNABLE TO BE PROCESSED. PLEASE RESUBMIT WITH ADDITIONAL REQUIRED FORMS, INCLUDING THE ENTIRE PERSONAL CARE SCREENING TOOL (PCST), F-11133; PERSONAL CARE ADDENDUM, F-11136; AND SUPPORTING DOCUMENTATION, AS DIRECTED.
PD25	THERE IS A PERSONAL CARE SCREENING TOOL (PCST), F-11133, COMPLETED BY ANOTHER AGENCY. CONTACT THE AGENCY TO TRANSFER SCREEN.
PD26	THERE IS A LIMITED TERM CARE FUNCTIONAL SCREEN (LTC-FS) COMPLETED BY ANOTHER AGENCY. THE PERSONAL CARE SCREENING TOOL (PCST), F-11133, INFORMATION IS IN CONFLICT WITH LTC-FS.
PD27	ONLY ONE LEVEL OF FUNCTION MAY BE SELECTED FOR ALL ELEMENTS EXCEPT TOILETING. COLORADO MEDICAID IS UNABLE TO PROCESS THE PRIOR AUTHORIZATION REQUEST.
PD28	NO UNITS MAY BE REQUESTED USING THIS PRIOR AUTHORIZATION PROCESS. PLEASE SUBMIT WITH THE APPROPRIATE ATTACHMENTS FOR REQUESTING SPECIFIC PERSONAL CARE WORKER UNITS.
PD29	CLIENT IS NOT ELIGIBLE FOR THE REQUESTED SERVICE(S) AS OF THE REQUESTED START DATE.
PD30	NO TRAVEL TIME MAY BE AUTHORIZED WHEN NO PERSONAL CARE WORKER SERVICE IS AUTHORIZED.
PD32	PROVIDER NOT CERTIFIED TO RENDER THE SERVICE(S) REQUESTED.
PD34	BASED ON THE DOCUMENTATION SUBMITTED, THIS REQUEST CAN NOT BE PRIOR AUTHORIZED. REFER TO THE PA MESSAGES FROM THE CONSULTANT FOR COMPLETE EXPLANATION.
PD98	PLEASE DOCUMENT HOW AND WHEN EACH PREVIOUSLY AUTHORIZED PRO RE NATA VISIT WAS USED.

Developmental Disabilities (DD)

Denial Code	Long Description
0201	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
0233	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0235	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0237	CLIENT IDENTIFICATION NUMBER DOES NOT MATCH CLIENTS FIRST NAME.
0238	THE CLIENT IDENTIFICATION NUMBER DOES NOT MATCH THE CLIENTS LAST NAME.
0242	SECONDARY DIAGNOSIS CODE IS INVALID.
0248	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0249	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0251	PROCEDURE CODE MODIFIER IN FIRST POSITION IS INVALID.
0252	THE PROCEDURE CODE MODIFIER IN SECOND POSITION IS INVALID FOR REQUESTED START DATE OR DATE OF RECEIPT.
0253	THE PROCEDURE CODE MODIFIER IN THIRD POSITION IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
0258	THE PRIMARY DIAGNOSIS CODE IS REQUIRED.
0272	THE PRIMARY DIAGNSOSIS CODE IS INVALID.
0400	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.

Denial Code	Long Description
0853	HCPCS - ANNUAL UPDATE
0885	NEVER EVENTS MODIFIERS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
0886	NEVER EVENTS DIAGNOSIS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
1000	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
1002	RENDERING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1003	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1007	RENDERING PROVIDER ID IS NOT ON FILE.
1047	THE RENDERING PROVIDERS CERTIFICATION HAS BEEN CANCELLED.
1048	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1801	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
1804	A CERTIFIED SUBSTANCE ABUSE DAY TREATMENT PROVIDER MUST SUBMIT A SUBSTANCE ABUSE DAY TREATMENT PROCEDURE CODE.
1806	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
1808	THE BILLING PROVIDER DOES NOT HAVE THE REQUIRED CERTIFICATION ADDENDUM ON FILE.
1900	THE BILLING PROVIDERS TAXONOMY CODE IS INVALID.
1901	THE RENDERING PROVIDERS TAXONOMY CODE IS INVALID.
1927	A NATIONAL PROVIDER IDENTIFIER IS REQUIRED FOR THE BILLING PROVIDER.
1934	A NATIONAL PROVIDER INDENTIFIER IS REQUIRED FOR THE RENDERING PROVIDER.
1936	THE BILLING PROVIDER NUMBER IS INVALID.
1937	THE RENDERING PROVIDER NUMBER IS INVALID.
1960	INTERNAL PROCESSING IS REQUIRED.
1963	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.
1964	THE BILLING PROVIDER INDICATED IS NOT ALLOWABLE AS A BILLING PROVIDER.
1965	RENDERING PROVIDER NUMBER IS MISSING/INVALID FOR THIS PROCEDURE PROVIDER.
1974	PRESCRIBING/REFERRING/ORDERING PROVIDER INDICATED IS NOT CERTIFIED AS A PRESCRIBING/REFERRING/ORDERING PROVIDER.
1975	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
1976	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
2001	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2003	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2017	THE CLIENT IS ENROLLED IN A MEDICAID OR OTHER MANAGED CARE PROGRAM.
2037	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2603	CLIENT LOCKED-IN TO A PROVIDER OR ENROLLED IN A HOSPICE. CONTACT CLIENTS HOSPICE FOR PAYMENT OF SERVICES OR RESUBMIT WITH DOCUMENTATION OF UNRELATED NATURE OF CARE.
3324	THE MODIFIER HAS BEEN DISCONTINUED BY THE CENTERS OF MEDICARE AND MEDICAID SERVICES OR THE AMERICAN MEDICAL ASSOCIATION FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
3337	THE PROCEDURE CODE HAS BEEN TERMINATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AMERICAN MEDICAL ASSOCIATION, OR AMERICAN DENTAL ASSOCIATION FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT. RESUBMIT WITH VALID A PROCEDURE CODE.
3339	THE PROCEDURE BILLED IS NOT PAYABLE ACCORDING TO DEFICIT REDUCTION ACT (DEFRA) GUIDELINES.
3351	THE PROCEDURE IS NOT COVERED FOR CLIENTS WITH A NURSING HOME AUTHORIZATION ON THE REQUESTED START DATE OR DATE OF RECEIPT.
3353	THE PROCEDURE IS NOT A COVERED SERVICE FOR HOME AND COMMUNITY-BASED WAIVER CLIENTS.
4021	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4027	THE DIAGNOSIS CODE IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
4031	THE PROCEDURE SUBMITTED IS NOT APPROPRIATE FOR CLIENTS GENDER.
4032	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4034	THE PROCEDURE CODE HAS AN AGE RESTRICTION.
4036	THE PLACE OF SERVICE CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4040	THE PRIMARY DIAGNOSIS CODE IS NOT ON FILE.
4041	THE SECONDARY DIAGNOSIS IS NOT ON FILE.
4046	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.

Denial Code	Long Description
4127	INTERNAL PROCESSING IS REQUIRED.
4131	INTERNAL PROCESSING IS REQUIRED.
4141	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4149	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4150	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4236	ETIOLOGY DIAGNOSIS CODE(S) (E-CODES) ARE INVALID AS THE PRIMARY DIAGNOSIS.
4244	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4245	THE FOURTH POSITION MODIFIER IS INVALID FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT.
4256	THE PROCEDURE CODE AND MODIFIER COMBINATION IS NOT PAYABLE FOR THE CLIENTS BENEFIT PLAN.
4257	THE MODIFIERS SUBMITTED ARE EITHER INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT OR THE MODIFIERS ARE MISSING.
4311	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4315	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4316	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4371	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4372	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4711	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR CLIENTS AGE.
4714	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS AGE.
4731	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS DIAGNOSIS.
4742	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4743	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4744	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4745	DIAGNOSIS AND/OR PROCEDURE AND/OR PLACE OF SERVICE (POS) CODE IS NOT COVERED FOR EXPRESS ENROLLMENT CLIENTS.
4746	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4801	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4802	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
4821	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
4871	PLEASE REFER TO PA MESSAGES FOR RETURN INFORMATION.
4963	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS GENDER.
4990	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
7500	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
7509	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
P001	THE BILLING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THE SERVICES.
P002	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P003	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P005	THE PRIOR AUTHORIZATION CAN NOT BE END DATED. THE PRIOR AUTHORIZATION STATUS IS NOT APPROVED OR APPROVED WITH REVISIONS.
P006	PLEASE FURNISH THE PROCEDURE CODE AND CORRESPONDING DESCRIPTION.
P008	THE BILLING PROVIDER NUMBER IS INVALID.
P009	THE BILLING PROVIDER NUMBER IS INVALID.
P010	THE REQUESTED END DATE IS INVALID.
P011	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P012	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P013	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P014	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.

Denial Code	Long Description
P015	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P016	THE REQUESTED START DATE IS MISSING OR INVALID.
P019	THE REQUESTED START DATE IS MISSING OR INVALID.
P020	THE RENDERING PROVIDER NUMBER IS INVALID.
P021	THE RENDERING PROVIDER NUMBER IS INVALID.
P022	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P023	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P024	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P026	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P027	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P030	FIRST MODIFIER IS INVALID.
P031	FIRST MODIFIER IS INVALID.
P032	SECOND MODIFIER IS INVALID.
P033	SECOND MODIFIER IS INVALID.
P034	THIRD MODIFIER IS INVALID.
P035	THIRD MODIFIER IS INVALID.
P036	FOURTH MODIFIER IS INVALID.
P037	FOURTH MODIFIER IS INVALID.
P038	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P039	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P040	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P041	CLIENTS FIRST NAME IS MISSING.
P042	CLIENTS LAST NAME IS MISSING.
P043	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P044	BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES REQUESTED.
P045	FIRST MODIFIER IS INVALID.
P046	SECOND MODIFIER IS INVALID.
P047	THIRD MODIFIER IS INVALID.
P048	FOURTH MODIFIER IS INVALID.
P052	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P053	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P054	RENDERING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES FOR THE BENEFIT PLAN.
P055	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P061	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P062	THE CLIENT ID AND/OR NAME INDICATED ON THE PA REQUEST IS INCORRECT. THE CLIENT ID AND/OR NAME HAS BEEN UPDATED. PLEASE VERIFY THE ID AND/OR NAME IS CORRECT.
P064	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
P067	THE FREQUENCY OF HOURS REQUESTED ARE NOT APPROPRIATE FOR THIS CLIENT AND HAVE BEEN MODIFIED ACCORDINGLY.
P079	BILLING PROVIDER IS ON PAYMENT SUSPENSION DUE TO CREDIBLE ALLEGATION OF FRAUD.
P120	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAS BEEN REDUCED.
P121	THE SERVICE/ PROCEDURE REQUESTED IS NOT SUPPORTED BY SUBMITTED DOCUMENTATION.
P126	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
P128	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.
P138	SERVICE(S) DO NOT MEET COLORADO MEDICAID GUIDELINES.
P167	REQUESTED DOCUMENTATION HAS NOT BEEN SUBMITTED.

Denial Code	Long Description
P178	THE SERVICE REQUESTED IS NOT MEDICALLY NECESSARY.
P179	THE MEDICAL NECESSITY FOR THIS SERVICE IS NOT SUPPORTED BY THE SUBMITTED DOCUMENTATION.
P233	THE DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE ADDITIONAL CARE.
P257	THIS CLIENTS FUNCTIONAL ASSESSMENT SCORES PLACE THIS CLIENT OUTSIDE ELIGIBILITY FOR DAY TREATMENT.
P274	OUR RECORDS INDICATE THIS CLIENT IS INVOLVED IN EFFECTIVE AND APPROPRIATE SERVICE ELSEWHERE.
P292	INTENSIVE REHABILITATION HOURS ARE NO LONGER APPROPRIATE AS INDICATED BY HISTORY, DIAGNOSIS, AND/ OR FUNCTIONAL ASSESSMENT SCORES.
P328	THE SERVICES REQUESTED INCLUDE NON-COVERED SERVICES, AND HOURS ARE REDUCED ACCORDINGLY.
P339	THE CLIENTS PAST HISTORY INDICATES REDUCED TREATMENT HOURS ARE WARRANTED.
P342	THE REQUEST DOES NOT MEET GENERALLY ACCEPTED CONDITIONS REQUIRING FLUORIDE TREATMENTS.
P346	SERVICES EXCEED COLORADO MEDICAID LIMITATION AND DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE MEDICAL NECESSITY OF THE SERVICE.
P349	THE SERVICE REQUESTED WAS PERFORMED LESS THAN FIVE YEARS AGO.
P353	THE EXISTING APPLIANCE HAS NOT BEEN WORN FOR THREE YEARS.
P367	THE CLIENT HAS BEEN TOTALLY WITHOUT TEETH AND AN APPLIANCE FOR FIVE YEARS.
P392	THE CLIENT IS MISSING AN ANTERIOR TOOTH AND/OR HAS TWO OR MORE POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P405	THE SERVICE(S) REQUESTED COULD ADEQUATELY BE PERFORMED IN THE DENTAL OFFICE.
P406	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE OF GOOD PERIODONTAL HEALTH (AMERICAN ACADEMY OF PERIODONTOLOGY PERIODONTAL CLASSIFICATION OF TYPE I OR II).
P407	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE VISIBLE ON RADIOGRAPHS THAT AT LEAST 50 PERCENT OF THE CLINICAL CROWN IS INTACT.
P409	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING SIX OR MORE TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED, INCLUDING THIRD MOLARS.
P410	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING ONE OR MORE ANTERIOR TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED.
P411	DOCUMENTATION DOES NOT SUPPORT THE NEED FOR PERIODONTIC SERVICES. POCKETS ARE LESS THAN 4MM AND/OR GREATER THAN 6MM FOR CLIENT AND/OR THE CLIENT IS UNDER THE AGE OF 13.
P412	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA.
P413	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA. THIS PA HAS BEEN GRANTED AS APPROVED NOT APPROVED WITH REVISIONS. THE DURATION REQUESTED MAY HAVE BEEN REDUCED TO REFLECT COVERAGE LIMITATIONS, PRESCRIBER ORDERS, CONFLICTI
P417	THE SERVICE(S) REQUESTED COULD BE ADEQUATELY PERFORMED WITH LOCAL ANESTHESIA.
P437	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO POOR ORAL HYGIENE.
P444	THIS LINE ITEM IS A DUPLICATE OF ANOTHER LINE ITEM ON THIS PRIOR AUTHORIZATION (PA) REQUEST. PLEASE CORRECT.
P446	THIS IS A DUPLICATE OF AN EXISTING PRIOR AUTHORIZATION (PA) REQUEST. YOU MAY CONTACT PROVIDER SERVICES IF YOU REQUIRE ASSISTANCE. DUPLICATE PA REQUEST
P448	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO DECAY HISTORY.
P449	QUESTIONABLE LONG TERM PROGNOSIS DUE TO GUM AND BONE DISEASE.
P456	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO APPARENT ROOT INFECTION.
P457	OUR RECORDS INDICATE THIS CLIENT HAS EXCEEDED ESTABLISHED PROGRAM LIMITATIONS. COLORADO MEDICAID WILL NOT AUTHORIZE NEW DENTURES.
P458	DOCUMENTATION PROVIDED INDICATES A LESS ELABORATE PROCEDURE SHOULD BE CONSIDERED.
P502	RENTAL ONLY ALLOWED; MEDICAL NEED FOR PURCHASE HAS NOT BEEN DOCUMENTED.
P503	PURCHASE ONLY ALLOWED; MEDICAL NEED FOR RENTAL HAS NOT BEEN DOCUMENTED.
P504	OCCUPATIONAL THERAPY GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P505	THE SERVICE REQUESTED IS INCLUDED IN THE NURSING HOME RATE STRUCTURE.
P511	THIS NATIONAL DRUG CODE IS ONLY BILLABLE AS PART OF A COMPOUND DRUG.
P515	THE PRESENCE OF A HANDICAPPING MALOCCLUSION OR HANDICAPPING DENTOFACIAL DEFORMITY IS NOT SUPPORTED BY THE DOCUMENTATION SUBMITTED.

Denial Code	Long Description
P521	THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVERED BY COLORADO MEDICAID.
P522	GASTRO-INTESTINAL SURGERY FOR THE PURPOSE OF WEIGHT CONTROL IS COVERED ONLY AS A LIFE THREATENING PROCEDURE.
P523	THE TREATMENT REQUEST IS NOT CONSISTENT WITH THE CLIENT'S DIAGNOSIS.
P524	PSYCHOTHERAPY PROVIDED IN THE CLIENTS HOME IS NOT A COVERED BENEFIT OF COLORADO MEDICAID.
P525	THE INFORMATION PROVIDED IS NOT CONSISTENT WITH THE INTENSITY OF SERVICES REQUESTED.
P526	INTENSIVE MULTIPLE MODALITY TREATMENT IS NOT CONSISTENT WITH THE INFORMATION PROVIDED.
P527	MULTIPLE PROVIDERS OF TREATMENT ARE NOT INDICATED FOR THIS CLIENT.
P528	THE DURATION OF TREATMENT SESSIONS EXCEED CURRENT COLORADO MEDICAID GUIDELINES.
P534	DOCUMENTATION OF POOR PHYSICAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P535	OTHER PHYSICAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P536	THE PHYSICAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P537	USE OF PHYSICAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P538	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF A PHYSICAL THERAPIST.
P539	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS AND LIVING ARRANGEMENT.
P540	GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P541	THE PROCEDURE(S) REQUESTED ARE NOT MEDICAL IN NATURE.
P542	DOCUMENTATION OF POOR OCCUPATIONAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P543	DOCUMENTATION OF POOR SPEECH THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P544	OTHER OCCUPATIONAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P546	THE OCCUPATIONAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P547	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF PHYSICAL THERAPY.
P548	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P549	ACTIVITIES TO PROMOTE DIVERSION OR GENERAL MOTIVATION ARE NONCOVERED COLORADO MEDICAID SERVICES.
P550	REVISIONS OF THE REQUEST IS NECESSITATED BY THE CLIENTS MINIMAL PROGRESS.
P551	RESTORATIVE NURSING INVOLVEMENT COULD BE INCREASED.
P552	CLIENTS DEMONSTRATED RESPONSE TO CURRENT THERAPY DOES NOT WARRANT THE INTENSE FREQUENCY REQUESTED.
P553	MAINTENANCE IS TWO TIMES PER WEEK OR LESS.
P554	THE SPEECH THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P555	USE OF OCCUPATIONAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P556	USE OF SPEECH THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P557	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF AN OCCUPATIONAL THERAPIST.
P558	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
P559	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P560	THE MATERIALS/ SERVICES REQUESTED ARE PRINCIPALLY COSMETIC IN NATURE.
P561	THE LENS FORMULA DOES NOT JUSTIFY REPLACEMENT.
P562	THE CHANGE IN THE LENS FORMULA DOES NOT WARRANT MULTIPLE REPLACEMENTS.
P563	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.

Denial Code	Long Description
P564	LENSES ONLY ARE APPROVED; PLEASE DISPENSE A CONTRACTED FRAME. THE NON-CONTRACTED FRAME IS NOT MEDICALLY JUSTIFIED.
P565	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P566	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P567	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF OCCUPATIONAL THERAPY.
P568	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF SPEECH THERAPY.
P569	LEVEL, INTENSITY, OR EXTENT OF SERVICE(S) REQUESTED HAS BEEN MODIFIED CONSISTENT WITH MEDICAL NEED AS DEFINED IN THE PLAN OF CARE.
P570	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P571	THE SERVICE ASKED FOR IS NOT COVERED BY COLORADO MEDICAID AS THESE TASKS CAN BE DONE BY NURSES OR ACTIVITY STAFF.
P572	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P573	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.
P574	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P575	MEDICAL NEED FOR EQUIPMENT/ SUPPLY REQUESTED IS NOT SUPPORTED BY DOCUMENTATION SUBMITTED.
P576	OTHER SPEECH THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P577	DOCUMENTATION SUBMITTED IDENTIFIES THAT THE CLIENT HAS FEWER THAN TWO POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P582	LESS EXPENSIVE ALTERNATIVE SERVICES ARE AVAILABLE FOR THIS CLIENT.
P634	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P711	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING PERIODONTAL SCALING AND ROOT PLANNING.
P712	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING GINGIVECTOMY.
P754	AN APPROVED SUBSTANCE ABUSE DAY TREATMENT PROGRAM CANNOT EXCEED A SIX WEEK PERIOD.
P761	THE CLIENT DOES NOT APPEAR TO BE ABLE OR WILLING TO ABSTAIN FROM ALCOHOL/DRUG USAGE WHILE IN TREATMENT. THEREFORE, SUBSTANCE ABUSE DAY TREATMENT SERVICES ARE NOT APPROVED.
P764	THIS CLIENT HAS COMPLETED INTENSIVE SUBSTANCE ABUSE TREATMENT WITHIN THE PAST 12 MONTHS. THE DOCUMENTATION PROVIDED IS NOT ADEQUATE TO JUSTIFY ADDITIONAL INTENSIVE TREATMENT AT THIS TIME.
P785	A LESS THAN SIX-WEEK HEALING PERIOD HAS BEEN SPECIFIED FOR THIS PRIOR AUTHORIZATION. THEREFORE IT IS NOT NECESSARY TO WAIT THE FULL SIX WEEKS AFTER EXTRACTIONS BEFORE TAKING DENTURE IMPRESSIONS.
P818	SIX-WEEK HEALING TIME IS REQUIRED BETWEEN EDENTULATION AND FINAL IMPRESSIONS. PAYMENT FOR DENTURES WILL BE DENIED OR RECOUPED IF HEALING PERIOD IS NOT OBSERVED.
P849	COLORADO MEDICAID HAS DETERMINED THERE WERE (ARE) SEVERAL HOME HEALTH AGENCIES WILLING TO PROVIDE MEDICALLY NECESSARY SKILLED NURSING SERVICES TO THIS CLIENT.
P864	THE DOCUMENTATION YOU HAVE SUBMITTED DOES NOT MEET THE REQUIREMENTS OF COLORADO MEDICAID.
P873	THE MEDICAL NECESSITY FOR THE HOURS REQUESTED IS NOT SUPPORTED BY THE INFORMATION SUBMITTED.
P874	THE DOCUMENTATION SUBMITTED INDICATES THE TASKS SPECIFIED CAN BE COMPLETED DURING THE VISITS APPROVED.
P878	THE DOCUMENTATION SUBMITTED DOES NOT INDICATE THAT MEDICALLY ORIENTED TASKS ARE MEDICALLY NECESSARY; THEREFORE PERSONAL CARE SERVICES HAVE BEEN APPROVED.
P880	THE QUANTITY OF SERVICES AUTHORIZED FOR THIS CLIENTS PERSONAL CARE HAS BEEN AMENDED BASED ON INFORMATION RECEIVED FROM ONE OR MORE OF THESE SOURCES: THE CLIENT, THEIR PHYSICIAN, AND/OR THE IN-HOME VISIT BY STAFF OF THE OIG (OFFICE OF INSPECTOR GENERAL).

Denial Code	Long Description
P885	THE USE OF THIS DRUG FOR THE INTENDED PURPOSE IS NOT COVERED BY COLORADO MEDICAID, CONSISTENT WITH COLORADO ADMINISTRATIVE CODE AND FEDERAL LAW.
P924	THE MEDICAL RECORDS SUBMITTED WITH THE CURRENT REQUEST CONFLICT OR DISAGREE WITH OUR MEDICAL RECORDS ON THIS CLIENT.
P950	INDEPENDENT NURSES, PLEASE NOTE PAYABLE SERVICES MAY NOT EXCEED 12 HOURS/DAY OR 60 HOURS/WEEK.
P951	SERVICES CAN ONLY BE AUTHORIZED THROUGH ONE YEAR FROM THE PRESCRIPTION DATE.
P952	LEAD INSPECTION IS A COVERED COLORADO MEDICAID SERVICE WHEN THE CHILD HAS BEEN SHOWN TO HAVE LEAD POISONING (E.G., CHILD HAS A BLOOD LEAD LEVEL > 19 UG/DL OR TWO CONSECUTIVE BLOOD LEAD LEVELS OF 15-19 UG/DL DONE AT LEAST 90 DAYS APART). THE INSPECTION MUS
P953	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P954	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P956	THE REQUEST CAN ONLY BE BACKDATED A MAXIMUM OF 14 DAYS FROM FIRST DATE RECEIVED BY COLORADO MEDICAID.
P957	COMPLETE PERIODONTAL CHARTING AT TIME OF SERVICE, AND SUBMIT CHARTING, COPY OF OPERATIVE REPORT, TOGETHER WITH A COPY OF THE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF), F-11035, TO PA UNIT ATTENTION DENTAL CONTSULTANT.
P958	NOTE THAT CODE D4341 HAS BEEN CHANGED. REFER TO THE DECISION NOTICE FOR AUTHORIZED QUANTITY.
P960	YOUR PA HAS BEEN APPROVED FOR 90 DAYS. THE 90 DAY APPROVAL DOES NOT IMPLY THE PA REQUEST MEETS PRIOR AUTHORIZATION CRITERIA. AFTER ADDITIONAL INFORMATION IS AVAILABLE IN INTERCHANGE, COLORADO MEDICAID WILL CREATE AN AMENDMENT REQUEST TO EXTEND THE PA FOR
P961	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P962	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
PA10	THE REQUESTED END DATE IS INVALID.
PA12	PLEASE FURNISH A WRITTEN DESCRIPTION OF THE CLIENTS DIAGNOSIS.
PA13	PROVIDE DIAGNOSES WITH DATES OF ONSET.
PA14	IDENTIFY PROBLEMS TO BE TREATED.
PA15	THE AUDIOLOGISTS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1), F-11020, AND PRIOR AUTHORIZATION REQUEST/HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2), F-11021.
PA16	THE PHYSICIANS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION/PHYSICIAN OTOLOGICAL REPORT (PA/POR), F-11019.
PA17	SUBMIT BRIEF HISTORY WITH REFERRAL INFORMATION, LIVING SITUATION, FUNCTIONAL STATUS, AND OTHER PERTINENT INFORMATION. WHAT CHANGE OF STATUS RESULTED IN REFERRAL AT THIS TIME?
PA18	PLEASE FURNISH THE CLIENTS HEIGHT AND WEIGHT.
PA19	PLEASE SUBMIT CLINICAL INFORMATION SUFFICIENT TO VERIFY THE NEED FOR THE REQUESTED SERVICE(S).
PA20	PLEASE RESUBMIT WITH COMPLETE PERIODONTAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PA21	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL EDUCATIONAL PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA22	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL PROGRAM PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA23	REFER TO THE DURABLE MEDICAL EQUIPMENT INDEX FOR APPROPRIATE CODE AND DESCRIPTION. DO NOT USE AN "UNLISTED" CODE.
PA24	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUALIZED FAMILY SERVICE PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA25	INFORMATION ON THE REQUEST FORM IS ILLEGIBLE, AND THE REQUEST CANNOT BE PROCESSED.

Denial Code	Long Description
PA26	RE-EVALUATE YOUR GOALS. EMPHASIS SHOULD BE ON FUNCTIONAL SELF-CARE. GOALS MUST BE RELATED TO FUNCTIONAL OUTCOME.
PA27	PLEASE CLARIFY THE NUMBER OF HOURS PER WEEK REQUESTED.
PA28	PLEASE CLARIFY THE NUMBER OF HOURS PER DAY REQUESTED.
PA29	PLEASE CLARIFY THE NUMBER OF VISITS PER DAY REQUESTED.
PA30	ATTACH SUPPORTIVE DOCUMENTATION; HOME EXERCISE PROGRAM AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA31	THE DIAGNOSIS CODE INDICATED ON THE REQUEST DOES NOT CORRESPOND TO THE DIAGNOSIS CODE DESCRIPTION.
PA32	PLEASE SUBMIT ADDITIONAL INFORMATION SUFFICIENT TO VERIFY APPROPRIATENESS AND NEED FOR TRANSPLANT.
PA33	PLEASE SUBMIT THE INITIAL AND PROGRESSIVE OBJECTIVE FINDINGS.
PA34	ATTACH SUPPORTIVE DOCUMENTATION, FACILITY PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA35	PLEASE SUBMIT THE CLIENTS ORIGINAL COMPLAINTS AND EXAMINATION FINDINGS.
PA36	ATTACH SUPPORTIVE DOCUMENTATION, IN-HOME AUTISM PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA37	PLEASE SUBMIT YOUR TREATMENT PLAN FOR THIS CLIENT.
PA38	ATTACH SUPPORTIVE DOCUMENTATION AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA39	INITIAL EVALUATIONS MUST BE PERFORMED BY AN OCCUPATIONAL THERAPIST REGISTERED (OTR), PER AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA) STANDARDS.
PA41	IDENTIFY THE PLACE OF SERVICE AND ITS EFFECT ON SUPPORTING THE DESIRED TREATMENT OUTCOME.
PA42	PLEASE INDICATE THE HOURS OF USE OF OXYGEN PER 24-HOUR PERIOD.
PA43	PROVIDE BASELINE DOCUMENTATION FOR THIS CLIENTS LIMITATIONS USING UNITS OF MEASUREMENT THAT ARE APPLIED CONSISTENTLY WHEN REPORTING STATUS.
PA44	IDENTIFY FUNCTIONAL LIMITATIONS AS THEY ARE RELATED TO IDENTIFIED CONDITIONS.
PA46	CORRELATE PLAN OF CARE TO REQUESTED PROCEDURE CODES.
PA47	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE FREQUENCY/DURATION REQUESTED.
PA48	PLEASE PROVIDE THE NAME AND CREDENTIALS OF THE RENDERING PROVIDER.
PA50	COLORADO MEDICAID RECORDS INDICATE THE CLIENT OWNS A WHEELCHAIR. DOCUMENT THE REASON AND NEED FOR REPLACEMENT AND COST TO REPAIR CURRENT WHEELCHAIR.
PA51	PLEASE DISTINGUISH PRIMARY AND SUPPORTIVE MODALITIES.
PA52	PLEASE SUBMIT A PROGRESS REPORT.
PA53	MULTIPLE FAMILY CLIENTS TREATMENT BY THE SAME PROVIDER REQUIRES FURTHER INFORMATION DOCUMENTING COORDINATION OF TREATMENT PLAN.
PA54	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE MINUTES REQUESTED.
PA55	MEDICAL NECESSITY OF TREATMENT REQUIRES ADDITIONAL DOCUMENTATION.
PA56	GIVEN AGE, DIAGNOSES, CURRENT LEVEL OF FUNCTION, PAST RESPONSE TO TREATMENT, AND LIVING SITUATION, EXPAND ON POTENTIAL FOR SIGNIFICANT FUNCTIONAL PROGRESS WITHIN THE NEXT SIX MONTHS. EMPHASIZE WHY PROGRESS IS EXPECTED WITH SERVICES AT THIS TIME.
PA57	SUBMIT THE INITIAL FINDINGS. INCLUDE A COMPREHENSIVE EVALUATION.
PA58	SUBMIT PROGRESSIVE, OBJECTIVE FINDINGS. INCLUDE A PERTINENT RE-EVALUATION.
PA59	PLEASE SUPPLY INFORMATION REGARDING THE CLIENTS MEDICATION REQUIREMENTS, IF ANY.
PA60	PLEASE SPECIFY IF THE CLIENT IS IN AN EDUCATIONAL SETTING.
PA61	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA62	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
PA63	THE SKILLS OF A THERAPIST ARE PURPOSEFUL AND SKILLED INTERVENTIONS REQUIRED TO CONTINUALLY DESIGN, IMPLEMENT, REASSESS, MODIFY/GRADE, AND/OR DISCONTINUE A PLAN OF CARE IN A TIMELY MANNER, BASED ON THE COMPLEXITY OF THE CLIENTS MEDICAL CONDITION AND/OR CO

Denial Code	Long Description
PA64	PLEASE SUBMIT A THERAPY PLAN OF CARE, INCLUDING A CURRENT, DATED EVALUATION.
PA65	A PLAN OF CARE SIGNED AND DATED BY THE PHYSICIAN IS REQUIRED.
PA66	THE SKILLS OF A THERAPIST ARE REQUIRED WHEN ONLY THE THERAPIST CAN SAFELY AND EFFECTIVELY DELIVER THE THERAPEUTIC PROCEDURES BECAUSE OF THEIR UNIQUE KNOWLEDGE, TRAINING, AND EXPERTISE. DESCRIBE THE REASON THAT SOMEONE OTHER THAN A THERAPIST CANNOT SAFELY
PA67	PLEASE SPECIFY IF THE CLIENTS WORK SITE DEMANDS GOOD BINAURAL HEARING.
PA68	DESCRIBE THE REASON, BASED ON THE CLIENTS COGNITIVE, PHYSICAL, COMMUNICATION, OR RESOURCE STATUS, THAT A HOME PROGRAM, EQUIPMENT, OR ENVIRONMENTAL ADAPTATIONS ALONE CANNOT MEET CLIENTS NEEDS.
PA69	PLEASE SPECIFY IF THE CLIENT HAS AN ACCOMPANYING DISABILITY THAT ADDS TO THE HEARING PROBLEM.
PA70	DISTINGUISH REQUESTED PROCEDURES AND GOALS FROM OTHER SERVICES THIS CLIENT RECEIVES. THEY MAY NOT BE DUPLICATIVE.
PA71	PLEASE INDICATE THE NUMBER OF DAYS REQUESTED.
PA73	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA74	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA75	PLEASE DOCUMENT CARRYOVER OF THE THERAPY PROGRAM TO NURSING.
PA76	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA79	PROVIDE EVIDENCE OF SIGNIFICANT FUNCTIONAL PROGRESS IN LAST SIX MONTHS.
PA84	THE GRANT DATE OF THIS REQUEST CANNOT BE PRIOR TO THE SIGNATURE DATE OF THE PRESCRIBING PHYSICIAN.
PA86	PROVIDE EVIDENCE OF SKILLS GAINED IN THERAPY CARRYING OVER TO OTHER SETTINGS WITHIN SIX MONTHS.
PA87	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE NUMBER OF SESSIONS REQUESTED.
PA88	THE REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL SCOPE OF PRACTICE.
PA89	PRIOR AUTHORIZATION IS NOT REQUIRED UNTIL LIMITATION OF SERVICE HAS BEEN REACHED.
PA91	PLEASE SUBMIT REQUIRED X-RAYS.
PA92	PLEASE PROVIDE AN EXPLANATION FOR THE MATERIAL SUBMITTED WITH THE REQUEST.
PA95	PLEASE DESCRIBE HOW THE PROVISION OF THIS SERVICE WOULD PREVENT INSTITUTIONALIZATION OF THE CLIENT.
PA96	COULD THE EXISTING DENTURE(S) BE RELINED OR REBASED? IF NOT, PLEASE EXPLAIN WHY NOT.
PA97	REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL STANDARDS OF PRACTICE.
PA98	PLEASE INDICATE IF THE CLIENT IS CURRENTLY BEING TUBE FED.
PB02	PLEASE PROVIDE THE REQUIRED DATED SIGNATURES ON THE ATTACHMENTS.
PB03	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING THE LOSS/DESTRUCTION/THEFT OF THE HEARING AID.
PB04	DESCRIBE THE CLIENTS ABILITY TO STAND OR AMBULATE SUFFICIENTLY TO ACCOMPLISH SELF-CARE ACTIVITIES.
PB07	PLEASE SUBMIT AN ORTHODONTIC STUDY MODEL OR DIAGNOSTIC CASTS.
PB09	PLEASE PROVIDE A PHOTOGRAPH OF THE INVOLVED AREA(S).
PB10	PLEASE PROVIDE AN ESTIMATION (IN GRAMS) OF THE TOTAL AMOUNT OF TISSUE TO BE RESECTED.
PB11	PLEASE SUBMIT THE PLAN OF CARE FOR CO-TREATMENT.
PB12	FURNISH A DETAILED DESCRIPTION FOR THE PROCEDURE CODE REQUESTED.
PB13	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB15	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB18	PLEASE COMPLETE THE ATTACHED OUT-OF-STATE PROVIDER DATA SHEET, F-11001, AND RESUBMIT.
PB20	A SIGNED AND DATED PRESCRIPTION IS REQUIRED WITHIN THREE MONTHS OF RECEIPT BY COLORADO MEDICAID FOR INITIAL REQUESTS AND WITHIN 12 MONTHS OF RECEIPT BY COLORADO MEDICAID FOR SUBSEQUENT REQUESTS.
PB21	PLEASE COMPLETE THE APPROPRIATE PRIOR AUTHORIZATION ATTACHMENT. CONTACT PROVIDER SERVICES OR THE PRIOR AUTHORIZATION UNIT FOR ASSISTANCE.

Denial Code	Long Description
PB23	PHYSICAL THERAPY ASSISTANT NOTES AND ALL FORMS SUBMITTED MUST BE COSIGNED BY A REGISTERED PHYSICAL THERAPIST.
PB31	ARE YOU REQUESTING A COMPLETE APPLIANCE, OR REPLACEMENT PARTS?
PB32	THE PROCEDURE CODE INDICATED ON THE REQUEST DOES NOT MATCH THE DESCRIPTION OF SERVICE; PLEASE CORRECT AND RESUBMIT.
PB35	THE SERVICE REQUESTED DOES NOT REQUIRE PRIOR AUTHORIZATION.
PB41	PLEASE FURNISH A CURRENT MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT, F-11090 (DATED WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID).
PB45	THE CERTIFICATION PERIOD ON THE PLAN OF CARE (POC) DOES NOT COVER THE REQUESTED GRANT/START DATE. PLEASE RESUBMIT YOUR REQUEST WITH A NEW POC.
PB49	A CERTIFIED OCCUPATIONAL THERAPY ASSISTANTS NOTES MUST BE COSIGNED BY AN OCCUPATIONAL THERAPIST REGISTERED.
PB51	ADDITIONAL INFORMATION IS REQUIRED ON PRIOR AUTHORIZATION TO ENABLE PRICING.
PB54	REQUESTED SERVICES DO NOT MATCH SERVICES ON THE PHYSICIANS ORDERS.
PB59	PLEASE PROVIDE AN INDIVIDUAL EDUCATIONAL PLAN (IEP), WHICH HAS BEEN SIGNED BY THE PROVIDER NO EARLIER THAN NINE MONTHS PRIOR TO RECEIPT AT COLORADO MEDICAID; OTHERWISE, DOCUMENT WHY NO IEP EXISTS.
PB65	PLEASE FURNISH THE ANTICIPATED TOTAL CHARGES FOR THIS REQUEST.
PB66	A PHOTOCOPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED; THE DATE MUST BE WITHIN SIX MONTHS OF RECEIPT BY COLORADO MEDICAID.
PB67	THE PRESCRIPTION DATE MUST INCLUDE MONTH, DAY, AND YEAR.
PB68	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID.
PB73	THE SERVICES IDENTIFIED ON THE PLAN OF CARE DO NOT APPEAR APPROPRIATE FOR THE PROCEDURE CODE(S) REQUESTED ON THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018.
PB74	THE CLIENT/PROVIDER DOES NOT HAVE RETROACTIVE ENROLLMENT.
PB75	THE REQUESTED START DATE IS MORE THAN 14 DAYS BEFORE OR 62 DAYS AFTER RECEIPT.
PB82	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
PB83	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A HOME HEALTH AIDE. PLEASE RESUBMIT AS A PERSONAL CARE WORKER OR PROVIDE ADDITIONAL DOCUMENTATION.
PB86	THE SERVICES REQUESTED ARE NOT BEING PROVIDED IN THE CLIENTS RESIDENCE. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL.
PB87	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A NURSE. PLEASE RESUBMIT AS A HOME HEALTH AIDE OR PROVIDE ADDITIONAL DOCUMENTATION.
PB92	PLEASE FURNISH THE CLIENTS COMPLETE ADDRESS.
PB94	IF THE CLIENT IS A RESIDENT OF A NURSING HOME, SUPPLY THE COMPLETE NAME AND ADDRESS OF THE NURSING HOME.
PB99	THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018, MUST BE SIGNED AND DATED.
PC01	PLEASE SUPPLY THE RENDERING PROVIDERS PROVIDER NUMBER.
PC03	THE DRUG ENFORCEMENT ADMINISTRATION NUMBER IS MISSING OR INVALID.
PC06	PLEASE DESCRIBE YOUR PROGRAM; INCLUDE ENTRY DATE, TERMINATION DATE, HOURS PER WEEK, AND NUMBER OF WEEKS OF PRIMARY INTENSIVE SERVICE REQUESTED.
PC07	PLEASE DESCRIBE YOUR "AFTERCARE/FOLLOW-UP" PLANS FOR THIS CLIENT.
PC08	PLEASE SUPPLY DOCUMENTATION OF PREVIOUS SUBSTANCE ABUSE SERVICES WITH DATE(S) AND OUTCOME.
PC09	PLEASE DESCRIBE IN DETAIL THE TREATMENT OBJECTIVES/GOALS FOR THIS CLIENT.
PC10	PLEASE DESCRIBE THE FAMILY SITUATION/DYNAMICS. EXPLAIN HOW THE FAMILY WILL BE INCORPORATED INTO THE CLIENTS PLAN OF CARE.
PC12	PLEASE EXPLAIN IF YOUR SERVICE ENCOURAGES THE CLIENT TO ATTEND SELF-HELP GROUPS.
PC13	PLEASE SUPPLY A SPECIFIC SCHEDULE OF ACTIVITIES, INCLUDING DAY, TIME OF DAY, LENGTH OF SESSION, AND SERVICE TO BE RENDERED DURING THAT TIME.
PC15	PLEASE FURNISH DIAGNOSTIC RATIONALE.
PC17	PLEASE DOCUMENT IF THE CLIENT EVER RECEIVED SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT.
PC19	PLEASE FURNISH MORE EXTENSIVE AND IN-DEPTH HISTORICAL AND PSYCHOSOCIAL DATA.

Denial Code	Long Description
PC20	PLEASE SUPPLY THE DATE THE CLIENT BECAME TOTALLY ENDENTULOUS.
PC23	PLEASE SUBMIT A PHYSICIANS STATEMENT REGARDING THE MEDICAL NECESSITY OF DENTURES FOR THIS CLIENT. THE PHYSICIANS STATEMENT MUST DOCUMENT THE MEDICAL NEED FOR DENTURES.
PC24	THE SERVICE REQUESTED WAS PREVIOUSLY AUTHORIZED. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT INDICATING THIS FACT IS REQUIRED.
PC25	PLEASE SUPPLY SUFFICIENT MITIGATING CIRCUMSTANCES TO WARRANT THE CONSTRUCTION OF NEW DENTURES(S).
PC26	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
PC28	PLEASE SUBMIT A PHYSICIANS STATEMENT INDICATING DENTURES ARE NECESSARY FOR THIS NURSING HOME CLIENT.
PC29	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING LOSS OR DESTRUCTION OF DENTURE(S). INCLUDE SIGNED STATEMENT FROM CLIENT OR FACILITY DIRECTOR REGARDING HOW, WHEN AND WHERE LOST.
PC30	PLEASE PROVIDE COMPLETE INTRAORAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PC31	PLEASE DESCRIBE ANY RELATED DEFORMITIES OF THE FEET.
PC34	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD WITH REQUESTED DME ITEM(S) AND DOCUMENT IF THE CLIENT CAN USE SAFELY AND INDEPENDENTLY.
PC35	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD AND DESCRIBE THE RESULTS AND EFFECTIVENESS OF THE SERVICE REQUESTED.
PC39	PLEASE INDICATE LITER FLOW PER MINUTE, HOURS OF USE PER 24 HOUR PERIOD, AND THE EXPECTED DURATION OF NEED.
PC40	THE ITEM DOES NOT REQUIRE PRIOR AUTHORIZATION UNTIL THE LIFE EXPECTANCY HAS BEEN REACHED.
PC41	PLEASE SUPPLY INFORMATION INDICATING THE NECESSITY OF POSITIONING THE CLIENT'S BODY IN MULTIPLE POSITIONS.
PC42	PLEASE INDICATE IF THE BED HEIGHT MUST BE CHANGED TO ALLOW FOR SAFE TRANSFER OR ADEQUATE BED CARE.
PC43	SUPPLY A PHYSICIANS STATEMENT INDICATING TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR UNIT HAS REDUCED PAIN, IMPROVED/INCREASED THE CLIENTS ACTIVITY LEVEL, AND/OR REDUCED CLIENTS USE OF PAIN MEDICATION.
PC44	A CURRENT AUTHORIZATION FOR THIS SERVICE IS ON FILE FOR ANOTHER PROVIDER. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT OF THAT FACT IS REQUIRED BY THE CLIENT OF FIRST PROVIDER.
PC59	DOCUMENT DECLINE OR PROGRESS IN SPECIFIC, MEASURABLE, OBJECTIVE TERMS.
PC60	DOCUMENT IF CLIENT HAS DEMONSTRATED A GOOD APPOINTMENT COMPLIANCE RECORD.
PC61	THE PHYSICIANS SIGNATURE DATE MUST NOT EXCEED 90 DAYS FROM THE DATE OF RECEIPT BY COLORADO MEDICAID.
PC62	REQUESTS FOR A CONTINUATION OF THERAPY SHOULD NOT BE SUBMITTED MORE THAN FOUR WEEKS PRIOR TO THE EXPIRATION DATE OF THE CURRENT AUTHORIZATION.
PC63	PLEASE FURNISH THE STYLE AND MANUFACTURER OF THE FRAME.
PC64	PLEASE FURNISH THE CLIENTS LENS FORMULA.
PC66	ALL REQUESTS FOR TINTS REQUIRE DOCUMENTATION OF THE VISUAL OR MEDICAL CONDITION RELATED TO PHOTOPHOBIA.
PC67	PLEASE DOCUMENT THE REASON AND JUSTIFICATION FOR REPLACEMENT BEYOND THE FIRST LENS/FRAME.
PC68	DOCUMENT IF ALL REMAINING MAXILLARY AND/OR MANDIBULAR TEETH ARE DECAY-FREE, PROPERLY RESTORED, AND PERIODONTICALLY SOUND.
PC72	SUPPLY MORE DETAIL REGARDING PROGRESS (ATTACHMENT OF GOALS, ETC.). CORRELATE PROGRESS TO PREVIOUS GOALS AND IDENTIFIED LIMITATIONS.
PC77	PLEASE SUBMIT A PLAN OF CARE DESCRIBING THE SERVICES THAT WOULD BE PROVIDED.
PC78	PLEASE DOCUMENT SPECIFIC, MEASURABLE GOALS.
PC82	THE PRIOR AUTHORIZATION (PA) SYSTEM CAN PROCESS ONLY 26 DETAILS PER PA REQUEST. PLEASE RESUBMIT YOUR REQUEST WITH NO MORE THAN 26 DETAILS.
PC83	PLEASE SUPPLY A PHYSICIANS PRESCRIPTION DATED WITHIN ONE MONTH OF REQUESTED SUBSTANCE ABUSE DAY TREATMENT.

Denial Code	Long Description
PC84	PLEASE PROVIDE INFORMATION INDICATING THIS CLIENT IS APPROPRIATELY DETOXIFIED FROM ALCOHOL AND/OR OTHER DRUGS.
PC85	PLEASE PROVIDE INFORMATION TO INDICATE THE CLIENTS ABILITY TO ABSTAIN FROM ALCOHOL OR DRUGS WHILE IN THE SUBSTANCE ABUSE DAY TREATMENT PROGRAM.
PC86	PLEASE INDICATE IF THIS CLIENT IS WILLING TO PARTICIPATE IN AFTERCARE OR CONTINUING CARE SERVICES.
PC87	PROVIDE MORE INFORMATION ON TREATMENT HISTORY; INCLUDE SERVICE PROVIDED, DATES, AND OUTCOME. PROVIDE DETAIL OF PREVIOUS TREATMENT.
PC88	PLEASE PROVIDE MORE RATIONALE FOR THE APPROPRIATENESS AND MEDICAL NECESSITY OF SUBSTANCE ABUSE DAY TREATMENT.
PC89	PROVIDE A TREATMENT PLAN THAT CONTAINS MEASURABLE GOALS AND OBJECTIVES CORRESPONDING TO THE IDENTIFIED DEFICIT.
PC91	PLEASE PROVIDE MORE INFORMATION ON FAMILY INVOLVEMENT TREATMENT.
PC92	PLEASE PROVIDE MORE HISTORY AND EXPLANATION ABOUT THE ISSUE OF ABSTINENCE FOR THIS CLIENT.
PC94	PLEASE PROVIDE THE ANTICIPATED BEGINNING DATE AND/OR THE ESTIMATED SUBSTANCE ABUSE DAY TREATMENT DISCHARGE DATE.
PC95	PLEASE SUPPLY JUSTIFICATION FOR BEGINNING CLIENT IN SERVICE PRIOR TO AUTHORIZATION BEING OBTAINED.
PC96	THE INITIAL THREE HOURS OF SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IN A CALENDAR YEAR DO NOT REQUIRE PRIOR AUTHORIZATION.
PC97	REIMBURSEMENT FOR INITIAL SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IS LIMITED TO THREE HOURS IN A CALENDAR YEAR AND DOES NOT REQUIRE PRIOR AUTHORIZATION.
PC98	THIS DRUG IS CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE BILL USING THE APPROPRIATE NATIONAL DRUG CODE (NDC) OR SUBMIT A COMPLETED DRUG ADDITION REQUEST FORM IF THE NDC IS NOT LISTED IN THE DRUG INDEX.
PC99	THIS DRUG IS NOT CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL, CURRENT ADMINISTRATIVE RULE, OR COLORADO DRUG INDEX FOR COVERAGE LIMITATIONS.
PD01	DOCUMENT THAT CLIENT HAS ACHIEVED GOOD ORAL HYGIENE, PERIODONTAL CASE TYPE 1 OR 2, AND IS MOTIVATED TO MAINTAIN SAME.
PD03	PLEASE PROVIDE AN ARTERIAL BLOOD GAS READING OR PULSE OXIMETRY RESULTS DONE ON ROOM AIR SIGNED AND DATED BY A MEDICAL DOCTOR. THIS SHOULD BE DONE WITHIN 60 DAYS OF REQUESTED SERVICE.
PD04	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 30 DAYS OF RECEIPT BY COLORADO MEDICAID.
PD07	SUBMIT A PHOTOCOPY OF A VALID PRESCRIPTION, ISSUED WITHIN THE PAST YEAR, OR COMPLETE SECTION B OF THE PRIOR AUTHORIZATION/DRUG ATTACHMENT (PA/DGA), F-11049.
PD10	BRAND MEDICALLY NECESSARY MUST BE IN THE PRESCRIBERS OWN HANDWRITING AND WRITTEN DIRECTLY ON THE PRESCRIPTION OR A SEPARATE ORDER ATTACHED TO THE ORIGINAL PRESCRIPTION.
PD12	COMPLETE DENTURES, PARTIAL DENTURES, DENTURE RELINES, AND FIXED PROSTHODONTIC SERVICES ARE NOT COVERED SERVICES FOR ADULTS FOR DATES OF SERVICE ON AND AFTER OCTOBER 1, 1995.
PD22	PLEASE COMPLETE ALL REQUIRED ELEMENTS ON THE PERSONAL CARE SCREENING TOOL (PCST), F-11133.
PD24	THIS PRIOR AUTHORIZATION REQUEST IS UNABLE TO BE PROCESSED. PLEASE RESUBMIT WITH ADDITIONAL REQUIRED FORMS, INCLUDING THE ENTIRE PERSONAL CARE SCREENING TOOL (PCST), F-11133; PERSONAL CARE ADDENDUM, F-11136; AND SUPPORTING DOCUMENTATION, AS DIRECTED.
PD25	THERE IS A PERSONAL CARE SCREENING TOOL (PCST), F-11133, COMPLETED BY ANOTHER AGENCY. CONTACT THE AGENCY TO TRANSFER SCREEN.
PD26	THERE IS A LIMITED TERM CARE FUNCTIONAL SCREEN (LTC-FS) COMPLETED BY ANOTHER AGENCY. THE PERSONAL CARE SCREENING TOOL (PCST), F-11133, INFORMATION IS IN CONFLICT WITH LTC-FS.
PD27	ONLY ONE LEVEL OF FUNCTION MAY BE SELECTED FOR ALL ELEMENTS EXCEPT TOILETING. COLORADO MEDICAID IS UNABLE TO PROCESS THE PRIOR AUTHORIZATION REQUEST.
PD28	NO UNITS MAY BE REQUESTED USING THIS PRIOR AUTHORIZATION PROCESS. PLEASE SUBMIT WITH THE APPROPRIATE ATTACHMENTS FOR REQUESTING SPECIFIC PERSONAL CARE WORKER UNITS.

Denial Code	Long Description
PD29	CLIENT IS NOT ELIGIBLE FOR THE REQUESTED SERVICE(S) AS OF THE REQUESTED START DATE.
PD30	NO TRAVEL TIME MAY BE AUTHORIZED WHEN NO PERSONAL CARE WORKER SERVICE IS AUTHORIZED.
PD32	PROVIDER NOT CERTIFIED TO RENDER THE SERVICE(S) REQUESTED.
PD34	BASED ON THE DOCUMENTATION SUBMITTED, THIS REQUEST CAN NOT BE PRIOR AUTHORIZED. REFER TO THE PA MESSAGES FROM THE CONSULTANT FOR COMPLETE EXPLANATION.
PD98	PLEASE DOCUMENT HOW AND WHEN EACH PREVIOUSLY AUTHORIZED PRO RE NATA VISIT WAS USED.

Disposable Medical Supplies

Denial Code	Long Description
0201	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
0233	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0235	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0237	CLIENT IDENTIFICATION NUMBER DOES NOT MATCH CLIENTS FIRST NAME.
0238	THE CLIENT IDENTIFICATION NUMBER DOES NOT MATCH THE CLIENTS LAST NAME.
0242	SECONDARY DIAGNOSIS CODE IS INVALID.
0248	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0249	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0251	PROCEDURE CODE MODIFIER IN FIRST POSITION IS INVALID.
0252	THE PROCEDURE CODE MODIFIER IN SECOND POSITION IS INVALID FOR REQUESTED START DATE OR DATE OF RECEIPT.
0253	THE PROCEDURE CODE MODIFIER IN THIRD POSITION IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
0258	THE PRIMARY DIAGNOSIS CODE IS REQUIRED.
0272	THE PRIMARY DIAGNSOSIS CODE IS INVALID.
0400	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0853	HCPCS - ANNUAL UPDATE
0885	NEVER EVENTS MODIFIERS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
0886	NEVER EVENTS DIAGNOSIS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
1000	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
1002	RENDERING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1003	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1007	RENDERING PROVIDER ID IS NOT ON FILE.
1047	THE RENDERING PROVIDERS CERTIFICATION HAS BEEN CANCELLED.
1048	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1801	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
1804	A CERTIFIED SUBSTANCE ABUSE DAY TREATMENT PROVIDER MUST SUBMIT A SUBSTANCE ABUSE DAY TREATMENT PROCEDURE CODE.
1806	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
1808	THE BILLING PROVIDER DOES NOT HAVE THE REQUIRED CERTIFICATION ADDENDUM ON FILE.
1900	THE BILLING PROVIDERS TAXONOMY CODE IS INVALID.
1901	THE RENDERING PROVIDERS TAXONOMY CODE IS INVALID.
1927	A NATIONAL PROVIDER IDENTIFIER IS REQUIRED FOR THE BILLING PROVIDER.
1934	A NATIONAL PROVIDER INDENTIFIER IS REQUIRED FOR THE RENDERING PROVIDER.
1936	THE BILLING PROVIDER NUMBER IS INVALID.
1937	THE RENDERING PROVIDER NUMBER IS INVALID.
1960	INTERNAL PROCESSING IS REQUIRED.
1963	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.

Denial Code	Long Description
1964	THE BILLING PROVIDER INDICATED IS NOT ALLOWABLE AS A BILLING PROVIDER.
1965	RENDERING PROVIDER NUMBER IS MISSING/INVALID FOR THIS PROCEDURE PROVIDER.
1974	PRESCRIBING/REFERRING/ORDERING PROVIDER INDICATED IS NOT CERTIFIED AS A PRESCRIBING/REFERRING/ORDERING PROVIDER.
1975	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
1976	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
2001	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2003	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2017	THE CLIENT IS ENROLLED IN A MEDICAID OR OTHER MANAGED CARE PROGRAM.
2037	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2603	CLIENT LOCKED-IN TO A PROVIDER OR ENROLLED IN A HOSPICE. CONTACT CLIENTS HOSPICE FOR PAYMENT OF SERVICES OR RESUBMIT WITH DOCUMENTATION OF UNRELATED NATURE OF CARE.
3324	THE MODIFIER HAS BEEN DISCONTINUED BY THE CENTERS OF MEDICARE AND MEDICAID SERVICES OR THE AMERICAN MEDICAL ASSOCIATION FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
3337	THE PROCEDURE CODE HAS BEEN TERMINATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AMERICAN MEDICAL ASSOCIATION, OR AMERICAN DENTAL ASSOCIATION FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT. RESUBMIT WITH VALID A PROCEDURE CODE.
3339	THE PROCEDURE BILLED IS NOT PAYABLE ACCORDING TO DEFICIT REDUCTION ACT (DEFRA) GUIDELINES.
3351	THE PROCEDURE IS NOT COVERED FOR CLIENTS WITH A NURSING HOME AUTHORIZATION ON THE REQUESTED START DATE OR DATE OF RECEIPT.
3353	THE PROCEDURE IS NOT A COVERED SERVICE FOR HOME AND COMMUNITY-BASED WAIVER CLIENTS.
4021	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4027	THE DIAGNOSIS CODE IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
4031	THE PROCEDURE SUBMITTED IS NOT APPROPRIATE FOR CLIENTS GENDER.
4032	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4034	THE PROCEDURE CODE HAS AN AGE RESTRICTION.
4036	THE PLACE OF SERVICE CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4040	THE PRIMARY DIAGNOSIS CODE IS NOT ON FILE.
4041	THE SECONDARY DIAGNOSIS IS NOT ON FILE.
4046	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4127	INTERNAL PROCESSING IS REQUIRED.
4131	INTERNAL PROCESSING IS REQUIRED.
4141	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4149	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4150	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4236	ETIOLOGY DIAGNOSIS CODE(S) (E-CODES) ARE INVALID AS THE PRIMARY DIAGNOSIS.
4244	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4245	THE FOURTH POSITION MODIFIER IS INVALID FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT.
4256	THE PROCEDURE CODE AND MODIFIER COMBINATION IS NOT PAYABLE FOR THE CLIENTS BENEFIT PLAN.
4257	THE MODIFIERS SUBMITTED ARE EITHER INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT OR THE MODIFIERS ARE MISSING.
4311	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4315	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4316	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4371	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4372	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4711	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR CLIENTS AGE.
4714	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS AGE.
4731	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS DIAGNOSIS.
4742	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4743	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4744	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.

Denial Code	Long Description
4745	DIAGNOSIS AND/OR PROCEDURE AND/OR PLACE OF SERVICE (POS) CODE IS NOT COVERED FOR EXPRESS ENROLLMENT CLIENTS.
4746	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4801	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4802	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
4821	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
4871	PLEASE REFER TO PA MESSAGES FOR RETURN INFORMATION.
4963	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS GENDER.
4990	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
7500	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
7509	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
P001	THE BILLING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THE SERVICES.
P002	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P003	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P005	THE PRIOR AUTHORIZATION CAN NOT BE END DATED. THE PRIOR AUTHORIZATION STATUS IS NOT APPROVED OR APPROVED WITH REVISIONS.
P006	PLEASE FURNISH THE PROCEDURE CODE AND CORRESPONDING DESCRIPTION.
P008	THE BILLING PROVIDER NUMBER IS INVALID.
P009	THE BILLING PROVIDER NUMBER IS INVALID.
P010	THE REQUESTED END DATE IS INVALID.
P011	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P012	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P013	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P014	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P015	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P016	THE REQUESTED START DATE IS MISSING OR INVALID.
P020	THE RENDERING PROVIDER NUMBER IS INVALID.
P021	THE RENDERING PROVIDER NUMBER IS INVALID.
P022	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P023	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P024	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P026	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P027	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P030	FIRST MODIFIER IS INVALID.
P031	FIRST MODIFIER IS INVALID.
P032	SECOND MODIFIER IS INVALID.
P033	SECOND MODIFIER IS INVALID.
P034	THIRD MODIFIER IS INVALID.
P035	THIRD MODIFIER IS INVALID.
P036	FOURTH MODIFIER IS INVALID.
P037	FOURTH MODIFIER IS INVALID.
P038	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P039	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P040	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.

Denial Code	Long Description
P041	CLIENTS FIRST NAME IS MISSING.
P042	CLIENTS LAST NAME IS MISSING.
P043	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P044	BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES REQUESTED.
P045	FIRST MODIFIER IS INVALID.
P046	SECOND MODIFIER IS INVALID.
P047	THIRD MODIFIER IS INVALID.
P048	FOURTH MODIFIER IS INVALID.
P052	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P053	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P054	RENDERING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES FOR THE BENEFIT PLAN.
P055	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P061	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P062	THE CLIENT ID AND/OR NAME INDICATED ON THE PA REQUEST IS INCORRECT. THE CLIENT ID AND/OR NAME HAS BEEN UPDATED. PLEASE VERIFY THE ID AND/OR NAME IS CORRECT.
P064	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
P067	THE FREQUENCY OF HOURS REQUESTED ARE NOT APPROPRIATE FOR THIS CLIENT AND HAVE BEEN MODIFIED ACCORDINGLY.
P079	BILLING PROVIDER IS ON PAYMENT SUSPENSION DUE TO CREDIBLE ALLEGATION OF FRAUD.
P120	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAS BEEN REDUCED.
P121	THE SERVICE/ PROCEDURE REQUESTED IS NOT SUPPORTED BY SUBMITTED DOCUMENTATION.
P126	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
P128	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.
P138	SERVICE(S) DO NOT MEET COLORADO MEDICAID GUIDELINES.
P167	REQUESTED DOCUMENTATION HAS NOT BEEN SUBMITTED.
P178	THE SERVICE REQUESTED IS NOT MEDICALLY NECESSARY.
P179	THE MEDICAL NECESSITY FOR THIS SERVICE IS NOT SUPPORTED BY THE SUBMITTED DOCUMENTATION.
P233	THE DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE ADDITIONAL CARE.
P257	THIS CLIENTS FUNCTIONAL ASSESSMENT SCORES PLACE THIS CLIENT OUTSIDE ELIGIBILITY FOR DAY TREATMENT.
P274	OUR RECORDS INDICATE THIS CLIENT IS INVOLVED IN EFFECTIVE AND APPROPRIATE SERVICE ELSEWHERE.
P292	INTENSIVE REHABILITATION HOURS ARE NO LONGER APPROPRIATE AS INDICATED BY HISTORY, DIAGNOSIS, AND/ OR FUNCTIONAL ASSESSMENT SCORES.
P328	THE SERVICES REQUESTED INCLUDE NON-COVERED SERVICES, AND HOURS ARE REDUCED ACCORDINGLY.
P339	THE CLIENTS PAST HISTORY INDICATES REDUCED TREATMENT HOURS ARE WARRANTED.
P342	THE REQUEST DOES NOT MEET GENERALLY ACCEPTED CONDITIONS REQUIRING FLUORIDE TREATMENTS.
P346	SERVICES EXCEED COLORADO MEDICAID LIMITATION AND DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE MEDICAL NECESSITY OF THE SERVICE.
P349	THE SERVICE REQUESTED WAS PERFORMED LESS THAN FIVE YEARS AGO.
P353	THE EXISTING APPLIANCE HAS NOT BEEN WORN FOR THREE YEARS.
P367	THE CLIENT HAS BEEN TOTALLY WITHOUT TEETH AND AN APPLIANCE FOR FIVE YEARS.
P392	THE CLIENT IS MISSING AN ANTERIOR TOOTH AND/OR HAS TWO OR MORE POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P405	THE SERVICE(S) REQUESTED COULD ADEQUATELY BE PERFORMED IN THE DENTAL OFFICE.
P406	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE OF GOOD PERIODONTAL HEALTH (AMERICAN ACADEMY OF PERIODONTOLOGY PERIODONTAL CLASSIFICATION OF TYPE I OR II).
P407	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE VISIBLE ON RADIOGRAPHS THAT AT LEAST 50 PERCENT OF THE CLINICAL CROWN IS INTACT.

Denial Code	Long Description
P409	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING SIX OR MORE TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED, INCLUDING THIRD MOLARS.
P410	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING ONE OR MORE ANTERIOR TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED.
P411	DOCUMENTATION DOES NOT SUPPORT THE NEED FOR PERIODONTIC SERVICES. POCKETS ARE LESS THAN 4MM AND/OR GREATER THAN 6MM FOR CLIENT AND/OR THE CLIENT IS UNDER THE AGE OF 13.
P412	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA.
P413	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA. THIS PA HAS BEEN GRANTED AS APPROVED NOT APPROVED WITH REVISIONS. THE DURATION REQUESTED MAY HAVE BEEN REDUCED TO REFLECT COVERAGE LIMITATIONS, PRESCRIBER ORDERS, CONFLICTI
P417	THE SERVICE(S) REQUESTED COULD BE ADEQUATELY PERFORMED WITH LOCAL ANESTHESIA.
P437	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO POOR ORAL HYGIENE.
P444	THIS LINE ITEM IS A DUPLICATE OF ANOTHER LINE ITEM ON THIS PRIOR AUTHORIZATION (PA) REQUEST. PLEASE CORRECT.
P446	THIS IS A DUPLICATE OF AN EXISTING PRIOR AUTHORIZATION (PA) REQUEST. YOU MAY CONTACT PROVIDER SERVICES IF YOU REQUIRE ASSISTANCE. DUPLICATE PA REQUEST
P448	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO DECAY HISTORY.
P449	QUESTIONABLE LONG TERM PROGNOSIS DUE TO GUM AND BONE DISEASE.
P456	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO APPARENT ROOT INFECTION.
P457	OUR RECORDS INDICATE THIS CLIENT HAS EXCEEDED ESTABLISHED PROGRAM LIMITATIONS. COLORADO MEDICAID WILL NOT AUTHORIZE NEW DENTURES.
P458	DOCUMENTATION PROVIDED INDICATES A LESS ELABORATE PROCEDURE SHOULD BE CONSIDERED.
P502	RENTAL ONLY ALLOWED; MEDICAL NEED FOR PURCHASE HAS NOT BEEN DOCUMENTED.
P503	PURCHASE ONLY ALLOWED; MEDICAL NEED FOR RENTAL HAS NOT BEEN DOCUMENTED.
P504	OCCUPATIONAL THERAPY GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P505	THE SERVICE REQUESTED IS INCLUDED IN THE NURSING HOME RATE STRUCTURE.
P511	THIS NATIONAL DRUG CODE IS ONLY BILLABLE AS PART OF A COMPOUND DRUG.
P515	THE PRESENCE OF A HANDICAPPING MALOCCLUSION OR HANDICAPPING DENTOFACIAL DEFORMITY IS NOT SUPPORTED BY THE DOCUMENTATION SUBMITTED.
P521	THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVERED BY COLORADO MEDICAID.
P522	GASTRO-INTESTINAL SURGERY FOR THE PURPOSE OF WEIGHT CONTROL IS COVERED ONLY AS A LIFE THREATENING PROCEDURE.
P523	THE TREATMENT REQUEST IS NOT CONSISTENT WITH THE CLIENT'S DIAGNOSIS.
P524	PSYCHOTHERAPY PROVIDED IN THE CLIENTS HOME IS NOT A COVERED BENEFIT OF COLORADO MEDICAID.
P525	THE INFORMATION PROVIDED IS NOT CONSISTENT WITH THE INTENSITY OF SERVICES REQUESTED.
P526	INTENSIVE MULTIPLE MODALITY TREATMENT IS NOT CONSISTENT WITH THE INFORMATION PROVIDED.
P527	MULTIPLE PROVIDERS OF TREATMENT ARE NOT INDICATED FOR THIS CLIENT.
P528	THE DURATION OF TREATMENT SESSIONS EXCEED CURRENT COLORADO MEDICAID GUIDELINES.
P534	DOCUMENTATION OF POOR PHYSICAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P535	OTHER PHYSICAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P536	THE PHYSICAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P537	USE OF PHYSICAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P538	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF A PHYSICAL THERAPIST.
P539	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS AND LIVING ARRANGEMENT.
P540	GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P541	THE PROCEDURE(S) REQUESTED ARE NOT MEDICAL IN NATURE.

Denial Code	Long Description
P542	DOCUMENTATION OF POOR OCCUPATIONAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P543	DOCUMENTATION OF POOR SPEECH THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P544	OTHER OCCUPATIONAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P546	THE OCCUPATIONAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P547	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF PHYSICAL THERAPY.
P548	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P549	ACTIVITIES TO PROMOTE DIVERSION OR GENERAL MOTIVATION ARE NONCOVERED COLORADO MEDICAID SERVICES.
P550	REVISIONS OF THE REQUEST IS NECESSITATED BY THE CLIENTS MINIMAL PROGRESS.
P551	RESTORATIVE NURSING INVOLVEMENT COULD BE INCREASED.
P552	CLIENTS DEMONSTRATED RESPONSE TO CURRENT THERAPY DOES NOT WARRANT THE INTENSE FREQUENCY REQUESTED.
P553	MAINTENANCE IS TWO TIMES PER WEEK OR LESS.
P554	THE SPEECH THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P555	USE OF OCCUPATIONAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P556	USE OF SPEECH THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P557	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF AN OCCUPATIONAL THERAPIST.
P558	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
P559	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P560	THE MATERIALS/ SERVICES REQUESTED ARE PRINCIPALLY COSMETIC IN NATURE.
P561	THE LENS FORMULA DOES NOT JUSTIFY REPLACEMENT.
P562	THE CHANGE IN THE LENS FORMULA DOES NOT WARRANT MULTIPLE REPLACEMENTS.
P563	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P564	LENSES ONLY ARE APPROVED; PLEASE DISPENSE A CONTRACTED FRAME. THE NON-CONTRACTED FRAME IS NOT MEDICALLY JUSTIFIED.
P565	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P566	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P567	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF OCCUPATIONAL THERAPY.
P568	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF SPEECH THERAPY.
P569	LEVEL, INTENSITY, OR EXTENT OF SERVICE(S) REQUESTED HAS BEEN MODIFIED CONSISTENT WITH MEDICAL NEED AS DEFINED IN THE PLAN OF CARE.
P570	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P571	THE SERVICE ASKED FOR IS NOT COVERED BY COLORADO MEDICAID AS THESE TASKS CAN BE DONE BY NURSES OR ACTIVITY STAFF.
P572	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P573	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.
P574	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P575	MEDICAL NEED FOR EQUIPMENT/ SUPPLY REQUESTED IS NOT SUPPORTED BY DOCUMENTATION SUBMITTED.
P576	OTHER SPEECH THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.

Denial Code	Long Description
P577	DOCUMENTATION SUBMITTED IDENTIFIES THAT THE CLIENT HAS FEWER THAN TWO POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P582	LESS EXPENSIVE ALTERNATIVE SERVICES ARE AVAILABLE FOR THIS CLIENT.
P634	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P711	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING PERIODONTAL SCALING AND ROOT PLANNING.
P712	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING GINGIVECTOMY.
P754	AN APPROVED SUBSTANCE ABUSE DAY TREATMENT PROGRAM CANNOT EXCEED A SIX WEEK PERIOD.
P761	THE CLIENT DOES NOT APPEAR TO BE ABLE OR WILLING TO ABSTAIN FROM ALCOHOL/DRUG USAGE WHILE IN TREATMENT. THEREFORE, SUBSTANCE ABUSE DAY TREATMENT SERVICES ARE NOT APPROVED.
P764	THIS CLIENT HAS COMPLETED INTENSIVE SUBSTANCE ABUSE TREATMENT WITHIN THE PAST 12 MONTHS. THE DOCUMENTATION PROVIDED IS NOT ADEQUATE TO JUSTIFY ADDITIONAL INTENSIVE TREATMENT AT THIS TIME.
P785	A LESS THAN SIX-WEEK HEALING PERIOD HAS BEEN SPECIFIED FOR THIS PRIOR AUTHORIZATION. THEREFORE IT IS NOT NECESSARY TO WAIT THE FULL SIX WEEKS AFTER EXTRACTIONS BEFORE TAKING DENTURE IMPRESSIONS.
P818	SIX-WEEK HEALING TIME IS REQUIRED BETWEEN EDENTULATION AND FINAL IMPRESSIONS. PAYMENT FOR DENTURES WILL BE DENIED OR RECOUPED IF HEALING PERIOD IS NOT OBSERVED.
P849	COLORADO MEDICAID HAS DETERMINED THERE WERE (ARE) SEVERAL HOME HEALTH AGENCIES WILLING TO PROVIDE MEDICALLY NECESSARY SKILLED NURSING SERVICES TO THIS CLIENT.
P864	THE DOCUMENTATION YOU HAVE SUBMITTED DOES NOT MEET THE REQUIREMENTS OF COLORADO MEDICAID.
P873	THE MEDICAL NECESSITY FOR THE HOURS REQUESTED IS NOT SUPPORTED BY THE INFORMATION SUBMITTED.
P874	THE DOCUMENTATION SUBMITTED INDICATES THE TASKS SPECIFIED CAN BE COMPLETED DURING THE VISITS APPROVED.
P878	THE DOCUMENTATION SUBMITTED DOES NOT INDICATE THAT MEDICALLY ORIENTED TASKS ARE MEDICALLY NECESSARY; THEREFORE PERSONAL CARE SERVICES HAVE BEEN APPROVED.
P880	THE QUANTITY OF SERVICES AUTHORIZED FOR THIS CLIENTS PERSONAL CARE HAS BEEN AMENDED BASED ON INFORMATION RECEIVED FROM ONE OR MORE OF THESE SOURCES: THE CLIENT, THEIR PHYSICIAN, AND/OR THE IN-HOME VISIT BY STAFF OF THE OIG (OFFICE OF INSPECTOR GENERAL).
P885	THE USE OF THIS DRUG FOR THE INTENDED PURPOSE IS NOT COVERED BY COLORADO MEDICAID, CONSISTENT WITH COLORADO ADMINISTRATIVE CODE AND FEDERAL LAW.
P924	THE MEDICAL RECORDS SUBMITTED WITH THE CURRENT REQUEST CONFLICT OR DISAGREE WITH OUR MEDICAL RECORDS ON THIS CLIENT.
P950	INDEPENDENT NURSES, PLEASE NOTE PAYABLE SERVICES MAY NOT EXCEED 12 HOURS/DAY OR 60 HOURS/WEEK.
P951	SERVICES CAN ONLY BE AUTHORIZED THROUGH ONE YEAR FROM THE PRESCRIPTION DATE.
P952	LEAD INSPECTION IS A COVERED COLORADO MEDICAID SERVICE WHEN THE CHILD HAS BEEN SHOWN TO HAVE LEAD POISONING (E.G., CHILD HAS A BLOOD LEAD LEVEL > 19 UG/DL OR TWO CONSECUTIVE BLOOD LEAD LEVELS OF 15-19 UG/DL DONE AT LEAST 90 DAYS APART). THE INSPECTION MUS
P953	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P954	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P956	THE REQUEST CAN ONLY BE BACKDATED A MAXIMUM OF 14 DAYS FROM FIRST DATE RECEIVED BY COLORADO MEDICAID.
P957	COMPLETE PERIODONTAL CHARTING AT TIME OF SERVICE, AND SUBMIT CHARTING, COPY OF OPERATIVE REPORT, TOGETHER WITH A COPY OF THE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF), F-11035, TO PA UNIT ATTENTION DENTAL CONTSULTANT.
P958	NOTE THAT CODE D4341 HAS BEEN CHANGED. REFER TO THE DECISION NOTICE FOR AUTHORIZED QUANTITY.

Denial Code	Long Description
P960	YOUR PA HAS BEEN APPROVED FOR 90 DAYS. THE 90 DAY APPROVAL DOES NOT IMPLY THE PA REQUEST MEETS PRIOR AUTHORIZATION CRITERIA. AFTER ADDITIONAL INFORMATION IS AVAILABLE IN INTERCHANGE, COLORADO MEDICAID WILL CREATE AN AMENDMENT REQUEST TO EXTEND THE PA FOR
P961	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P962	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
PA10	THE REQUESTED END DATE IS INVALID.
PA12	PLEASE FURNISH A WRITTEN DESCRIPTION OF THE CLIENTS DIAGNOSIS.
PA13	PROVIDE DIAGNOSES WITH DATES OF ONSET.
PA14	IDENTIFY PROBLEMS TO BE TREATED.
PA15	THE AUDIOLOGISTS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1), F-11020, AND PRIOR AUTHORIZATION REQUEST/HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2), F-11021.
PA16	THE PHYSICIANS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION/PHYSICIAN OTOLOGICAL REPORT (PA/POR), F-11019.
PA17	SUBMIT BRIEF HISTORY WITH REFERRAL INFORMATION, LIVING SITUATION, FUNCTIONAL STATUS, AND OTHER PERTINENT INFORMATION. WHAT CHANGE OF STATUS RESULTED IN REFERRAL AT THIS TIME?
PA18	PLEASE FURNISH THE CLIENTS HEIGHT AND WEIGHT.
PA19	PLEASE SUBMIT CLINICAL INFORMATION SUFFICIENT TO VERIFY THE NEED FOR THE REQUESTED SERVICE(S).
PA20	PLEASE RESUBMIT WITH COMPLETE PERIODONTAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PA21	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL EDUCATIONAL PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA22	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL PROGRAM PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA23	REFER TO THE DURABLE MEDICAL EQUIPMENT INDEX FOR APPROPRIATE CODE AND DESCRIPTION. DO NOT USE AN "UNLISTED" CODE.
PA24	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUALIZED FAMILY SERVICE PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA25	INFORMATION ON THE REQUEST FORM IS ILLEGIBLE, AND THE REQUEST CANNOT BE PROCESSED.
PA26	RE-EVALUATE YOUR GOALS. EMPHASIS SHOULD BE ON FUNCTIONAL SELF-CARE. GOALS MUST BE RELATED TO FUNCTIONAL OUTCOME.
PA27	PLEASE CLARIFY THE NUMBER OF HOURS PER WEEK REQUESTED.
PA28	PLEASE CLARIFY THE NUMBER OF HOURS PER DAY REQUESTED.
PA29	PLEASE CLARIFY THE NUMBER OF VISITS PER DAY REQUESTED.
PA30	ATTACH SUPPORTIVE DOCUMENTATION; HOME EXERCISE PROGRAM AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA31	THE DIAGNOSIS CODE INDICATED ON THE REQUEST DOES NOT CORRESPOND TO THE DIAGNOSIS CODE DESCRIPTION.
PA32	PLEASE SUBMIT ADDITIONAL INFORMATION SUFFICIENT TO VERIFY APPROPRIATENESS AND NEED FOR TRANSPLANT.
PA33	PLEASE SUBMIT THE INITIAL AND PROGRESSIVE OBJECTIVE FINDINGS.
PA34	ATTACH SUPPORTIVE DOCUMENTATION, FACILITY PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA35	PLEASE SUBMIT THE CLIENTS ORIGINAL COMPLAINTS AND EXAMINATION FINDINGS.
PA36	ATTACH SUPPORTIVE DOCUMENTATION, IN-HOME AUTISM PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA37	PLEASE SUBMIT YOUR TREATMENT PLAN FOR THIS CLIENT.
PA38	ATTACH SUPPORTIVE DOCUMENTATION AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.

Denial Code	Long Description
PA39	INITIAL EVALUATIONS MUST BE PERFORMED BY AN OCCUPATIONAL THERAPIST REGISTERED (OTR), PER AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA) STANDARDS.
PA41	IDENTIFY THE PLACE OF SERVICE AND ITS EFFECT ON SUPPORTING THE DESIRED TREATMENT OUTCOME.
PA42	PLEASE INDICATE THE HOURS OF USE OF OXYGEN PER 24-HOUR PERIOD.
PA43	PROVIDE BASELINE DOCUMENTATION FOR THIS CLIENTS LIMITATIONS USING UNITS OF MEASUREMENT THAT ARE APPLIED CONSISTENTLY WHEN REPORTING STATUS.
PA44	IDENTIFY FUNCTIONAL LIMITATIONS AS THEY ARE RELATED TO IDENTIFIED CONDITIONS.
PA46	CORRELATE PLAN OF CARE TO REQUESTED PROCEDURE CODES.
PA47	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE FREQUENCY/DURATION REQUESTED.
PA48	PLEASE PROVIDE THE NAME AND CREDENTIALS OF THE RENDERING PROVIDER.
PA50	COLORADO MEDICAID RECORDS INDICATE THE CLIENT OWNS A WHEELCHAIR. DOCUMENT THE REASON AND NEED FOR REPLACEMENT AND COST TO REPAIR CURRENT WHEELCHAIR.
PA51	PLEASE DISTINGUISH PRIMARY AND SUPPORTIVE MODALITIES.
PA52	PLEASE SUBMIT A PROGRESS REPORT.
PA53	MULTIPLE FAMILY CLIENTS TREATMENT BY THE SAME PROVIDER REQUIRES FURTHER INFORMATION DOCUMENTING COORDINATION OF TREATMENT PLAN.
PA54	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE MINUTES REQUESTED.
PA55	MEDICAL NECESSITY OF TREATMENT REQUIRES ADDITIONAL DOCUMENTATION.
PA56	GIVEN AGE, DIAGNOSES, CURRENT LEVEL OF FUNCTION, PAST RESPONSE TO TREATMENT, AND LIVING SITUATION, EXPAND ON POTENTIAL FOR SIGNIFICANT FUNCTIONAL PROGRESS WITHIN THE NEXT SIX MONTHS. EMPHASIZE WHY PROGRESS IS EXPECTED WITH SERVICES AT THIS TIME.
PA57	SUBMIT THE INITIAL FINDINGS. INCLUDE A COMPREHENSIVE EVALUATION.
PA58	SUBMIT PROGRESSIVE, OBJECTIVE FINDINGS. INCLUDE A PERTINENT RE-EVALUATION.
PA59	PLEASE SUPPLY INFORMATION REGARDING THE CLIENTS MEDICATION REQUIREMENTS, IF ANY.
PA60	PLEASE SPECIFY IF THE CLIENT IS IN AN EDUCATIONAL SETTING.
PA61	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA62	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
PA63	THE SKILLS OF A THERAPIST ARE PURPOSEFUL AND SKILLED INTERVENTIONS REQUIRED TO CONTINUALLY DESIGN, IMPLEMENT, REASSESS, MODIFY/GRADE, AND/OR DISCONTINUE A PLAN OF CARE IN A TIMELY MANNER, BASED ON THE COMPLEXITY OF THE CLIENTS MEDICAL CONDITION AND/OR CO
PA64	PLEASE SUBMIT A THERAPY PLAN OF CARE, INCLUDING A CURRENT, DATED EVALUATION.
PA65	A PLAN OF CARE SIGNED AND DATED BY THE PHYSICIAN IS REQUIRED.
PA66	THE SKILLS OF A THERAPIST ARE REQUIRED WHEN ONLY THE THERAPIST CAN SAFELY AND EFFECTIVELY DELIVER THE THERAPEUTIC PROCEDURES BECAUSE OF THEIR UNIQUE KNOWLEDGE, TRAINING, AND EXPERTISE. DESCRIBE THE REASON THAT SOMEONE OTHER THAN A THERAPIST CANNOT SAFELY
PA67	PLEASE SPECIFY IF THE CLIENTS WORK SITE DEMANDS GOOD BINAURAL HEARING.
PA68	DESCRIBE THE REASON, BASED ON THE CLIENTS COGNITIVE, PHYSICAL, COMMUNICATION, OR RESOURCE STATUS, THAT A HOME PROGRAM, EQUIPMENT, OR ENVIRONMENTAL ADAPTATIONS ALONE CANNOT MEET CLIENTS NEEDS.
PA69	PLEASE SPECIFY IF THE CLIENT HAS AN ACCOMPANYING DISABILITY THAT ADDS TO THE HEARING PROBLEM.
PA70	DISTINGUISH REQUESTED PROCEDURES AND GOALS FROM OTHER SERVICES THIS CLIENT RECEIVES. THEY MAY NOT BE DUPLICATIVE.
PA71	PLEASE INDICATE THE NUMBER OF DAYS REQUESTED.
PA73	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA74	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA75	PLEASE DOCUMENT CARRYOVER OF THE THERAPY PROGRAM TO NURSING.
PA76	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).

Denial Code	Long Description
PA79	PROVIDE EVIDENCE OF SIGNIFICANT FUNCTIONAL PROGRESS IN LAST SIX MONTHS.
PA84	THE GRANT DATE OF THIS REQUEST CANNOT BE PRIOR TO THE SIGNATURE DATE OF THE PRESCRIBING PHYSICIAN.
PA86	PROVIDE EVIDENCE OF SKILLS GAINED IN THERAPY CARRYING OVER TO OTHER SETTINGS WITHIN SIX MONTHS.
PA87	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE NUMBER OF SESSIONS REQUESTED.
PA88	THE REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL SCOPE OF PRACTICE.
PA89	PRIOR AUTHORIZATION IS NOT REQUIRED UNTIL LIMITATION OF SERVICE HAS BEEN REACHED.
PA91	PLEASE SUBMIT REQUIRED X-RAYS.
PA92	PLEASE PROVIDE AN EXPLANATION FOR THE MATERIAL SUBMITTED WITH THE REQUEST.
PA95	PLEASE DESCRIBE HOW THE PROVISION OF THIS SERVICE WOULD PREVENT INSTITUTIONALIZATION OF THE CLIENT.
PA96	COULD THE EXISTING DENTURE(S) BE RELINED OR REBASED? IF NOT, PLEASE EXPLAIN WHY NOT.
PA97	REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL STANDARDS OF PRACTICE.
PA98	PLEASE INDICATE IF THE CLIENT IS CURRENTLY BEING TUBE FED.
PB02	PLEASE PROVIDE THE REQUIRED DATED SIGNATURES ON THE ATTACHMENTS.
PB03	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING THE LOSS/DESTRUCTION/THEFT OF THE HEARING AID.
PB04	DESCRIBE THE CLIENTS ABILITY TO STAND OR AMBULATE SUFFICIENTLY TO ACCOMPLISH SELF-CARE ACTIVITIES.
PB07	PLEASE SUBMIT AN ORTHODONTIC STUDY MODEL OR DIAGNOSTIC CASTS.
PB09	PLEASE PROVIDE A PHOTOGRAPH OF THE INVOLVED AREA(S).
PB10	PLEASE PROVIDE AN ESTIMATION (IN GRAMS) OF THE TOTAL AMOUNT OF TISSUE TO BE RESECTED.
PB11	PLEASE SUBMIT THE PLAN OF CARE FOR CO-TREATMENT.
PB12	FURNISH A DETAILED DESCRIPTION FOR THE PROCEDURE CODE REQUESTED.
PB13	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB15	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB18	PLEASE COMPLETE THE ATTACHED OUT-OF-STATE PROVIDER DATA SHEET, F-11001, AND RESUBMIT.
PB20	A SIGNED AND DATED PRESCRIPTION IS REQUIRED WITHIN THREE MONTHS OF RECEIPT BY COLORADO MEDICAID FOR INITIAL REQUESTS AND WITHIN 12 MONTHS OF RECEIPT BY COLORADO MEDICAID FOR SUBSEQUENT REQUESTS.
PB21	PLEASE COMPLETE THE APPROPRIATE PRIOR AUTHORIZATION ATTACHMENT. CONTACT PROVIDER SERVICES OR THE PRIOR AUTHORIZATION UNIT FOR ASSISTANCE.
PB23	PHYSICAL THERAPY ASSISTANT NOTES AND ALL FORMS SUBMITTED MUST BE COSIGNED BY A REGISTERED PHYSICAL THERAPIST.
PB31	ARE YOU REQUESTING A COMPLETE APPLIANCE, OR REPLACEMENT PARTS?
PB32	THE PROCEDURE CODE INDICATED ON THE REQUEST DOES NOT MATCH THE DESCRIPTION OF SERVICE; PLEASE CORRECT AND RESUBMIT.
PB35	THE SERVICE REQUESTED DOES NOT REQUIRE PRIOR AUTHORIZATION.
PB41	PLEASE FURNISH A CURRENT MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT, F-11090 (DATED WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID).
PB45	THE CERTIFICATION PERIOD ON THE PLAN OF CARE (POC) DOES NOT COVER THE REQUESTED GRANT/START DATE. PLEASE RESUBMIT YOUR REQUEST WITH A NEW POC.
PB49	A CERTIFIED OCCUPATIONAL THERAPY ASSISTANTS NOTES MUST BE COSIGNED BY AN OCCUPATIONAL THERAPIST REGISTERED.
PB51	ADDITIONAL INFORMATION IS REQUIRED ON PRIOR AUTHORIZATION TO ENABLE PRICING.
PB54	REQUESTED SERVICES DO NOT MATCH SERVICES ON THE PHYSICIANS ORDERS.
PB59	PLEASE PROVIDE AN INDIVIDUAL EDUCATIONAL PLAN (IEP), WHICH HAS BEEN SIGNED BY THE PROVIDER NO EARLIER THAN NINE MONTHS PRIOR TO RECEIPT AT COLORADO MEDICAID; OTHERWISE, DOCUMENT WHY NO IEP EXISTS.
PB65	PLEASE FURNISH THE ANTICIPATED TOTAL CHARGES FOR THIS REQUEST.
PB66	A PHOTOCOPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED; THE DATE MUST BE WITHIN SIX MONTHS OF RECEIPT BY COLORADO MEDICAID.

Denial Code	Long Description
PB67	THE PRESCRIPTION DATE MUST INCLUDE MONTH, DAY, AND YEAR.
PB68	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID.
PB73	THE SERVICES IDENTIFIED ON THE PLAN OF CARE DO NOT APPEAR APPROPRIATE FOR THE PROCEDURE CODE(S) REQUESTED ON THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018.
PB74	THE CLIENT/PROVIDER DOES NOT HAVE RETROACTIVE ENROLLMENT.
PB75	THE REQUESTED START DATE IS MORE THAN 14 DAYS BEFORE OR 62 DAYS AFTER RECEIPT.
PB82	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
PB83	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A HOME HEALTH AIDE. PLEASE RESUBMIT AS A PERSONAL CARE WORKER OR PROVIDE ADDITIONAL DOCUMENTATION.
PB86	THE SERVICES REQUESTED ARE NOT BEING PROVIDED IN THE CLIENTS RESIDENCE. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL.
PB87	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A NURSE. PLEASE RESUBMIT AS A HOME HEALTH AIDE OR PROVIDE ADDITIONAL DOCUMENTATION.
PB92	PLEASE FURNISH THE CLIENTS COMPLETE ADDRESS.
PB94	IF THE CLIENT IS A RESIDENT OF A NURSING HOME, SUPPLY THE COMPLETE NAME AND ADDRESS OF THE NURSING HOME.
PB99	THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018, MUST BE SIGNED AND DATED.
PC01	PLEASE SUPPLY THE RENDERING PROVIDERS PROVIDER NUMBER.
PC03	THE DRUG ENFORCEMENT ADMINISTRATION NUMBER IS MISSING OR INVALID.
PC06	PLEASE DESCRIBE YOUR PROGRAM; INCLUDE ENTRY DATE, TERMINATION DATE, HOURS PER WEEK, AND NUMBER OF WEEKS OF PRIMARY INTENSIVE SERVICE REQUESTED.
PC07	PLEASE DESCRIBE YOUR "AFTERCARE/FOLLOW-UP" PLANS FOR THIS CLIENT.
PC08	PLEASE SUPPLY DOCUMENTATION OF PREVIOUS SUBSTANCE ABUSE SERVICES WITH DATE(S) AND OUTCOME.
PC09	PLEASE DESCRIBE IN DETAIL THE TREATMENT OBJECTIVES/GOALS FOR THIS CLIENT.
PC10	PLEASE DESCRIBE THE FAMILY SITUATION/DYNAMICS. EXPLAIN HOW THE FAMILY WILL BE INCORPORATED INTO THE CLIENTS PLAN OF CARE.
PC12	PLEASE EXPLAIN IF YOUR SERVICE ENCOURAGES THE CLIENT TO ATTEND SELF-HELP GROUPS.
PC13	PLEASE SUPPLY A SPECIFIC SCHEDULE OF ACTIVITIES, INCLUDING DAY, TIME OF DAY, LENGTH OF SESSION, AND SERVICE TO BE RENDERED DURING THAT TIME.
PC15	PLEASE FURNISH DIAGNOSTIC RATIONALE.
PC17	PLEASE DOCUMENT IF THE CLIENT EVER RECEIVED SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT.
PC19	PLEASE FURNISH MORE EXTENSIVE AND IN-DEPTH HISTORICAL AND PSYCHOSOCIAL DATA.
PC20	PLEASE SUPPLY THE DATE THE CLIENT BECAME TOTALLY ENDENTULOUS.
PC23	PLEASE SUBMIT A PHYSICIANS STATEMENT REGARDING THE MEDICAL NECESSITY OF DENTURES FOR THIS CLIENT. THE PHYSICIANS STATEMENT MUST DOCUMENT THE MEDICAL NEED FOR DENTURES.
PC24	THE SERVICE REQUESTED WAS PREVIOUSLY AUTHORIZED. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT INDICATING THIS FACT IS REQUIRED.
PC25	PLEASE SUPPLY SUFFICIENT MITIGATING CIRCUMSTANCES TO WARRANT THE CONSTRUCTION OF NEW DENTURES(S).
PC26	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
PC28	PLEASE SUBMIT A PHYSICIANS STATEMENT INDICATING DENTURES ARE NECESSARY FOR THIS NURSING HOME CLIENT.
PC29	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING LOSS OR DESTRUCTION OF DENTURE(S). INCLUDE SIGNED STATEMENT FROM CLIENT OR FACILITY DIRECTOR REGARDING HOW, WHEN AND WHERE LOST.
PC30	PLEASE PROVIDE COMPLETE INTRAORAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PC31	PLEASE DESCRIBE ANY RELATED DEFORMITIES OF THE FEET.
PC34	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD WITH REQUESTED DME ITEM(S) AND DOCUMENT IF THE CLIENT CAN USE SAFELY AND INDEPENDENTLY.
PC35	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD AND DESCRIBE THE RESULTS AND EFFECTIVENESS OF THE SERVICE REQUESTED.

Denial Code	Long Description
PC39	PLEASE INDICATE LITER FLOW PER MINUTE, HOURS OF USE PER 24 HOUR PERIOD, AND THE EXPECTED DURATION OF NEED.
PC40	THE ITEM DOES NOT REQUIRE PRIOR AUTHORIZATION UNTIL THE LIFE EXPECTANCY HAS BEEN REACHED.
PC41	PLEASE SUPPLY INFORMATION INDICATING THE NECESSITY OF POSITIONING THE CLIENT'S BODY IN MULTIPLE POSITIONS.
PC42	PLEASE INDICATE IF THE BED HEIGHT MUST BE CHANGED TO ALLOW FOR SAFE TRANSFER OR ADEQUATE BED CARE.
PC43	SUPPLY A PHYSICIANS STATEMENT INDICATING TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR UNIT HAS REDUCED PAIN, IMPROVED/INCREASED THE CLIENTS ACTIVITY LEVEL, AND/OR REDUCED CLIENTS USE OF PAIN MEDICATION.
PC44	A CURRENT AUTHORIZATION FOR THIS SERVICE IS ON FILE FOR ANOTHER PROVIDER. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT OF THAT FACT IS REQUIRED BY THE CLIENT OF FIRST PROVIDER.
PC59	DOCUMENT DECLINE OR PROGRESS IN SPECIFIC, MEASURABLE, OBJECTIVE TERMS.
PC60	DOCUMENT IF CLIENT HAS DEMONSTRATED A GOOD APPOINTMENT COMPLIANCE RECORD.
PC61	THE PHYSICIANS SIGNATURE DATE MUST NOT EXCEED 90 DAYS FROM THE DATE OF RECEIPT BY COLORADO MEDICAID.
PC62	REQUESTS FOR A CONTINUATION OF THERAPY SHOULD NOT BE SUBMITTED MORE THAN FOUR WEEKS PRIOR TO THE EXPIRATION DATE OF THE CURRENT AUTHORIZATION.
PC63	PLEASE FURNISH THE STYLE AND MANUFACTURER OF THE FRAME.
PC64	PLEASE FURNISH THE CLIENTS LENS FORMULA.
PC66	ALL REQUESTS FOR TINTS REQUIRE DOCUMENTATION OF THE VISUAL OR MEDICAL CONDITION RELATED TO PHOTOPHOBIA.
PC67	PLEASE DOCUMENT THE REASON AND JUSTIFICATION FOR REPLACEMENT BEYOND THE FIRST LENS/FRAME.
PC68	DOCUMENT IF ALL REMAINING MAXILLARY AND/OR MANDIBULAR TEETH ARE DECAY-FREE, PROPERLY RESTORED, AND PERIODONTICALLY SOUND.
PC72	SUPPLY MORE DETAIL REGARDING PROGRESS (ATTACHMENT OF GOALS, ETC.). CORRELATE PROGRESS TO PREVIOUS GOALS AND IDENTIFIED LIMITATIONS.
PC77	PLEASE SUBMIT A PLAN OF CARE DESCRIBING THE SERVICES THAT WOULD BE PROVIDED.
PC78	PLEASE DOCUMENT SPECIFIC, MEASURABLE GOALS.
PC82	THE PRIOR AUTHORIZATION (PA) SYSTEM CAN PROCESS ONLY 26 DETAILS PER PA REQUEST. PLEASE RESUBMIT YOUR REQUEST WITH NO MORE THAN 26 DETAILS.
PC83	PLEASE SUPPLY A PHYSICIANS PRESCRIPTION DATED WITHIN ONE MONTH OF REQUESTED SUBSTANCE ABUSE DAY TREATMENT.
PC84	PLEASE PROVIDE INFORMATION INDICATING THIS CLIENT IS APPROPRIATELY DETOXIFIED FROM ALCOHOL AND/OR OTHER DRUGS.
PC85	PLEASE PROVIDE INFORMATION TO INDICATE THE CLIENTS ABILITY TO ABSTAIN FROM ALCOHOL OR DRUGS WHILE IN THE SUBSTANCE ABUSE DAY TREATMENT PROGRAM.
PC86	PLEASE INDICATE IF THIS CLIENT IS WILLING TO PARTICIPATE IN AFTERCARE OR CONTINUING CARE SERVICES.
PC87	PROVIDE MORE INFORMATION ON TREATMENT HISTORY; INCLUDE SERVICE PROVIDED, DATES, AND OUTCOME. PROVIDE DETAIL OF PREVIOUS TREATMENT.
PC88	PLEASE PROVIDE MORE RATIONALE FOR THE APPROPRIATENESS AND MEDICAL NECESSITY OF SUBSTANCE ABUSE DAY TREATMENT.
PC89	PROVIDE A TREATMENT PLAN THAT CONTAINS MEASURABLE GOALS AND OBJECTIVES CORRESPONDING TO THE IDENTIFIED DEFICIT.
PC91	PLEASE PROVIDE MORE INFORMATION ON FAMILY INVOLVEMENT TREATMENT.
PC92	PLEASE PROVIDE MORE HISTORY AND EXPLANATION ABOUT THE ISSUE OF ABSTINENCE FOR THIS CLIENT.
PC94	PLEASE PROVIDE THE ANTICIPATED BEGINNING DATE AND/OR THE ESTIMATED SUBSTANCE ABUSE DAY TREATMENT DISCHARGE DATE.
PC95	PLEASE SUPPLY JUSTIFICATION FOR BEGINNING CLIENT IN SERVICE PRIOR TO AUTHORIZATION BEING OBTAINED.
PC96	THE INITIAL THREE HOURS OF SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IN A CALENDAR YEAR DO NOT REQUIRE PRIOR AUTHORIZATION.

Denial Code	Long Description
PC97	REIMBURSEMENT FOR INITIAL SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IS LIMITED TO THREE HOURS IN A CALENDAR YEAR AND DOES NOT REQUIRE PRIOR AUTHORIZATION.
PC98	THIS DRUG IS CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE BILL USING THE APPROPRIATE NATIONAL DRUG CODE (NDC) OR SUBMIT A COMPLETED DRUG ADDITION REQUEST FORM IF THE NDC IS NOT LISTED IN THE DRUG INDEX.
PC99	THIS DRUG IS NOT CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL, CURRENT ADMINISTRATIVE RULE, OR COLORADO DRUG INDEX FOR COVERAGE LIMITATIONS.
PD01	DOCUMENT THAT CLIENT HAS ACHIEVED GOOD ORAL HYGIENE, PERIODONTAL CASE TYPE 1 OR 2, AND IS MOTIVATED TO MAINTAIN SAME.
PD03	PLEASE PROVIDE AN ARTERIAL BLOOD GAS READING OR PULSE OXIMETRY RESULTS DONE ON ROOM AIR SIGNED AND DATED BY A MEDICAL DOCTOR. THIS SHOULD BE DONE WITHIN 60 DAYS OF REQUESTED SERVICE.
PD04	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 30 DAYS OF RECEIPT BY COLORADO MEDICAID.
PD07	SUBMIT A PHOTOCOPY OF A VALID PRESCRIPTION, ISSUED WITHIN THE PAST YEAR, OR COMPLETE SECTION B OF THE PRIOR AUTHORIZATION/DRUG ATTACHMENT (PA/DGA), F-11049.
PD10	BRAND MEDICALLY NECESSARY MUST BE IN THE PRESCRIBERS OWN HANDWRITING AND WRITTEN DIRECTLY ON THE PRESCRIPTION OR A SEPARATE ORDER ATTACHED TO THE ORIGINAL PRESCRIPTION.
PD12	COMPLETE DENTURES, PARTIAL DENTURES, DENTURE RELINES, AND FIXED PROSTHODONTIC SERVICES ARE NOT COVERED SERVICES FOR ADULTS FOR DATES OF SERVICE ON AND AFTER OCTOBER 1, 1995.
PD22	PLEASE COMPLETE ALL REQUIRED ELEMENTS ON THE PERSONAL CARE SCREENING TOOL (PCST), F-11133.
PD24	THIS PRIOR AUTHORIZATION REQUEST IS UNABLE TO BE PROCESSED. PLEASE RESUBMIT WITH ADDITIONAL REQUIRED FORMS, INCLUDING THE ENTIRE PERSONAL CARE SCREENING TOOL (PCST), F-11133; PERSONAL CARE ADDENDUM, F-11136; AND SUPPORTING DOCUMENTATION, AS DIRECTED.
PD25	THERE IS A PERSONAL CARE SCREENING TOOL (PCST), F-11133, COMPLETED BY ANOTHER AGENCY. CONTACT THE AGENCY TO TRANSFER SCREEN.
PD26	THERE IS A LIMITED TERM CARE FUNCTIONAL SCREEN (LTC-FS) COMPLETED BY ANOTHER AGENCY. THE PERSONAL CARE SCREENING TOOL (PCST), F-11133, INFORMATION IS IN CONFLICT WITH LTC-FS.
PD27	ONLY ONE LEVEL OF FUNCTION MAY BE SELECTED FOR ALL ELEMENTS EXCEPT TOILETING. COLORADO MEDICAID IS UNABLE TO PROCESS THE PRIOR AUTHORIZATION REQUEST.
PD28	NO UNITS MAY BE REQUESTED USING THIS PRIOR AUTHORIZATION PROCESS. PLEASE SUBMIT WITH THE APPROPRIATE ATTACHMENTS FOR REQUESTING SPECIFIC PERSONAL CARE WORKER UNITS.
PD29	CLIENT IS NOT ELIGIBLE FOR THE REQUESTED SERVICE(S) AS OF THE REQUESTED START DATE.
PD30	NO TRAVEL TIME MAY BE AUTHORIZED WHEN NO PERSONAL CARE WORKER SERVICE IS AUTHORIZED.
PD32	PROVIDER NOT CERTIFIED TO RENDER THE SERVICE(S) REQUESTED.
PD34	BASED ON THE DOCUMENTATION SUBMITTED, THIS REQUEST CAN NOT BE PRIOR AUTHORIZED. REFER TO THE PA MESSAGES FROM THE CONSULTANT FOR COMPLETE EXPLANATION.
PD98	PLEASE DOCUMENT HOW AND WHEN EACH PREVIOUSLY AUTHORIZED PRO RE NATA VISIT WAS USED.

Drugs Non-PBMS

Denial Code	Long Description
0201	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
0205	PRESCRIBER ID IS REQUIRED.
0218	THE NATIONAL DRUG CODE IS REQUIRED.
0219	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0220	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0233	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0235	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0237	CLIENT IDENTIFICATION NUMBER DOES NOT MATCH CLIENTS FIRST NAME.

Denial Code	Long Description
0238	THE CLIENT IDENTIFICATION NUMBER DOES NOT MATCH THE CLIENTS LAST NAME.
0242	SECONDARY DIAGNOSIS CODE IS INVALID.
0248	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0249	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0251	PROCEDURE CODE MODIFIER IN FIRST POSITION IS INVALID.
0252	THE PROCEDURE CODE MODIFIER IN SECOND POSITION IS INVALID FOR REQUESTED START DATE OR DATE OF RECEIPT.
0253	THE PROCEDURE CODE MODIFIER IN THIRD POSITION IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
0258	THE PRIMARY DIAGNOSIS CODE IS REQUIRED.
0272	THE PRIMARY DIAGNSOSIS CODE IS INVALID.
0400	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0820	THE PATIENT LOCATION IS INVALID.
0834	THE PRESCRIBING PROVIDER ID IS INVALID FOR THE NATIONAL DRUG CODE SUBMITTED.
0853	HCPCS - ANNUAL UPDATE
0867	NDC IS OBSOLETE FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
0879	THE PLACE OF SERVICE (POS) IS MISSING OR THE POS IS INVALID.
0885	NEVER EVENTS MODIFIERS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
0886	NEVER EVENTS DIAGNOSIS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
1000	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
1001	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1002	RENDERING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1003	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1007	RENDERING PROVIDER ID IS NOT ON FILE.
1016	A FEDERAL DRUG REBATE AGREEMENT IS NOT ON FILE. THIS DRUG CODE IS NOT A BENEFIT.
1047	THE RENDERING PROVIDERS CERTIFICATION HAS BEEN CANCELLED.
1048	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1049	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1801	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
1804	A CERTIFIED SUBSTANCE ABUSE DAY TREATMENT PROVIDER MUST SUBMIT A SUBSTANCE ABUSE DAY TREATMENT PROCEDURE CODE.
1805	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
1806	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
1808	THE BILLING PROVIDER DOES NOT HAVE THE REQUIRED CERTIFICATION ADDENDUM ON FILE.
1900	THE BILLING PROVIDERS TAXONOMY CODE IS INVALID.
1901	THE RENDERING PROVIDERS TAXONOMY CODE IS INVALID.
1927	A NATIONAL PROVIDER IDENTIFIER IS REQUIRED FOR THE BILLING PROVIDER.
1934	A NATIONAL PROVIDER INDENTIFIER IS REQUIRED FOR THE RENDERING PROVIDER.
1936	THE BILLING PROVIDER NUMBER IS INVALID.
1937	THE RENDERING PROVIDER NUMBER IS INVALID.
1960	INTERNAL PROCESSING IS REQUIRED.
1963	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.
1964	THE BILLING PROVIDER INDICATED IS NOT ALLOWABLE AS A BILLING PROVIDER.
1965	RENDERING PROVIDER NUMBER IS MISSING/INVALID FOR THIS PROCEDURE PROVIDER.
1974	PRESCRIBING/REFERRING/ORDERING PROVIDER INDICATED IS NOT CERTIFIED AS A PRESCRIBING/REFERRING/ORDERING PROVIDER.
1975	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
1976	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
2001	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2002	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.

Denial Code	Long Description
2003	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2017	THE CLIENT IS ENROLLED IN A MEDICAID OR OTHER MANAGED CARE PROGRAM.
2037	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2603	CLIENT LOCKED-IN TO A PROVIDER OR ENROLLED IN A HOSPICE. CONTACT CLIENTS HOSPICE FOR PAYMENT OF SERVICES OR RESUBMIT WITH DOCUMENTATION OF UNRELATED NATURE OF CARE.
3324	THE MODIFIER HAS BEEN DISCONTINUED BY THE CENTERS OF MEDICARE AND MEDICAID SERVICES OR THE AMERICAN MEDICAL ASSOCIATION FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
3337	THE PROCEDURE CODE HAS BEEN TERMINATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AMERICAN MEDICAL ASSOCIATION, OR AMERICAN DENTAL ASSOCIATION FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT. RESUBMIT WITH VALID A PROCEDURE CODE.
3339	THE PROCEDURE BILLED IS NOT PAYABLE ACCORDING TO DEFICIT REDUCTION ACT (DEFRA) GUIDELINES.
3351	THE PROCEDURE IS NOT COVERED FOR CLIENTS WITH A NURSING HOME AUTHORIZATION ON THE REQUESTED START DATE OR DATE OF RECEIPT.
3353	THE PROCEDURE IS NOT A COVERED SERVICE FOR HOME AND COMMUNITY-BASED WAIVER CLIENTS.
3850	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
3874	THE NATIONAL DRUG CODE HAS DIAGNOSIS RESTRICTIONS.
3876	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4002	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICE ON THE REQUESTED START DATE OR DATE OF RECEIPT.
4004	THE NATIONAL DRUG CODE IS REQUIRED.
4007	THE NATIONAL DRUG CODE HAS BEEN TERMINATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
4021	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4023	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS GENDER.
4027	THE DIAGNOSIS CODE IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
4031	THE PROCEDURE SUBMITTED IS NOT APPROPRIATE FOR CLIENTS GENDER.
4032	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4034	THE PROCEDURE CODE HAS AN AGE RESTRICTION.
4036	THE PLACE OF SERVICE CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4040	THE PRIMARY DIAGNOSIS CODE IS NOT ON FILE.
4041	THE SECONDARY DIAGNOSIS IS NOT ON FILE.
4046	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4127	INTERNAL PROCESSING IS REQUIRED.
4131	INTERNAL PROCESSING IS REQUIRED.
4138	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
4141	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4149	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4150	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4236	ETIOLOGY DIAGNOSIS CODE(S) (E-CODES) ARE INVALID AS THE PRIMARY DIAGNOSIS.
4244	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4245	THE FOURTH POSITION MODIFIER IS INVALID FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT.
4256	THE PROCEDURE CODE AND MODIFIER COMBINATION IS NOT PAYABLE FOR THE CLIENTS BENEFIT PLAN.
4257	THE MODIFIERS SUBMITTED ARE EITHER INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT OR THE MODIFIERS ARE MISSING.
4311	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4315	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4316	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4347	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4371	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4372	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.

Denial Code	Long Description
4711	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR CLIENTS AGE.
4713	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS AGE.
4714	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS AGE.
4731	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS DIAGNOSIS.
4742	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4743	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4744	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4745	DIAGNOSIS AND/OR PROCEDURE AND/OR PLACE OF SERVICE (POS) CODE IS NOT COVERED FOR EXPRESS ENROLLMENT CLIENTS.
4746	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4775	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4801	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4802	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
4803	THE NATIONAL DRUG CODE SUBMITTED IS NOT VALID.
4821	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
4963	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS GENDER.
4965	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4990	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
7500	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
7509	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
P001	THE BILLING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THE SERVICES.
P002	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P003	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P006	PLEASE FURNISH THE PROCEDURE CODE AND CORRESPONDING DESCRIPTION.
P007	THE PATIENT LOCATION IS REQUIRED.
P008	THE BILLING PROVIDER NUMBER IS INVALID.
P009	THE BILLING PROVIDER NUMBER IS INVALID.
P010	THE REQUESTED END DATE IS INVALID.
P011	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P012	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P013	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P014	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P015	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P016	THE REQUESTED START DATE IS MISSING OR INVALID.
P019	THE REQUESTED START DATE IS MISSING OR INVALID.
P020	THE RENDERING PROVIDER NUMBER IS INVALID.
P022	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P023	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P024	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P026	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P027	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P030	FIRST MODIFIER IS INVALID.
P031	FIRST MODIFIER IS INVALID.
P032	SECOND MODIFIER IS INVALID.
P033	SECOND MODIFIER IS INVALID.
P034	THIRD MODIFIER IS INVALID.

Denial Code	Long Description
P035	THIRD MODIFIER IS INVALID.
P036	FOURTH MODIFIER IS INVALID.
P037	FOURTH MODIFIER IS INVALID.
P038	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P039	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P040	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P041	CLIENTS FIRST NAME IS MISSING.
P042	CLIENTS LAST NAME IS MISSING.
P043	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P044	BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES REQUESTED.
P045	FIRST MODIFIER IS INVALID.
P046	SECOND MODIFIER IS INVALID.
P047	THIRD MODIFIER IS INVALID.
P048	FOURTH MODIFIER IS INVALID.
P052	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P053	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P054	RENDERING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES FOR THE BENEFIT PLAN.
P055	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P056	PLEASE FURNISH THE NATIONAL DRUG CODE AND CORRESPONDING DESCRIPTION.
P060	THE PATIENT LOCATION IS MISSING OR INVALID.
P061	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P062	THE CLIENT ID AND/OR NAME INDICATED ON THE PA REQUEST IS INCORRECT. THE CLIENT ID AND/OR NAME HAS BEEN UPDATED. PLEASE VERIFY THE ID AND/OR NAME IS CORRECT.
P064	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
P067	THE FREQUENCY OF HOURS REQUESTED ARE NOT APPROPRIATE FOR THIS CLIENT AND HAVE BEEN MODIFIED ACCORDINGLY.
P079	BILLING PROVIDER IS ON PAYMENT SUSPENSION DUE TO CREDIBLE ALLEGATION OF FRAUD.
P120	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAS BEEN REDUCED.
P121	THE SERVICE/ PROCEDURE REQUESTED IS NOT SUPPORTED BY SUBMITTED DOCUMENTATION.
P126	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
P128	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.
P138	SERVICE(S) DO NOT MEET COLORADO MEDICAID GUIDELINES.
P167	REQUESTED DOCUMENTATION HAS NOT BEEN SUBMITTED.
P178	THE SERVICE REQUESTED IS NOT MEDICALLY NECESSARY.
P179	THE MEDICAL NECESSITY FOR THIS SERVICE IS NOT SUPPORTED BY THE SUBMITTED DOCUMENTATION.
P233	THE DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE ADDITIONAL CARE.
P257	THIS CLIENTS FUNCTIONAL ASSESSMENT SCORES PLACE THIS CLIENT OUTSIDE ELIGIBILITY FOR DAY TREATMENT.
P274	OUR RECORDS INDICATE THIS CLIENT IS INVOLVED IN EFFECTIVE AND APPROPRIATE SERVICE ELSEWHERE.
P292	INTENSIVE REHABILITATION HOURS ARE NO LONGER APPROPRIATE AS INDICATED BY HISTORY, DIAGNOSIS, AND/ OR FUNCTIONAL ASSESSMENT SCORES.
P328	THE SERVICES REQUESTED INCLUDE NON-COVERED SERVICES, AND HOURS ARE REDUCED ACCORDINGLY.
P339	THE CLIENTS PAST HISTORY INDICATES REDUCED TREATMENT HOURS ARE WARRANTED.
P342	THE REQUEST DOES NOT MEET GENERALLY ACCEPTED CONDITIONS REQUIRING FLUORIDE TREATMENTS.
P346	SERVICES EXCEED COLORADO MEDICAID LIMITATION AND DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE MEDICAL NECESSITY OF THE SERVICE.
P349	THE SERVICE REQUESTED WAS PERFORMED LESS THAN FIVE YEARS AGO.

Denial Code	Long Description
P353	THE EXISTING APPLIANCE HAS NOT BEEN WORN FOR THREE YEARS.
P367	THE CLIENT HAS BEEN TOTALLY WITHOUT TEETH AND AN APPLIANCE FOR FIVE YEARS.
P392	THE CLIENT IS MISSING AN ANTERIOR TOOTH AND/OR HAS TWO OR MORE POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P405	THE SERVICE(S) REQUESTED COULD ADEQUATELY BE PERFORMED IN THE DENTAL OFFICE.
P406	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE OF GOOD PERIODONTAL HEALTH (AMERICAN ACADEMY OF PERIODONTOLOGY PERIODONTAL CLASSIFICATION OF TYPE I OR II).
P407	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE VISIBLE ON RADIOGRAPHS THAT AT LEAST 50 PERCENT OF THE CLINICAL CROWN IS INTACT.
P409	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING SIX OR MORE TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED, INCLUDING THIRD MOLARS.
P410	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING ONE OR MORE ANTERIOR TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED.
P411	DOCUMENTATION DOES NOT SUPPORT THE NEED FOR PERIODONTIC SERVICES. POCKETS ARE LESS THAN 4MM AND/OR GREATER THAN 6MM FOR CLIENT AND/OR THE CLIENT IS UNDER THE AGE OF 13.
P412	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA.
P413	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA. THIS PA HAS BEEN GRANTED AS APPROVED NOT APPROVED WITH REVISIONS. THE DURATION REQUESTED MAY HAVE BEEN REDUCED TO REFLECT COVERAGE LIMITATIONS, PRESCRIBER ORDERS, CONFLICTI
P417	THE SERVICE(S) REQUESTED COULD BE ADEQUATELY PERFORMED WITH LOCAL ANESTHESIA.
P420	THE PRIOR AUTHORIZATION REQUEST FOR ENTERAL NUTRITION SUBMITTED ON THE COLORADO MEDICAID PORTAL HAS BEEN APPROVED.
P437	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO POOR ORAL HYGIENE.
P444	THIS LINE ITEM IS A DUPLICATE OF ANOTHER LINE ITEM ON THIS PRIOR AUTHORIZATION (PA) REQUEST. PLEASE CORRECT.
P446	THIS IS A DUPLICATE OF AN EXISTING PRIOR AUTHORIZATION (PA) REQUEST. YOU MAY CONTACT PROVIDER SERVICES IF YOU REQUIRE ASSISTANCE. DUPLICATE PA REQUEST
P448	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO DECAY HISTORY.
P449	QUESTIONABLE LONG TERM PROGNOSIS DUE TO GUM AND BONE DISEASE.
P456	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO APPARENT ROOT INFECTION.
P457	OUR RECORDS INDICATE THIS CLIENT HAS EXCEEDED ESTABLISHED PROGRAM LIMITATIONS. COLORADO MEDICAID WILL NOT AUTHORIZE NEW DENTURES.
P458	DOCUMENTATION PROVIDED INDICATES A LESS ELABORATE PROCEDURE SHOULD BE CONSIDERED.
P502	RENTAL ONLY ALLOWED; MEDICAL NEED FOR PURCHASE HAS NOT BEEN DOCUMENTED.
P503	PURCHASE ONLY ALLOWED; MEDICAL NEED FOR RENTAL HAS NOT BEEN DOCUMENTED.
P504	OCCUPATIONAL THERAPY GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P505	THE SERVICE REQUESTED IS INCLUDED IN THE NURSING HOME RATE STRUCTURE.
P511	THIS NATIONAL DRUG CODE IS ONLY BILLABLE AS PART OF A COMPOUND DRUG.
P515	THE PRESENCE OF A HANDICAPPING MALOCCLUSION OR HANDICAPPING DENTOFACIAL DEFORMITY IS NOT SUPPORTED BY THE DOCUMENTATION SUBMITTED.
P521	THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVERED BY COLORADO MEDICAID.
P522	GASTRO-INTESTINAL SURGERY FOR THE PURPOSE OF WEIGHT CONTROL IS COVERED ONLY AS A LIFE THREATENING PROCEDURE.
P523	THE TREATMENT REQUEST IS NOT CONSISTENT WITH THE CLIENT'S DIAGNOSIS.
P524	PSYCHOTHERAPY PROVIDED IN THE CLIENTS HOME IS NOT A COVERED BENEFIT OF COLORADO MEDICAID.
P525	THE INFORMATION PROVIDED IS NOT CONSISTENT WITH THE INTENSITY OF SERVICES REQUESTED.
P526	INTENSIVE MULTIPLE MODALITY TREATMENT IS NOT CONSISTENT WITH THE INFORMATION PROVIDED.
P527	MULTIPLE PROVIDERS OF TREATMENT ARE NOT INDICATED FOR THIS CLIENT.
P528	THE DURATION OF TREATMENT SESSIONS EXCEED CURRENT COLORADO MEDICAID GUIDELINES.

Denial Code	Long Description
P534	DOCUMENTATION OF POOR PHYSICAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P535	OTHER PHYSICAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P536	THE PHYSICAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P537	USE OF PHYSICAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P538	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF A PHYSICAL THERAPIST.
P539	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS AND LIVING ARRANGEMENT.
P540	GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P541	THE PROCEDURE(S) REQUESTED ARE NOT MEDICAL IN NATURE.
P542	DOCUMENTATION OF POOR OCCUPATIONAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P543	DOCUMENTATION OF POOR SPEECH THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P544	OTHER OCCUPATIONAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P546	THE OCCUPATIONAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P547	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF PHYSICAL THERAPY.
P548	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P549	ACTIVITIES TO PROMOTE DIVERSION OR GENERAL MOTIVATION ARE NONCOVERED COLORADO MEDICAID SERVICES.
P550	REVISIONS OF THE REQUEST IS NECESSITATED BY THE CLIENTS MINIMAL PROGRESS.
P551	RESTORATIVE NURSING INVOLVEMENT COULD BE INCREASED.
P552	CLIENTS DEMONSTRATED RESPONSE TO CURRENT THERAPY DOES NOT WARRANT THE INTENSE FREQUENCY REQUESTED.
P553	MAINTENANCE IS TWO TIMES PER WEEK OR LESS.
P554	THE SPEECH THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P555	USE OF OCCUPATIONAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P556	USE OF SPEECH THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P557	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF AN OCCUPATIONAL THERAPIST.
P558	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
P559	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P560	THE MATERIALS/ SERVICES REQUESTED ARE PRINCIPALLY COSMETIC IN NATURE.
P561	THE LENS FORMULA DOES NOT JUSTIFY REPLACEMENT.
P562	THE CHANGE IN THE LENS FORMULA DOES NOT WARRANT MULTIPLE REPLACEMENTS.
P563	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P564	LENSES ONLY ARE APPROVED; PLEASE DISPENSE A CONTRACTED FRAME. THE NON-CONTRACTED FRAME IS NOT MEDICALLY JUSTIFIED.
P565	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P566	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P567	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF OCCUPATIONAL THERAPY.
P568	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF SPEECH THERAPY.
P569	LEVEL, INTENSITY, OR EXTENT OF SERVICE(S) REQUESTED HAS BEEN MODIFIED CONSISTENT WITH MEDICAL NEED AS DEFINED IN THE PLAN OF CARE.

Denial Code	Long Description
P570	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P571	THE SERVICE ASKED FOR IS NOT COVERED BY COLORADO MEDICAID AS THESE TASKS CAN BE DONE BY NURSES OR ACTIVITY STAFF.
P572	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P573	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.
P574	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P575	MEDICAL NEED FOR EQUIPMENT/ SUPPLY REQUESTED IS NOT SUPPORTED BY DOCUMENTATION SUBMITTED.
P576	OTHER SPEECH THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P577	DOCUMENTATION SUBMITTED IDENTIFIES THAT THE CLIENT HAS FEWER THAN TWO POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P582	LESS EXPENSIVE ALTERNATIVE SERVICES ARE AVAILABLE FOR THIS CLIENT.
P634	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P711	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING PERIODONTAL SCALING AND ROOT PLANNING.
P712	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING GINGIVECTOMY.
P754	AN APPROVED SUBSTANCE ABUSE DAY TREATMENT PROGRAM CANNOT EXCEED A SIX WEEK PERIOD.
P761	THE CLIENT DOES NOT APPEAR TO BE ABLE OR WILLING TO ABSTAIN FROM ALCOHOL/DRUG USAGE WHILE IN TREATMENT. THEREFORE, SUBSTANCE ABUSE DAY TREATMENT SERVICES ARE NOT APPROVED.
P764	THIS CLIENT HAS COMPLETED INTENSIVE SUBSTANCE ABUSE TREATMENT WITHIN THE PAST 12 MONTHS. THE DOCUMENTATION PROVIDED IS NOT ADEQUATE TO JUSTIFY ADDITIONAL INTENSIVE TREATMENT AT THIS TIME.
P785	A LESS THAN SIX-WEEK HEALING PERIOD HAS BEEN SPECIFIED FOR THIS PRIOR AUTHORIZATION. THEREFORE IT IS NOT NECESSARY TO WAIT THE FULL SIX WEEKS AFTER EXTRACTIONS BEFORE TAKING DENTURE IMPRESSIONS.
P818	SIX-WEEK HEALING TIME IS REQUIRED BETWEEN EDENTULATION AND FINAL IMPRESSIONS. PAYMENT FOR DENTURES WILL BE DENIED OR RECOUPED IF HEALING PERIOD IS NOT OBSERVED.
P849	COLORADO MEDICAID HAS DETERMINED THERE WERE (ARE) SEVERAL HOME HEALTH AGENCIES WILLING TO PROVIDE MEDICALLY NECESSARY SKILLED NURSING SERVICES TO THIS CLIENT.
P864	THE DOCUMENTATION YOU HAVE SUBMITTED DOES NOT MEET THE REQUIREMENTS OF COLORADO MEDICAID.
P873	THE MEDICAL NECESSITY FOR THE HOURS REQUESTED IS NOT SUPPORTED BY THE INFORMATION SUBMITTED.
P874	THE DOCUMENTATION SUBMITTED INDICATES THE TASKS SPECIFIED CAN BE COMPLETED DURING THE VISITS APPROVED.
P878	THE DOCUMENTATION SUBMITTED DOES NOT INDICATE THAT MEDICALLY ORIENTED TASKS ARE MEDICALLY NECESSARY; THEREFORE PERSONAL CARE SERVICES HAVE BEEN APPROVED.
P880	THE QUANTITY OF SERVICES AUTHORIZED FOR THIS CLIENTS PERSONAL CARE HAS BEEN AMENDED BASED ON INFORMATION RECEIVED FROM ONE OR MORE OF THESE SOURCES: THE CLIENT, THEIR PHYSICIAN, AND/OR THE IN-HOME VISIT BY STAFF OF THE OIG (OFFICE OF INSPECTOR GENERAL).
P885	THE USE OF THIS DRUG FOR THE INTENDED PURPOSE IS NOT COVERED BY COLORADO MEDICAID, CONSISTENT WITH COLORADO ADMINISTRATIVE CODE AND FEDERAL LAW.
P924	THE MEDICAL RECORDS SUBMITTED WITH THE CURRENT REQUEST CONFLICT OR DISAGREE WITH OUR MEDICAL RECORDS ON THIS CLIENT.
P950	INDEPENDENT NURSES, PLEASE NOTE PAYABLE SERVICES MAY NOT EXCEED 12 HOURS/DAY OR 60 HOURS/WEEK.
P951	SERVICES CAN ONLY BE AUTHORIZED THROUGH ONE YEAR FROM THE PRESCRIPTION DATE.
P952	LEAD INSPECTION IS A COVERED COLORADO MEDICAID SERVICE WHEN THE CHILD HAS BEEN SHOWN TO HAVE LEAD POISONING (E.G., CHILD HAS A BLOOD LEAD LEVEL > 19 UG/DL OR TWO CONSECUTIVE BLOOD LEAD LEVELS OF 15-19 UG/DL DONE AT LEAST 90 DAYS APART). THE INSPECTION MUS

Denial Code	Long Description
P953	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P954	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P956	THE REQUEST CAN ONLY BE BACKDATED A MAXIMUM OF 14 DAYS FROM FIRST DATE RECEIVED BY COLORADO MEDICAID.
P957	COMPLETE PERIODONTAL CHARTING AT TIME OF SERVICE, AND SUBMIT CHARTING, COPY OF OPERATIVE REPORT, TOGETHER WITH A COPY OF THE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF), F-11035, TO PA UNIT ATTENTION DENTAL CONTSULTANT.
P958	NOTE THAT CODE D4341 HAS BEEN CHANGED. REFER TO THE DECISION NOTICE FOR AUTHORIZED QUANTITY.
P960	YOUR PA HAS BEEN APPROVED FOR 90 DAYS. THE 90 DAY APPROVAL DOES NOT IMPLY THE PA REQUEST MEETS PRIOR AUTHORIZATION CRITERIA. AFTER ADDITIONAL INFORMATION IS AVAILABLE IN INTERCHANGE, COLORADO MEDICAID WILL CREATE AN AMENDMENT REQUEST TO EXTEND THE PA FOR
P961	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P962	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P967	PA POLICY BYPASS NAMENDA
P987	ANTIPSYCHOTIC ATTESTATION IS REQUIRED WHEN MORE THAN ONE ANTIPSYCHOTIC DRUG IS PRESCRIBED FOR A CLIENT 16 YEARS OF AGE OR YOUNGER. EACH ANTIPSYCHOTIC DRUG MUST BE ENTERED IN THE ATTESTATION PROCESS. ANTIPSYCHOTIC ATTESTATION AUTHORIZATIONS CANNOT BE AMEN
P988	THE PRIOR AUTHORIZATION FOR THIS DRUG HAS BEEN APPROVED AT THE ACTIVE INGREDIENT LEVEL INSTEAD OF THE DRUG STRENGTH AND DOSAGE FORM LEVEL. ADDITIONAL PAS ARE NOT NEEDED FOR A DIFFERENT STRENGTH OF THIS SAME DRUG.
PA10	THE REQUESTED END DATE IS INVALID.
PA12	PLEASE FURNISH A WRITTEN DESCRIPTION OF THE CLIENTS DIAGNOSIS.
PA13	PROVIDE DIAGNOSES WITH DATES OF ONSET.
PA14	IDENTIFY PROBLEMS TO BE TREATED.
PA15	THE AUDIOLOGISTS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1), F-11020, AND PRIOR AUTHORIZATION REQUEST/HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2), F-11021.
PA16	THE PHYSICIANS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION/PHYSICIAN OTOLOGICAL REPORT (PA/POR), F-11019.
PA17	SUBMIT BRIEF HISTORY WITH REFERRAL INFORMATION, LIVING SITUATION, FUNCTIONAL STATUS, AND OTHER PERTINENT INFORMATION. WHAT CHANGE OF STATUS RESULTED IN REFERRAL AT THIS TIME?
PA18	PLEASE FURNISH THE CLIENTS HEIGHT AND WEIGHT.
PA19	PLEASE SUBMIT CLINICAL INFORMATION SUFFICIENT TO VERIFY THE NEED FOR THE REQUESTED SERVICE(S).
PA20	PLEASE RESUBMIT WITH COMPLETE PERIODONTAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PA21	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL EDUCATIONAL PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA22	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL PROGRAM PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA23	REFER TO THE DURABLE MEDICAL EQUIPMENT INDEX FOR APPROPRIATE CODE AND DESCRIPTION. DO NOT USE AN "UNLISTED" CODE.
PA24	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUALIZED FAMILY SERVICE PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA25	INFORMATION ON THE REQUEST FORM IS ILLEGIBLE, AND THE REQUEST CANNOT BE PROCESSED.
PA26	RE-EVALUATE YOUR GOALS. EMPHASIS SHOULD BE ON FUNCTIONAL SELF-CARE. GOALS MUST BE RELATED TO FUNCTIONAL OUTCOME.
PA27	PLEASE CLARIFY THE NUMBER OF HOURS PER WEEK REQUESTED.

Denial Code	Long Description
PA28	PLEASE CLARIFY THE NUMBER OF HOURS PER DAY REQUESTED.
PA29	PLEASE CLARIFY THE NUMBER OF VISITS PER DAY REQUESTED.
PA30	ATTACH SUPPORTIVE DOCUMENTATION; HOME EXERCISE PROGRAM AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA31	THE DIAGNOSIS CODE INDICATED ON THE REQUEST DOES NOT CORRESPOND TO THE DIAGNOSIS CODE DESCRIPTION.
PA32	PLEASE SUBMIT ADDITIONAL INFORMATION SUFFICIENT TO VERIFY APPROPRIATENESS AND NEED FOR TRANSPLANT.
PA33	PLEASE SUBMIT THE INITIAL AND PROGRESSIVE OBJECTIVE FINDINGS.
PA34	ATTACH SUPPORTIVE DOCUMENTATION, FACILITY PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA35	PLEASE SUBMIT THE CLIENTS ORIGINAL COMPLAINTS AND EXAMINATION FINDINGS.
PA36	ATTACH SUPPORTIVE DOCUMENTATION, IN-HOME AUTISM PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA37	PLEASE SUBMIT YOUR TREATMENT PLAN FOR THIS CLIENT.
PA38	ATTACH SUPPORTIVE DOCUMENTATION AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA39	INITIAL EVALUATIONS MUST BE PERFORMED BY AN OCCUPATIONAL THERAPIST REGISTERED (OTR), PER AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA) STANDARDS.
PA41	IDENTIFY THE PLACE OF SERVICE AND ITS EFFECT ON SUPPORTING THE DESIRED TREATMENT OUTCOME.
PA42	PLEASE INDICATE THE HOURS OF USE OF OXYGEN PER 24-HOUR PERIOD.
PA43	PROVIDE BASELINE DOCUMENTATION FOR THIS CLIENTS LIMITATIONS USING UNITS OF MEASUREMENT THAT ARE APPLIED CONSISTENTLY WHEN REPORTING STATUS.
PA44	IDENTIFY FUNCTIONAL LIMITATIONS AS THEY ARE RELATED TO IDENTIFIED CONDITIONS.
PA46	CORRELATE PLAN OF CARE TO REQUESTED PROCEDURE CODES.
PA47	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE FREQUENCY/DURATION REQUESTED.
PA48	PLEASE PROVIDE THE NAME AND CREDENTIALS OF THE RENDERING PROVIDER.
PA50	COLORADO MEDICAID RECORDS INDICATE THE CLIENT OWNS A WHEELCHAIR. DOCUMENT THE REASON AND NEED FOR REPLACEMENT AND COST TO REPAIR CURRENT WHEELCHAIR.
PA51	PLEASE DISTINGUISH PRIMARY AND SUPPORTIVE MODALITIES.
PA52	PLEASE SUBMIT A PROGRESS REPORT.
PA53	MULTIPLE FAMILY CLIENTS TREATMENT BY THE SAME PROVIDER REQUIRES FURTHER INFORMATION DOCUMENTING COORDINATION OF TREATMENT PLAN.
PA54	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE MINUTES REQUESTED.
PA55	MEDICAL NECESSITY OF TREATMENT REQUIRES ADDITIONAL DOCUMENTATION.
PA56	GIVEN AGE, DIAGNOSES, CURRENT LEVEL OF FUNCTION, PAST RESPONSE TO TREATMENT, AND LIVING SITUATION, EXPAND ON POTENTIAL FOR SIGNIFICANT FUNCTIONAL PROGRESS WITHIN THE NEXT SIX MONTHS. EMPHASIZE WHY PROGRESS IS EXPECTED WITH SERVICES AT THIS TIME.
PA57	SUBMIT THE INITIAL FINDINGS. INCLUDE A COMPREHENSIVE EVALUATION.
PA58	SUBMIT PROGRESSIVE, OBJECTIVE FINDINGS. INCLUDE A PERTINENT RE-EVALUATION.
PA59	PLEASE SUPPLY INFORMATION REGARDING THE CLIENTS MEDICATION REQUIREMENTS, IF ANY.
PA60	PLEASE SPECIFY IF THE CLIENT IS IN AN EDUCATIONAL SETTING.
PA61	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA62	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
PA63	THE SKILLS OF A THERAPIST ARE PURPOSEFUL AND SKILLED INTERVENTIONS REQUIRED TO CONTINUALLY DESIGN, IMPLEMENT, REASSESS, MODIFY/GRADE, AND/OR DISCONTINUE A PLAN OF CARE IN A TIMELY MANNER, BASED ON THE COMPLEXITY OF THE CLIENTS MEDICAL CONDITION AND/OR CO
PA64	PLEASE SUBMIT A THERAPY PLAN OF CARE, INCLUDING A CURRENT, DATED EVALUATION.
PA65	A PLAN OF CARE SIGNED AND DATED BY THE PHYSICIAN IS REQUIRED.

Denial Code	Long Description
PA66	THE SKILLS OF A THERAPIST ARE REQUIRED WHEN ONLY THE THERAPIST CAN SAFELY AND EFFECTIVELY DELIVER THE THERAPEUTIC PROCEDURES BECAUSE OF THEIR UNIQUE KNOWLEDGE, TRAINING, AND EXPERTISE. DESCRIBE THE REASON THAT SOMEONE OTHER THAN A THERAPIST CANNOT SAFELY
PA67	PLEASE SPECIFY IF THE CLIENTS WORK SITE DEMANDS GOOD BINAURAL HEARING.
PA68	DESCRIBE THE REASON, BASED ON THE CLIENTS COGNITIVE, PHYSICAL, COMMUNICATION, OR RESOURCE STATUS, THAT A HOME PROGRAM, EQUIPMENT, OR ENVIRONMENTAL ADAPTATIONS ALONE CANNOT MEET CLIENTS NEEDS.
PA69	PLEASE SPECIFY IF THE CLIENT HAS AN ACCOMPANYING DISABILITY THAT ADDS TO THE HEARING PROBLEM.
PA70	DISTINGUISH REQUESTED PROCEDURES AND GOALS FROM OTHER SERVICES THIS CLIENT RECEIVES. THEY MAY NOT BE DUPLICATIVE.
PA71	PLEASE INDICATE THE NUMBER OF DAYS REQUESTED.
PA73	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA74	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA75	PLEASE DOCUMENT CARRYOVER OF THE THERAPY PROGRAM TO NURSING.
PA76	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA79	PROVIDE EVIDENCE OF SIGNIFICANT FUNCTIONAL PROGRESS IN LAST SIX MONTHS.
PA84	THE GRANT DATE OF THIS REQUEST CANNOT BE PRIOR TO THE SIGNATURE DATE OF THE PRESCRIBING PHYSICIAN.
PA86	PROVIDE EVIDENCE OF SKILLS GAINED IN THERAPY CARRYING OVER TO OTHER SETTINGS WITHIN SIX MONTHS.
PA87	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE NUMBER OF SESSIONS REQUESTED.
PA88	THE REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL SCOPE OF PRACTICE.
PA89	PRIOR AUTHORIZATION IS NOT REQUIRED UNTIL LIMITATION OF SERVICE HAS BEEN REACHED.
PA91	PLEASE SUBMIT REQUIRED X-RAYS.
PA92	PLEASE PROVIDE AN EXPLANATION FOR THE MATERIAL SUBMITTED WITH THE REQUEST.
PA95	PLEASE DESCRIBE HOW THE PROVISION OF THIS SERVICE WOULD PREVENT INSTITUTIONALIZATION OF THE CLIENT.
PA96	COULD THE EXISTING DENTURE(S) BE RELINED OR REBASED? IF NOT, PLEASE EXPLAIN WHY NOT.
PA97	REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL STANDARDS OF PRACTICE.
PA98	PLEASE INDICATE IF THE CLIENT IS CURRENTLY BEING TUBE FED.
PB02	PLEASE PROVIDE THE REQUIRED DATED SIGNATURES ON THE ATTACHMENTS.
PB03	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING THE LOSS/DESTRUCTION/THEFT OF THE HEARING AID.
PB04	DESCRIBE THE CLIENTS ABILITY TO STAND OR AMBULATE SUFFICIENTLY TO ACCOMPLISH SELF-CARE ACTIVITIES.
PB07	PLEASE SUBMIT AN ORTHODONTIC STUDY MODEL OR DIAGNOSTIC CASTS.
PB09	PLEASE PROVIDE A PHOTOGRAPH OF THE INVOLVED AREA(S).
PB10	PLEASE PROVIDE AN ESTIMATION (IN GRAMS) OF THE TOTAL AMOUNT OF TISSUE TO BE RESECTED.
PB11	PLEASE SUBMIT THE PLAN OF CARE FOR CO-TREATMENT.
PB12	FURNISH A DETAILED DESCRIPTION FOR THE PROCEDURE CODE REQUESTED.
PB13	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB15	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB18	PLEASE COMPLETE THE ATTACHED OUT-OF-STATE PROVIDER DATA SHEET, F-11001, AND RESUBMIT.
PB20	A SIGNED AND DATED PRESCRIPTION IS REQUIRED WITHIN THREE MONTHS OF RECEIPT BY COLORADO MEDICAID FOR INITIAL REQUESTS AND WITHIN 12 MONTHS OF RECEIPT BY COLORADO MEDICAID FOR SUBSEQUENT REQUESTS.
PB21	PLEASE COMPLETE THE APPROPRIATE PRIOR AUTHORIZATION ATTACHMENT. CONTACT PROVIDER SERVICES OR THE PRIOR AUTHORIZATION UNIT FOR ASSISTANCE.
PB23	PHYSICAL THERAPY ASSISTANT NOTES AND ALL FORMS SUBMITTED MUST BE COSIGNED BY A REGISTERED PHYSICAL THERAPIST.

Denial Code	Long Description
PB31	ARE YOU REQUESTING A COMPLETE APPLIANCE, OR REPLACEMENT PARTS?
PB32	THE PROCEDURE CODE INDICATED ON THE REQUEST DOES NOT MATCH THE DESCRIPTION OF SERVICE; PLEASE CORRECT AND RESUBMIT.
PB35	THE SERVICE REQUESTED DOES NOT REQUIRE PRIOR AUTHORIZATION.
PB41	PLEASE FURNISH A CURRENT MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT, F-11090 (DATED WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID).
PB45	THE CERTIFICATION PERIOD ON THE PLAN OF CARE (POC) DOES NOT COVER THE REQUESTED GRANT/START DATE. PLEASE RESUBMIT YOUR REQUEST WITH A NEW POC.
PB49	A CERTIFIED OCCUPATIONAL THERAPY ASSISTANTS NOTES MUST BE COSIGNED BY AN OCCUPATIONAL THERAPIST REGISTERED.
PB51	ADDITIONAL INFORMATION IS REQUIRED ON PRIOR AUTHORIZATION TO ENABLE PRICING.
PB54	REQUESTED SERVICES DO NOT MATCH SERVICES ON THE PHYSICIANS ORDERS.
PB59	PLEASE PROVIDE AN INDIVIDUAL EDUCATIONAL PLAN (IEP), WHICH HAS BEEN SIGNED BY THE PROVIDER NO EARLIER THAN NINE MONTHS PRIOR TO RECEIPT AT COLORADO MEDICAID; OTHERWISE, DOCUMENT WHY NO IEP EXISTS.
PB65	PLEASE FURNISH THE ANTICIPATED TOTAL CHARGES FOR THIS REQUEST.
PB66	A PHOTOCOPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED; THE DATE MUST BE WITHIN SIX MONTHS OF RECEIPT BY COLORADO MEDICAID.
PB67	THE PRESCRIPTION DATE MUST INCLUDE MONTH, DAY, AND YEAR.
PB68	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID.
PB73	THE SERVICES IDENTIFIED ON THE PLAN OF CARE DO NOT APPEAR APPROPRIATE FOR THE PROCEDURE CODE(S) REQUESTED ON THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018.
PB74	THE CLIENT/PROVIDER DOES NOT HAVE RETROACTIVE ENROLLMENT.
PB75	THE REQUESTED START DATE IS MORE THAN 14 DAYS BEFORE OR 62 DAYS AFTER RECEIPT.
PB82	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
PB83	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A HOME HEALTH AIDE. PLEASE RESUBMIT AS A PERSONAL CARE WORKER OR PROVIDE ADDITIONAL DOCUMENTATION.
PB86	THE SERVICES REQUESTED ARE NOT BEING PROVIDED IN THE CLIENTS RESIDENCE. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL.
PB87	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A NURSE. PLEASE RESUBMIT AS A HOME HEALTH AIDE OR PROVIDE ADDITIONAL DOCUMENTATION.
PB92	PLEASE FURNISH THE CLIENTS COMPLETE ADDRESS.
PB94	IF THE CLIENT IS A RESIDENT OF A NURSING HOME, SUPPLY THE COMPLETE NAME AND ADDRESS OF THE NURSING HOME.
PB99	THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018, MUST BE SIGNED AND DATED.
PC01	PLEASE SUPPLY THE RENDERING PROVIDERS PROVIDER NUMBER.
PC03	THE DRUG ENFORCEMENT ADMINISTRATION NUMBER IS MISSING OR INVALID.
PC06	PLEASE DESCRIBE YOUR PROGRAM; INCLUDE ENTRY DATE, TERMINATION DATE, HOURS PER WEEK, AND NUMBER OF WEEKS OF PRIMARY INTENSIVE SERVICE REQUESTED.
PC07	PLEASE DESCRIBE YOUR "AFTERCARE/FOLLOW-UP" PLANS FOR THIS CLIENT.
PC08	PLEASE SUPPLY DOCUMENTATION OF PREVIOUS SUBSTANCE ABUSE SERVICES WITH DATE(S) AND OUTCOME.
PC09	PLEASE DESCRIBE IN DETAIL THE TREATMENT OBJECTIVES/GOALS FOR THIS CLIENT.
PC10	PLEASE DESCRIBE THE FAMILY SITUATION/DYNAMICS. EXPLAIN HOW THE FAMILY WILL BE INCORPORATED INTO THE CLIENTS PLAN OF CARE.
PC12	PLEASE EXPLAIN IF YOUR SERVICE ENCOURAGES THE CLIENT TO ATTEND SELF-HELP GROUPS.
PC13	PLEASE SUPPLY A SPECIFIC SCHEDULE OF ACTIVITIES, INCLUDING DAY, TIME OF DAY, LENGTH OF SESSION, AND SERVICE TO BE RENDERED DURING THAT TIME.
PC15	PLEASE FURNISH DIAGNOSTIC RATIONALE.
PC17	PLEASE DOCUMENT IF THE CLIENT EVER RECEIVED SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT.
PC19	PLEASE FURNISH MORE EXTENSIVE AND IN-DEPTH HISTORICAL AND PSYCHOSOCIAL DATA.
PC20	PLEASE SUPPLY THE DATE THE CLIENT BECAME TOTALLY ENDENTULOUS.

Denial Code	Long Description
PC23	PLEASE SUBMIT A PHYSICIANS STATEMENT REGARDING THE MEDICAL NECESSITY OF DENTURES FOR THIS CLIENT. THE PHYSICIANS STATEMENT MUST DOCUMENT THE MEDICAL NEED FOR DENTURES.
PC24	THE SERVICE REQUESTED WAS PREVIOUSLY AUTHORIZED. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT INDICATING THIS FACT IS REQUIRED.
PC25	PLEASE SUPPLY SUFFICIENT MITIGATING CIRCUMSTANCES TO WARRANT THE CONSTRUCTION OF NEW DENTURES(S).
PC26	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
PC28	PLEASE SUBMIT A PHYSICIANS STATEMENT INDICATING DENTURES ARE NECESSARY FOR THIS NURSING HOME CLIENT.
PC29	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING LOSS OR DESTRUCTION OF DENTURE(S). INCLUDE SIGNED STATEMENT FROM CLIENT OR FACILITY DIRECTOR REGARDING HOW, WHEN AND WHERE LOST.
PC30	PLEASE PROVIDE COMPLETE INTRAORAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PC31	PLEASE DESCRIBE ANY RELATED DEFORMITIES OF THE FEET.
PC34	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD WITH REQUESTED DME ITEM(S) AND DOCUMENT IF THE CLIENT CAN USE SAFELY AND INDEPENDENTLY.
PC35	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD AND DESCRIBE THE RESULTS AND EFFECTIVENESS OF THE SERVICE REQUESTED.
PC39	PLEASE INDICATE LITER FLOW PER MINUTE, HOURS OF USE PER 24 HOUR PERIOD, AND THE EXPECTED DURATION OF NEED.
PC40	THE ITEM DOES NOT REQUIRE PRIOR AUTHORIZATION UNTIL THE LIFE EXPECTANCY HAS BEEN REACHED.
PC41	PLEASE SUPPLY INFORMATION INDICATING THE NECESSITY OF POSITIONING THE CLIENT'S BODY IN MULTIPLE POSITIONS.
PC42	PLEASE INDICATE IF THE BED HEIGHT MUST BE CHANGED TO ALLOW FOR SAFE TRANSFER OR ADEQUATE BED CARE.
PC43	SUPPLY A PHYSICIANS STATEMENT INDICATING TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR UNIT HAS REDUCED PAIN, IMPROVED/INCREASED THE CLIENTS ACTIVITY LEVEL, AND/OR REDUCED CLIENTS USE OF PAIN MEDICATION.
PC44	A CURRENT AUTHORIZATION FOR THIS SERVICE IS ON FILE FOR ANOTHER PROVIDER. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT OF THAT FACT IS REQUIRED BY THE CLIENT OF FIRST PROVIDER.
PC59	DOCUMENT DECLINE OR PROGRESS IN SPECIFIC, MEASURABLE, OBJECTIVE TERMS.
PC60	DOCUMENT IF CLIENT HAS DEMONSTRATED A GOOD APPOINTMENT COMPLIANCE RECORD.
PC61	THE PHYSICIANS SIGNATURE DATE MUST NOT EXCEED 90 DAYS FROM THE DATE OF RECEIPT BY COLORADO MEDICAID.
PC62	REQUESTS FOR A CONTINUATION OF THERAPY SHOULD NOT BE SUBMITTED MORE THAN FOUR WEEKS PRIOR TO THE EXPIRATION DATE OF THE CURRENT AUTHORIZATION.
PC63	PLEASE FURNISH THE STYLE AND MANUFACTURER OF THE FRAME.
PC64	PLEASE FURNISH THE CLIENTS LENS FORMULA.
PC66	ALL REQUESTS FOR TINTS REQUIRE DOCUMENTATION OF THE VISUAL OR MEDICAL CONDITION RELATED TO PHOTOPHOBIA.
PC67	PLEASE DOCUMENT THE REASON AND JUSTIFICATION FOR REPLACEMENT BEYOND THE FIRST LENS/FRAME.
PC68	DOCUMENT IF ALL REMAINING MAXILLARY AND/OR MANDIBULAR TEETH ARE DECAY-FREE, PROPERLY RESTORED, AND PERIODONTICALLY SOUND.
PC72	SUPPLY MORE DETAIL REGARDING PROGRESS (ATTACHMENT OF GOALS, ETC.). CORRELATE PROGRESS TO PREVIOUS GOALS AND IDENTIFIED LIMITATIONS.
PC77	PLEASE SUBMIT A PLAN OF CARE DESCRIBING THE SERVICES THAT WOULD BE PROVIDED.
PC78	PLEASE DOCUMENT SPECIFIC, MEASURABLE GOALS.
PC82	THE PRIOR AUTHORIZATION (PA) SYSTEM CAN PROCESS ONLY 26 DETAILS PER PA REQUEST. PLEASE RESUBMIT YOUR REQUEST WITH NO MORE THAN 26 DETAILS.
PC83	PLEASE SUPPLY A PHYSICIANS PRESCRIPTION DATED WITHIN ONE MONTH OF REQUESTED SUBSTANCE ABUSE DAY TREATMENT.

Denial Code	Long Description
PC84	PLEASE PROVIDE INFORMATION INDICATING THIS CLIENT IS APPROPRIATELY DETOXIFIED FROM ALCOHOL AND/OR OTHER DRUGS.
PC85	PLEASE PROVIDE INFORMATION TO INDICATE THE CLIENTS ABILITY TO ABSTAIN FROM ALCOHOL OR DRUGS WHILE IN THE SUBSTANCE ABUSE DAY TREATMENT PROGRAM.
PC86	PLEASE INDICATE IF THIS CLIENT IS WILLING TO PARTICIPATE IN AFTERCARE OR CONTINUING CARE SERVICES.
PC87	PROVIDE MORE INFORMATION ON TREATMENT HISTORY; INCLUDE SERVICE PROVIDED, DATES, AND OUTCOME. PROVIDE DETAIL OF PREVIOUS TREATMENT.
PC88	PLEASE PROVIDE MORE RATIONALE FOR THE APPROPRIATENESS AND MEDICAL NECESSITY OF SUBSTANCE ABUSE DAY TREATMENT.
PC89	PROVIDE A TREATMENT PLAN THAT CONTAINS MEASURABLE GOALS AND OBJECTIVES CORRESPONDING TO THE IDENTIFIED DEFICIT.
PC91	PLEASE PROVIDE MORE INFORMATION ON FAMILY INVOLVEMENT TREATMENT.
PC92	PLEASE PROVIDE MORE HISTORY AND EXPLANATION ABOUT THE ISSUE OF ABSTINENCE FOR THIS CLIENT.
PC94	PLEASE PROVIDE THE ANTICIPATED BEGINNING DATE AND/OR THE ESTIMATED SUBSTANCE ABUSE DAY TREATMENT DISCHARGE DATE.
PC95	PLEASE SUPPLY JUSTIFICATION FOR BEGINNING CLIENT IN SERVICE PRIOR TO AUTHORIZATION BEING OBTAINED.
PC96	THE INITIAL THREE HOURS OF SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IN A CALENDAR YEAR DO NOT REQUIRE PRIOR AUTHORIZATION.
PC97	REIMBURSEMENT FOR INITIAL SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IS LIMITED TO THREE HOURS IN A CALENDAR YEAR AND DOES NOT REQUIRE PRIOR AUTHORIZATION.
PC98	THIS DRUG IS CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE BILL USING THE APPROPRIATE NATIONAL DRUG CODE (NDC) OR SUBMIT A COMPLETED DRUG ADDITION REQUEST FORM IF THE NDC IS NOT LISTED IN THE DRUG INDEX.
PC99	THIS DRUG IS NOT CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL, CURRENT ADMINISTRATIVE RULE, OR COLORADO DRUG INDEX FOR COVERAGE LIMITATIONS.
PD01	DOCUMENT THAT CLIENT HAS ACHIEVED GOOD ORAL HYGIENE, PERIODONTAL CASE TYPE 1 OR 2, AND IS MOTIVATED TO MAINTAIN SAME.
PD03	PLEASE PROVIDE AN ARTERIAL BLOOD GAS READING OR PULSE OXIMETRY RESULTS DONE ON ROOM AIR SIGNED AND DATED BY A MEDICAL DOCTOR. THIS SHOULD BE DONE WITHIN 60 DAYS OF REQUESTED SERVICE.
PD04	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 30 DAYS OF RECEIPT BY COLORADO MEDICAID.
PD07	SUBMIT A PHOTOCOPY OF A VALID PRESCRIPTION, ISSUED WITHIN THE PAST YEAR, OR COMPLETE SECTION B OF THE PRIOR AUTHORIZATION/DRUG ATTACHMENT (PA/DGA), F-11049.
PD10	BRAND MEDICALLY NECESSARY MUST BE IN THE PRESCRIBERS OWN HANDWRITING AND WRITTEN DIRECTLY ON THE PRESCRIPTION OR A SEPARATE ORDER ATTACHED TO THE ORIGINAL PRESCRIPTION.
PD12	COMPLETE DENTURES, PARTIAL DENTURES, DENTURE RELINES, AND FIXED PROSTHODONTIC SERVICES ARE NOT COVERED SERVICES FOR ADULTS FOR DATES OF SERVICE ON AND AFTER OCTOBER 1, 1995.
PD22	PLEASE COMPLETE ALL REQUIRED ELEMENTS ON THE PERSONAL CARE SCREENING TOOL (PCST), F-11133.
PD24	THIS PRIOR AUTHORIZATION REQUEST IS UNABLE TO BE PROCESSED. PLEASE RESUBMIT WITH ADDITIONAL REQUIRED FORMS, INCLUDING THE ENTIRE PERSONAL CARE SCREENING TOOL (PCST), F-11133; PERSONAL CARE ADDENDUM, F-11136; AND SUPPORTING DOCUMENTATION, AS DIRECTED.
PD25	THERE IS A PERSONAL CARE SCREENING TOOL (PCST), F-11133, COMPLETED BY ANOTHER AGENCY. CONTACT THE AGENCY TO TRANSFER SCREEN.
PD26	THERE IS A LIMITED TERM CARE FUNCTIONAL SCREEN (LTC-FS) COMPLETED BY ANOTHER AGENCY. THE PERSONAL CARE SCREENING TOOL (PCST), F-11133, INFORMATION IS IN CONFLICT WITH LTC-FS.
PD27	ONLY ONE LEVEL OF FUNCTION MAY BE SELECTED FOR ALL ELEMENTS EXCEPT TOILETING. COLORADO MEDICAID IS UNABLE TO PROCESS THE PRIOR AUTHORIZATION REQUEST.
PD28	NO UNITS MAY BE REQUESTED USING THIS PRIOR AUTHORIZATION PROCESS. PLEASE SUBMIT WITH THE APPROPRIATE ATTACHMENTS FOR REQUESTING SPECIFIC PERSONAL CARE WORKER UNITS.

Denial Code	Long Description
PD29	CLIENT IS NOT ELIGIBLE FOR THE REQUESTED SERVICE(S) AS OF THE REQUESTED START DATE.
PD30	NO TRAVEL TIME MAY BE AUTHORIZED WHEN NO PERSONAL CARE WORKER SERVICE IS AUTHORIZED.
PD32	PROVIDER NOT CERTIFIED TO RENDER THE SERVICE(S) REQUESTED.
PD34	BASED ON THE DOCUMENTATION SUBMITTED, THIS REQUEST CAN NOT BE PRIOR AUTHORIZED. REFER TO THE PA MESSAGES FROM THE CONSULTANT FOR COMPLETE EXPLANATION.
PD98	PLEASE DOCUMENT HOW AND WHEN EACH PREVIOUSLY AUTHORIZED PRO RE NATA VISIT WAS USED.

Durable Medical Equipment (DME) - Oxygen and Respiratory

Denial Code	Long Description
0201	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
0233	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0235	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0237	CLIENT IDENTIFICATION NUMBER DOES NOT MATCH CLIENTS FIRST NAME.
0238	THE CLIENT IDENTIFICATION NUMBER DOES NOT MATCH THE CLIENTS LAST NAME.
0242	SECONDARY DIAGNOSIS CODE IS INVALID.
0248	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0249	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0251	PROCEDURE CODE MODIFIER IN FIRST POSITION IS INVALID.
0252	THE PROCEDURE CODE MODIFIER IN SECOND POSITION IS INVALID FOR REQUESTED START DATE OR DATE OF RECEIPT.
0253	THE PROCEDURE CODE MODIFIER IN THIRD POSITION IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
0258	THE PRIMARY DIAGNOSIS CODE IS REQUIRED.
0272	THE PRIMARY DIAGNSOSIS CODE IS INVALID.
0400	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0853	HCPCS - ANNUAL UPDATE
0885	NEVER EVENTS MODIFIERS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
0886	NEVER EVENTS DIAGNOSIS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
1000	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
1002	RENDERING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1003	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1007	RENDERING PROVIDER ID IS NOT ON FILE.
1047	THE RENDERING PROVIDERS CERTIFICATION HAS BEEN CANCELLED.
1048	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1801	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
1804	A CERTIFIED SUBSTANCE ABUSE DAY TREATMENT PROVIDER MUST SUBMIT A SUBSTANCE ABUSE DAY TREATMENT PROCEDURE CODE.
1806	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
1808	THE BILLING PROVIDER DOES NOT HAVE THE REQUIRED CERTIFICATION ADDENDUM ON FILE.
1900	THE BILLING PROVIDERS TAXONOMY CODE IS INVALID.
1901	THE RENDERING PROVIDERS TAXONOMY CODE IS INVALID.
1927	A NATIONAL PROVIDER IDENTIFIER IS REQUIRED FOR THE BILLING PROVIDER.
1934	A NATIONAL PROVIDER INDENTIFIER IS REQUIRED FOR THE RENDERING PROVIDER.
1936	THE BILLING PROVIDER NUMBER IS INVALID.
1937	THE RENDERING PROVIDER NUMBER IS INVALID.
1960	INTERNAL PROCESSING IS REQUIRED.
1963	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.

Denial Code	Long Description
1964	THE BILLING PROVIDER INDICATED IS NOT ALLOWABLE AS A BILLING PROVIDER.
1965	RENDERING PROVIDER NUMBER IS MISSING/INVALID FOR THIS PROCEDURE PROVIDER.
1974	PRESCRIBING/REFERRING/ORDERING PROVIDER INDICATED IS NOT CERTIFIED AS A PRESCRIBING/REFERRING/ORDERING PROVIDER.
1975	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
1976	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
2001	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2003	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2017	THE CLIENT IS ENROLLED IN A MEDICAID OR OTHER MANAGED CARE PROGRAM.
2037	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2603	CLIENT LOCKED-IN TO A PROVIDER OR ENROLLED IN A HOSPICE. CONTACT CLIENTS HOSPICE FOR PAYMENT OF SERVICES OR RESUBMIT WITH DOCUMENTATION OF UNRELATED NATURE OF CARE.
3324	THE MODIFIER HAS BEEN DISCONTINUED BY THE CENTERS OF MEDICARE AND MEDICAID SERVICES OR THE AMERICAN MEDICAL ASSOCIATION FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
3337	THE PROCEDURE CODE HAS BEEN TERMINATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AMERICAN MEDICAL ASSOCIATION, OR AMERICAN DENTAL ASSOCIATION FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT. RESUBMIT WITH VALID A PROCEDURE CODE.
3339	THE PROCEDURE BILLED IS NOT PAYABLE ACCORDING TO DEFICIT REDUCTION ACT (DEFRA) GUIDELINES.
3351	THE PROCEDURE IS NOT COVERED FOR CLIENTS WITH A NURSING HOME AUTHORIZATION ON THE REQUESTED START DATE OR DATE OF RECEIPT.
3353	THE PROCEDURE IS NOT A COVERED SERVICE FOR HOME AND COMMUNITY-BASED WAIVER CLIENTS.
4021	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4027	THE DIAGNOSIS CODE IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
4031	THE PROCEDURE SUBMITTED IS NOT APPROPRIATE FOR CLIENTS GENDER.
4032	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4034	THE PROCEDURE CODE HAS AN AGE RESTRICTION.
4036	THE PLACE OF SERVICE CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4040	THE PRIMARY DIAGNOSIS CODE IS NOT ON FILE.
4041	THE SECONDARY DIAGNOSIS IS NOT ON FILE.
4046	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4127	INTERNAL PROCESSING IS REQUIRED.
4131	INTERNAL PROCESSING IS REQUIRED.
4141	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4149	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4150	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4236	ETIOLOGY DIAGNOSIS CODE(S) (E-CODES) ARE INVALID AS THE PRIMARY DIAGNOSIS.
4245	THE FOURTH POSITION MODIFIER IS INVALID FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT.
4256	THE PROCEDURE CODE AND MODIFIER COMBINATION IS NOT PAYABLE FOR THE CLIENTS BENEFIT PLAN.
4257	THE MODIFIERS SUBMITTED ARE EITHER INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT OR THE MODIFIERS ARE MISSING.
4311	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4315	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4316	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4372	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4714	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS AGE.
4731	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS DIAGNOSIS.
4742	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4743	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4744	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4745	DIAGNOSIS AND/OR PROCEDURE AND/OR PLACE OF SERVICE (POS) CODE IS NOT COVERED FOR EXPRESS ENROLLMENT CLIENTS.
4746	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.

Denial Code	Long Description
4801	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4802	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
4821	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
4871	PLEASE REFER TO PA MESSAGES FOR RETURN INFORMATION.
4963	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS GENDER.
4990	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
7500	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
7509	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
P001	THE BILLING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THE SERVICES.
P002	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P003	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P005	THE PRIOR AUTHORIZATION CAN NOT BE END DATED. THE PRIOR AUTHORIZATION STATUS IS NOT APPROVED OR APPROVED WITH REVISIONS.
P006	PLEASE FURNISH THE PROCEDURE CODE AND CORRESPONDING DESCRIPTION.
P008	THE BILLING PROVIDER NUMBER IS INVALID.
P009	THE BILLING PROVIDER NUMBER IS INVALID.
P010	THE REQUESTED END DATE IS INVALID.
P011	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P012	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P013	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P014	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P015	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P016	THE REQUESTED START DATE IS MISSING OR INVALID.
P020	THE RENDERING PROVIDER NUMBER IS INVALID.
P021	THE RENDERING PROVIDER NUMBER IS INVALID.
P022	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P023	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P024	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P026	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P027	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P030	FIRST MODIFIER IS INVALID.
P031	FIRST MODIFIER IS INVALID.
P032	SECOND MODIFIER IS INVALID.
P033	SECOND MODIFIER IS INVALID.
P034	THIRD MODIFIER IS INVALID.
P035	THIRD MODIFIER IS INVALID.
P036	FOURTH MODIFIER IS INVALID.
P037	FOURTH MODIFIER IS INVALID.
P038	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P039	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P040	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P041	CLIENTS FIRST NAME IS MISSING.
P042	CLIENTS LAST NAME IS MISSING.
P043	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.

Denial Code	Long Description
P044	BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES REQUESTED.
P045	FIRST MODIFIER IS INVALID.
P046	SECOND MODIFIER IS INVALID.
P047	THIRD MODIFIER IS INVALID.
P048	FOURTH MODIFIER IS INVALID.
P052	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P053	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P054	RENDERING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES FOR THE BENEFIT PLAN.
P055	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P061	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P062	THE CLIENT ID AND/OR NAME INDICATED ON THE PA REQUEST IS INCORRECT. THE CLIENT ID AND/OR NAME HAS BEEN UPDATED. PLEASE VERIFY THE ID AND/OR NAME IS CORRECT.
P064	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
P067	THE FREQUENCY OF HOURS REQUESTED ARE NOT APPROPRIATE FOR THIS CLIENT AND HAVE BEEN MODIFIED ACCORDINGLY.
P079	BILLING PROVIDER IS ON PAYMENT SUSPENSION DUE TO CREDIBLE ALLEGATION OF FRAUD.
P120	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAS BEEN REDUCED.
P121	THE SERVICE/ PROCEDURE REQUESTED IS NOT SUPPORTED BY SUBMITTED DOCUMENTATION.
P126	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
P128	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.
P138	SERVICE(S) DO NOT MEET COLORADO MEDICAID GUIDELINES.
P167	REQUESTED DOCUMENTATION HAS NOT BEEN SUBMITTED.
P178	THE SERVICE REQUESTED IS NOT MEDICALLY NECESSARY.
P179	THE MEDICAL NECESSITY FOR THIS SERVICE IS NOT SUPPORTED BY THE SUBMITTED DOCUMENTATION.
P233	THE DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE ADDITIONAL CARE.
P257	THIS CLIENTS FUNCTIONAL ASSESSMENT SCORES PLACE THIS CLIENT OUTSIDE ELIGIBILITY FOR DAY TREATMENT.
P274	OUR RECORDS INDICATE THIS CLIENT IS INVOLVED IN EFFECTIVE AND APPROPRIATE SERVICE ELSEWHERE.
P292	INTENSIVE REHABILITATION HOURS ARE NO LONGER APPROPRIATE AS INDICATED BY HISTORY, DIAGNOSIS, AND/ OR FUNCTIONAL ASSESSMENT SCORES.
P328	THE SERVICES REQUESTED INCLUDE NON-COVERED SERVICES, AND HOURS ARE REDUCED ACCORDINGLY.
P339	THE CLIENTS PAST HISTORY INDICATES REDUCED TREATMENT HOURS ARE WARRANTED.
P342	THE REQUEST DOES NOT MEET GENERALLY ACCEPTED CONDITIONS REQUIRING FLUORIDE TREATMENTS.
P346	SERVICES EXCEED COLORADO MEDICAID LIMITATION AND DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE MEDICAL NECESSITY OF THE SERVICE.
P349	THE SERVICE REQUESTED WAS PERFORMED LESS THAN FIVE YEARS AGO.
P353	THE EXISTING APPLIANCE HAS NOT BEEN WORN FOR THREE YEARS.
P367	THE CLIENT HAS BEEN TOTALLY WITHOUT TEETH AND AN APPLIANCE FOR FIVE YEARS.
P392	THE CLIENT IS MISSING AN ANTERIOR TOOTH AND/OR HAS TWO OR MORE POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P405	THE SERVICE(S) REQUESTED COULD ADEQUATELY BE PERFORMED IN THE DENTAL OFFICE.
P406	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE OF GOOD PERIODONTAL HEALTH (AMERICAN ACADEMY OF PERIODONTOLOGY PERIODONTAL CLASSIFICATION OF TYPE I OR II).
P407	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE VISIBLE ON RADIOGRAPHS THAT AT LEAST 50 PERCENT OF THE CLINICAL CROWN IS INTACT.
P409	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING SIX OR MORE TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED, INCLUDING THIRD MOLARS.
P410	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING ONE OR MORE ANTERIOR TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED.

Denial Code	Long Description
P411	DOCUMENTATION DOES NOT SUPPORT THE NEED FOR PERIODONTIC SERVICES. POCKETS ARE LESS THAN 4MM AND/OR GREATER THAN 6MM FOR CLIENT AND/OR THE CLIENT IS UNDER THE AGE OF 13.
P412	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA.
P413	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA. THIS PA HAS BEEN GRANTED AS APPROVED NOT APPROVED WITH REVISIONS. THE DURATION REQUESTED MAY HAVE BEEN REDUCED TO REFLECT COVERAGE LIMITATIONS, PRESCRIBER ORDERS, CONFLICTI
P417	THE SERVICE(S) REQUESTED COULD BE ADEQUATELY PERFORMED WITH LOCAL ANESTHESIA.
P437	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO POOR ORAL HYGIENE.
P444	THIS LINE ITEM IS A DUPLICATE OF ANOTHER LINE ITEM ON THIS PRIOR AUTHORIZATION (PA) REQUEST. PLEASE CORRECT.
P446	THIS IS A DUPLICATE OF AN EXISTING PRIOR AUTHORIZATION (PA) REQUEST. YOU MAY CONTACT PROVIDER SERVICES IF YOU REQUIRE ASSISTANCE. DUPLICATE PA REQUEST
P448	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO DECAY HISTORY.
P449	QUESTIONABLE LONG TERM PROGNOSIS DUE TO GUM AND BONE DISEASE.
P456	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO APPARENT ROOT INFECTION.
P457	OUR RECORDS INDICATE THIS CLIENT HAS EXCEEDED ESTABLISHED PROGRAM LIMITATIONS. COLORADO MEDICAID WILL NOT AUTHORIZE NEW DENTURES.
P458	DOCUMENTATION PROVIDED INDICATES A LESS ELABORATE PROCEDURE SHOULD BE CONSIDERED.
P502	RENTAL ONLY ALLOWED; MEDICAL NEED FOR PURCHASE HAS NOT BEEN DOCUMENTED.
P503	PURCHASE ONLY ALLOWED; MEDICAL NEED FOR RENTAL HAS NOT BEEN DOCUMENTED.
P504	OCCUPATIONAL THERAPY GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P505	THE SERVICE REQUESTED IS INCLUDED IN THE NURSING HOME RATE STRUCTURE.
P511	THIS NATIONAL DRUG CODE IS ONLY BILLABLE AS PART OF A COMPOUND DRUG.
P515	THE PRESENCE OF A HANDICAPPING MALOCCLUSION OR HANDICAPPING DENTOFACIAL DEFORMITY IS NOT SUPPORTED BY THE DOCUMENTATION SUBMITTED.
P521	THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVERED BY COLORADO MEDICAID.
P522	GASTRO-INTESTINAL SURGERY FOR THE PURPOSE OF WEIGHT CONTROL IS COVERED ONLY AS A LIFE THREATENING PROCEDURE.
P523	THE TREATMENT REQUEST IS NOT CONSISTENT WITH THE CLIENT'S DIAGNOSIS.
P524	PSYCHOTHERAPY PROVIDED IN THE CLIENTS HOME IS NOT A COVERED BENEFIT OF COLORADO MEDICAID.
P525	THE INFORMATION PROVIDED IS NOT CONSISTENT WITH THE INTENSITY OF SERVICES REQUESTED.
P526	INTENSIVE MULTIPLE MODALITY TREATMENT IS NOT CONSISTENT WITH THE INFORMATION PROVIDED.
P527	MULTIPLE PROVIDERS OF TREATMENT ARE NOT INDICATED FOR THIS CLIENT.
P528	THE DURATION OF TREATMENT SESSIONS EXCEED CURRENT COLORADO MEDICAID GUIDELINES.
P534	DOCUMENTATION OF POOR PHYSICAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P535	OTHER PHYSICAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P536	THE PHYSICAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P537	USE OF PHYSICAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P538	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF A PHYSICAL THERAPIST.
P539	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS AND LIVING ARRANGEMENT.
P540	GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P541	THE PROCEDURE(S) REQUESTED ARE NOT MEDICAL IN NATURE.
P542	DOCUMENTATION OF POOR OCCUPATIONAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P543	DOCUMENTATION OF POOR SPEECH THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.

Denial Code	Long Description
P544	OTHER OCCUPATIONAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P546	THE OCCUPATIONAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P547	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF PHYSICAL THERAPY.
P548	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P549	ACTIVITIES TO PROMOTE DIVERSION OR GENERAL MOTIVATION ARE NONCOVERED COLORADO MEDICAID SERVICES.
P550	REVISIONS OF THE REQUEST IS NECESSITATED BY THE CLIENTS MINIMAL PROGRESS.
P551	RESTORATIVE NURSING INVOLVEMENT COULD BE INCREASED.
P552	CLIENTS DEMONSTRATED RESPONSE TO CURRENT THERAPY DOES NOT WARRANT THE INTENSE FREQUENCY REQUESTED.
P553	MAINTENANCE IS TWO TIMES PER WEEK OR LESS.
P554	THE SPEECH THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P555	USE OF OCCUPATIONAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P556	USE OF SPEECH THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P557	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF AN OCCUPATIONAL THERAPIST.
P558	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
P559	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P560	THE MATERIALS/ SERVICES REQUESTED ARE PRINCIPALLY COSMETIC IN NATURE.
P561	THE LENS FORMULA DOES NOT JUSTIFY REPLACEMENT.
P562	THE CHANGE IN THE LENS FORMULA DOES NOT WARRANT MULTIPLE REPLACEMENTS.
P563	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P564	LENSES ONLY ARE APPROVED; PLEASE DISPENSE A CONTRACTED FRAME. THE NON-CONTRACTED FRAME IS NOT MEDICALLY JUSTIFIED.
P565	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P566	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P567	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF OCCUPATIONAL THERAPY.
P568	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF SPEECH THERAPY.
P569	LEVEL, INTENSITY, OR EXTENT OF SERVICE(S) REQUESTED HAS BEEN MODIFIED CONSISTENT WITH MEDICAL NEED AS DEFINED IN THE PLAN OF CARE.
P570	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P571	THE SERVICE ASKED FOR IS NOT COVERED BY COLORADO MEDICAID AS THESE TASKS CAN BE DONE BY NURSES OR ACTIVITY STAFF.
P572	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P573	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.
P574	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P575	MEDICAL NEED FOR EQUIPMENT/ SUPPLY REQUESTED IS NOT SUPPORTED BY DOCUMENTATION SUBMITTED.
P576	OTHER SPEECH THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P577	DOCUMENTATION SUBMITTED IDENTIFIES THAT THE CLIENT HAS FEWER THAN TWO POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P582	LESS EXPENSIVE ALTERNATIVE SERVICES ARE AVAILABLE FOR THIS CLIENT.
P634	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P711	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING PERIODONTAL SCALING AND ROOT PLANNING.

Denial Code	Long Description
P712	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING GINGIVECTOMY.
P754	AN APPROVED SUBSTANCE ABUSE DAY TREATMENT PROGRAM CANNOT EXCEED A SIX WEEK PERIOD.
P761	THE CLIENT DOES NOT APPEAR TO BE ABLE OR WILLING TO ABSTAIN FROM ALCOHOL/DRUG USAGE WHILE IN TREATMENT. THEREFORE, SUBSTANCE ABUSE DAY TREATMENT SERVICES ARE NOT APPROVED.
P764	THIS CLIENT HAS COMPLETED INTENSIVE SUBSTANCE ABUSE TREATMENT WITHIN THE PAST 12 MONTHS. THE DOCUMENTATION PROVIDED IS NOT ADEQUATE TO JUSTIFY ADDITIONAL INTENSIVE TREATMENT AT THIS TIME.
P785	A LESS THAN SIX-WEEK HEALING PERIOD HAS BEEN SPECIFIED FOR THIS PRIOR AUTHORIZATION. THEREFORE IT IS NOT NECESSARY TO WAIT THE FULL SIX WEEKS AFTER EXTRACTIONS BEFORE TAKING DENTURE IMPRESSIONS.
P818	SIX-WEEK HEALING TIME IS REQUIRED BETWEEN EDENTULATION AND FINAL IMPRESSIONS. PAYMENT FOR DENTURES WILL BE DENIED OR RECOUPED IF HEALING PERIOD IS NOT OBSERVED.
P849	COLORADO MEDICAID HAS DETERMINED THERE WERE (ARE) SEVERAL HOME HEALTH AGENCIES WILLING TO PROVIDE MEDICALLY NECESSARY SKILLED NURSING SERVICES TO THIS CLIENT.
P864	THE DOCUMENTATION YOU HAVE SUBMITTED DOES NOT MEET THE REQUIREMENTS OF COLORADO MEDICAID.
P873	THE MEDICAL NECESSITY FOR THE HOURS REQUESTED IS NOT SUPPORTED BY THE INFORMATION SUBMITTED.
P874	THE DOCUMENTATION SUBMITTED INDICATES THE TASKS SPECIFIED CAN BE COMPLETED DURING THE VISITS APPROVED.
P878	THE DOCUMENTATION SUBMITTED DOES NOT INDICATE THAT MEDICALLY ORIENTED TASKS ARE MEDICALLY NECESSARY; THEREFORE PERSONAL CARE SERVICES HAVE BEEN APPROVED.
P880	THE QUANTITY OF SERVICES AUTHORIZED FOR THIS CLIENTS PERSONAL CARE HAS BEEN AMENDED BASED ON INFORMATION RECEIVED FROM ONE OR MORE OF THESE SOURCES: THE CLIENT, THEIR PHYSICIAN, AND/OR THE IN-HOME VISIT BY STAFF OF THE OIG (OFFICE OF INSPECTOR GENERAL).
P885	THE USE OF THIS DRUG FOR THE INTENDED PURPOSE IS NOT COVERED BY COLORADO MEDICAID, CONSISTENT WITH COLORADO ADMINISTRATIVE CODE AND FEDERAL LAW.
P924	THE MEDICAL RECORDS SUBMITTED WITH THE CURRENT REQUEST CONFLICT OR DISAGREE WITH OUR MEDICAL RECORDS ON THIS CLIENT.
P950	INDEPENDENT NURSES, PLEASE NOTE PAYABLE SERVICES MAY NOT EXCEED 12 HOURS/DAY OR 60 HOURS/WEEK.
P951	SERVICES CAN ONLY BE AUTHORIZED THROUGH ONE YEAR FROM THE PRESCRIPTION DATE.
P952	LEAD INSPECTION IS A COVERED COLORADO MEDICAID SERVICE WHEN THE CHILD HAS BEEN SHOWN TO HAVE LEAD POISONING (E.G., CHILD HAS A BLOOD LEAD LEVEL > 19 UG/DL OR TWO CONSECUTIVE BLOOD LEAD LEVELS OF 15-19 UG/DL DONE AT LEAST 90 DAYS APART). THE INSPECTION MUS
P953	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P954	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P956	THE REQUEST CAN ONLY BE BACKDATED A MAXIMUM OF 14 DAYS FROM FIRST DATE RECEIVED BY COLORADO MEDICAID.
P957	COMPLETE PERIODONTAL CHARTING AT TIME OF SERVICE, AND SUBMIT CHARTING, COPY OF OPERATIVE REPORT, TOGETHER WITH A COPY OF THE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF), F-11035, TO PA UNIT ATTENTION DENTAL CONTSULTANT.
P958	NOTE THAT CODE D4341 HAS BEEN CHANGED. REFER TO THE DECISION NOTICE FOR AUTHORIZED QUANTITY.
P960	YOUR PA HAS BEEN APPROVED FOR 90 DAYS. THE 90 DAY APPROVAL DOES NOT IMPLY THE PA REQUEST MEETS PRIOR AUTHORIZATION CRITERIA. AFTER ADDITIONAL INFORMATION IS AVAILABLE IN INTERCHANGE, COLORADO MEDICAID WILL CREATE AN AMENDMENT REQUEST TO EXTEND THE PA FOR
P961	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P962	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.

Denial Code	Long Description
PA10	THE REQUESTED END DATE IS INVALID.
PA12	PLEASE FURNISH A WRITTEN DESCRIPTION OF THE CLIENTS DIAGNOSIS.
PA13	PROVIDE DIAGNOSES WITH DATES OF ONSET.
PA14	IDENTIFY PROBLEMS TO BE TREATED.
PA15	THE AUDIOLOGISTS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1), F-11020, AND PRIOR AUTHORIZATION REQUEST/HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2), F-11021.
PA16	THE PHYSICIANS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION/PHYSICIAN OTOLOGICAL REPORT (PA/POR), F-11019.
PA17	SUBMIT BRIEF HISTORY WITH REFERRAL INFORMATION, LIVING SITUATION, FUNCTIONAL STATUS, AND OTHER PERTINENT INFORMATION. WHAT CHANGE OF STATUS RESULTED IN REFERRAL AT THIS TIME?
PA18	PLEASE FURNISH THE CLIENTS HEIGHT AND WEIGHT.
PA19	PLEASE SUBMIT CLINICAL INFORMATION SUFFICIENT TO VERIFY THE NEED FOR THE REQUESTED SERVICE(S).
PA20	PLEASE RESUBMIT WITH COMPLETE PERIODONTAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PA21	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL EDUCATIONAL PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA22	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL PROGRAM PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA23	REFER TO THE DURABLE MEDICAL EQUIPMENT INDEX FOR APPROPRIATE CODE AND DESCRIPTION. DO NOT USE AN "UNLISTED" CODE.
PA24	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUALIZED FAMILY SERVICE PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA25	INFORMATION ON THE REQUEST FORM IS ILLEGIBLE, AND THE REQUEST CANNOT BE PROCESSED.
PA26	RE-EVALUATE YOUR GOALS. EMPHASIS SHOULD BE ON FUNCTIONAL SELF-CARE. GOALS MUST BE RELATED TO FUNCTIONAL OUTCOME.
PA27	PLEASE CLARIFY THE NUMBER OF HOURS PER WEEK REQUESTED.
PA28	PLEASE CLARIFY THE NUMBER OF HOURS PER DAY REQUESTED.
PA29	PLEASE CLARIFY THE NUMBER OF VISITS PER DAY REQUESTED.
PA30	ATTACH SUPPORTIVE DOCUMENTATION; HOME EXERCISE PROGRAM AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA31	THE DIAGNOSIS CODE INDICATED ON THE REQUEST DOES NOT CORRESPOND TO THE DIAGNOSIS CODE DESCRIPTION.
PA32	PLEASE SUBMIT ADDITIONAL INFORMATION SUFFICIENT TO VERIFY APPROPRIATENESS AND NEED FOR TRANSPLANT.
PA33	PLEASE SUBMIT THE INITIAL AND PROGRESSIVE OBJECTIVE FINDINGS.
PA34	ATTACH SUPPORTIVE DOCUMENTATION, FACILITY PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA35	PLEASE SUBMIT THE CLIENTS ORIGINAL COMPLAINTS AND EXAMINATION FINDINGS.
PA36	ATTACH SUPPORTIVE DOCUMENTATION, IN-HOME AUTISM PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA37	PLEASE SUBMIT YOUR TREATMENT PLAN FOR THIS CLIENT.
PA38	ATTACH SUPPORTIVE DOCUMENTATION AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA39	INITIAL EVALUATIONS MUST BE PERFORMED BY AN OCCUPATIONAL THERAPIST REGISTERED (OTR), PER AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA) STANDARDS.
PA41	IDENTIFY THE PLACE OF SERVICE AND ITS EFFECT ON SUPPORTING THE DESIRED TREATMENT OUTCOME.
PA42	PLEASE INDICATE THE HOURS OF USE OF OXYGEN PER 24-HOUR PERIOD.
PA43	PROVIDE BASELINE DOCUMENTATION FOR THIS CLIENTS LIMITATIONS USING UNITS OF MEASUREMENT THAT ARE APPLIED CONSISTENTLY WHEN REPORTING STATUS.
PA44	IDENTIFY FUNCTIONAL LIMITATIONS AS THEY ARE RELATED TO IDENTIFIED CONDITIONS.
PA46	CORRELATE PLAN OF CARE TO REQUESTED PROCEDURE CODES.

Denial Code	Long Description
PA47	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE FREQUENCY/DURATION REQUESTED.
PA48	PLEASE PROVIDE THE NAME AND CREDENTIALS OF THE RENDERING PROVIDER.
PA50	COLORADO MEDICAID RECORDS INDICATE THE CLIENT OWNS A WHEELCHAIR. DOCUMENT THE REASON AND NEED FOR REPLACEMENT AND COST TO REPAIR CURRENT WHEELCHAIR.
PA51	PLEASE DISTINGUISH PRIMARY AND SUPPORTIVE MODALITIES.
PA52	PLEASE SUBMIT A PROGRESS REPORT.
PA53	MULTIPLE FAMILY CLIENTS TREATMENT BY THE SAME PROVIDER REQUIRES FURTHER INFORMATION DOCUMENTING COORDINATION OF TREATMENT PLAN.
PA54	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE MINUTES REQUESTED.
PA55	MEDICAL NECESSITY OF TREATMENT REQUIRES ADDITIONAL DOCUMENTATION.
PA56	GIVEN AGE, DIAGNOSES, CURRENT LEVEL OF FUNCTION, PAST RESPONSE TO TREATMENT, AND LIVING SITUATION, EXPAND ON POTENTIAL FOR SIGNIFICANT FUNCTIONAL PROGRESS WITHIN THE NEXT SIX MONTHS. EMPHASIZE WHY PROGRESS IS EXPECTED WITH SERVICES AT THIS TIME.
PA57	SUBMIT THE INITIAL FINDINGS. INCLUDE A COMPREHENSIVE EVALUATION.
PA58	SUBMIT PROGRESSIVE, OBJECTIVE FINDINGS. INCLUDE A PERTINENT RE-EVALUATION.
PA59	PLEASE SUPPLY INFORMATION REGARDING THE CLIENTS MEDICATION REQUIREMENTS, IF ANY.
PA60	PLEASE SPECIFY IF THE CLIENT IS IN AN EDUCATIONAL SETTING.
PA61	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA62	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
PA63	THE SKILLS OF A THERAPIST ARE PURPOSEFUL AND SKILLED INTERVENTIONS REQUIRED TO CONTINUALLY DESIGN, IMPLEMENT, REASSESS, MODIFY/GRADE, AND/OR DISCONTINUE A PLAN OF CARE IN A TIMELY MANNER, BASED ON THE COMPLEXITY OF THE CLIENTS MEDICAL CONDITION AND/OR CO
PA64	PLEASE SUBMIT A THERAPY PLAN OF CARE, INCLUDING A CURRENT, DATED EVALUATION.
PA65	A PLAN OF CARE SIGNED AND DATED BY THE PHYSICIAN IS REQUIRED.
PA66	THE SKILLS OF A THERAPIST ARE REQUIRED WHEN ONLY THE THERAPIST CAN SAFELY AND EFFECTIVELY DELIVER THE THERAPEUTIC PROCEDURES BECAUSE OF THEIR UNIQUE KNOWLEDGE, TRAINING, AND EXPERTISE. DESCRIBE THE REASON THAT SOMEONE OTHER THAN A THERAPIST CANNOT SAFELY
PA67	PLEASE SPECIFY IF THE CLIENTS WORK SITE DEMANDS GOOD BINAURAL HEARING.
PA68	DESCRIBE THE REASON, BASED ON THE CLIENTS COGNITIVE, PHYSICAL, COMMUNICATION, OR RESOURCE STATUS, THAT A HOME PROGRAM, EQUIPMENT, OR ENVIRONMENTAL ADAPTATIONS ALONE CANNOT MEET CLIENTS NEEDS.
PA69	PLEASE SPECIFY IF THE CLIENT HAS AN ACCOMPANYING DISABILITY THAT ADDS TO THE HEARING PROBLEM.
PA70	DISTINGUISH REQUESTED PROCEDURES AND GOALS FROM OTHER SERVICES THIS CLIENT RECEIVES. THEY MAY NOT BE DUPLICATIVE.
PA71	PLEASE INDICATE THE NUMBER OF DAYS REQUESTED.
PA73	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA74	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA75	PLEASE DOCUMENT CARRYOVER OF THE THERAPY PROGRAM TO NURSING.
PA76	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA79	PROVIDE EVIDENCE OF SIGNIFICANT FUNCTIONAL PROGRESS IN LAST SIX MONTHS.
PA84	THE GRANT DATE OF THIS REQUEST CANNOT BE PRIOR TO THE SIGNATURE DATE OF THE PRESCRIBING PHYSICIAN.
PA86	PROVIDE EVIDENCE OF SKILLS GAINED IN THERAPY CARRYING OVER TO OTHER SETTINGS WITHIN SIX MONTHS.
PA87	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE NUMBER OF SESSIONS REQUESTED.
PA88	THE REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL SCOPE OF PRACTICE.

Denial Code	Long Description
PA89	PRIOR AUTHORIZATION IS NOT REQUIRED UNTIL LIMITATION OF SERVICE HAS BEEN REACHED.
PA91	PLEASE SUBMIT REQUIRED X-RAYS.
PA92	PLEASE PROVIDE AN EXPLANATION FOR THE MATERIAL SUBMITTED WITH THE REQUEST.
PA95	PLEASE DESCRIBE HOW THE PROVISION OF THIS SERVICE WOULD PREVENT INSTITUTIONALIZATION OF THE CLIENT.
PA96	COULD THE EXISTING DENTURE(S) BE RELINED OR REBASED? IF NOT, PLEASE EXPLAIN WHY NOT.
PA97	REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL STANDARDS OF PRACTICE.
PA98	PLEASE INDICATE IF THE CLIENT IS CURRENTLY BEING TUBE FED.
PB02	PLEASE PROVIDE THE REQUIRED DATED SIGNATURES ON THE ATTACHMENTS.
PB03	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING THE LOSS/DESTRUCTION/THEFT OF THE HEARING AID.
PB04	DESCRIBE THE CLIENTS ABILITY TO STAND OR AMBULATE SUFFICIENTLY TO ACCOMPLISH SELF-CARE ACTIVITIES.
PB07	PLEASE SUBMIT AN ORTHODONTIC STUDY MODEL OR DIAGNOSTIC CASTS.
PB09	PLEASE PROVIDE A PHOTOGRAPH OF THE INVOLVED AREA(S).
PB10	PLEASE PROVIDE AN ESTIMATION (IN GRAMS) OF THE TOTAL AMOUNT OF TISSUE TO BE RESECTED.
PB11	PLEASE SUBMIT THE PLAN OF CARE FOR CO-TREATMENT.
PB12	FURNISH A DETAILED DESCRIPTION FOR THE PROCEDURE CODE REQUESTED.
PB13	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB15	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB18	PLEASE COMPLETE THE ATTACHED OUT-OF-STATE PROVIDER DATA SHEET, F-11001, AND RESUBMIT.
PB20	A SIGNED AND DATED PRESCRIPTION IS REQUIRED WITHIN THREE MONTHS OF RECEIPT BY COLORADO MEDICAID FOR INITIAL REQUESTS AND WITHIN 12 MONTHS OF RECEIPT BY COLORADO MEDICAID FOR SUBSEQUENT REQUESTS.
PB21	PLEASE COMPLETE THE APPROPRIATE PRIOR AUTHORIZATION ATTACHMENT. CONTACT PROVIDER SERVICES OR THE PRIOR AUTHORIZATION UNIT FOR ASSISTANCE.
PB23	PHYSICAL THERAPY ASSISTANT NOTES AND ALL FORMS SUBMITTED MUST BE COSIGNED BY A REGISTERED PHYSICAL THERAPIST.
PB31	ARE YOU REQUESTING A COMPLETE APPLIANCE, OR REPLACEMENT PARTS?
PB32	THE PROCEDURE CODE INDICATED ON THE REQUEST DOES NOT MATCH THE DESCRIPTION OF SERVICE; PLEASE CORRECT AND RESUBMIT.
PB35	THE SERVICE REQUESTED DOES NOT REQUIRE PRIOR AUTHORIZATION.
PB41	PLEASE FURNISH A CURRENT MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT, F-11090 (DATED WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID).
PB45	THE CERTIFICATION PERIOD ON THE PLAN OF CARE (POC) DOES NOT COVER THE REQUESTED GRANT/START DATE. PLEASE RESUBMIT YOUR REQUEST WITH A NEW POC.
PB49	A CERTIFIED OCCUPATIONAL THERAPY ASSISTANTS NOTES MUST BE COSIGNED BY AN OCCUPATIONAL THERAPIST REGISTERED.
PB51	ADDITIONAL INFORMATION IS REQUIRED ON PRIOR AUTHORIZATION TO ENABLE PRICING.
PB54	REQUESTED SERVICES DO NOT MATCH SERVICES ON THE PHYSICIANS ORDERS.
PB59	PLEASE PROVIDE AN INDIVIDUAL EDUCATIONAL PLAN (IEP), WHICH HAS BEEN SIGNED BY THE PROVIDER NO EARLIER THAN NINE MONTHS PRIOR TO RECEIPT AT COLORADO MEDICAID; OTHERWISE, DOCUMENT WHY NO IEP EXISTS.
PB65	PLEASE FURNISH THE ANTICIPATED TOTAL CHARGES FOR THIS REQUEST.
PB66	A PHOTOCOPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED; THE DATE MUST BE WITHIN SIX MONTHS OF RECEIPT BY COLORADO MEDICAID.
PB67	THE PRESCRIPTION DATE MUST INCLUDE MONTH, DAY, AND YEAR.
PB68	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID.
PB73	THE SERVICES IDENTIFIED ON THE PLAN OF CARE DO NOT APPEAR APPROPRIATE FOR THE PROCEDURE CODE(S) REQUESTED ON THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018.
PB74	THE CLIENT/PROVIDER DOES NOT HAVE RETROACTIVE ENROLLMENT.
PB75	THE REQUESTED START DATE IS MORE THAN 14 DAYS BEFORE OR 62 DAYS AFTER RECEIPT.
PB82	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.

Denial Code	Long Description
PB83	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A HOME HEALTH AIDE. PLEASE RESUBMIT AS A PERSONAL CARE WORKER OR PROVIDE ADDITIONAL DOCUMENTATION.
PB86	THE SERVICES REQUESTED ARE NOT BEING PROVIDED IN THE CLIENTS RESIDENCE. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL.
PB87	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A NURSE. PLEASE RESUBMIT AS A HOME HEALTH AIDE OR PROVIDE ADDITIONAL DOCUMENTATION.
PB92	PLEASE FURNISH THE CLIENTS COMPLETE ADDRESS.
PB94	IF THE CLIENT IS A RESIDENT OF A NURSING HOME, SUPPLY THE COMPLETE NAME AND ADDRESS OF THE NURSING HOME.
PB99	THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018, MUST BE SIGNED AND DATED.
PC01	PLEASE SUPPLY THE RENDERING PROVIDERS PROVIDER NUMBER.
PC03	THE DRUG ENFORCEMENT ADMINISTRATION NUMBER IS MISSING OR INVALID.
PC06	PLEASE DESCRIBE YOUR PROGRAM; INCLUDE ENTRY DATE, TERMINATION DATE, HOURS PER WEEK, AND NUMBER OF WEEKS OF PRIMARY INTENSIVE SERVICE REQUESTED.
PC07	PLEASE DESCRIBE YOUR "AFTERCARE/FOLLOW-UP" PLANS FOR THIS CLIENT.
PC08	PLEASE SUPPLY DOCUMENTATION OF PREVIOUS SUBSTANCE ABUSE SERVICES WITH DATE(S) AND OUTCOME.
PC09	PLEASE DESCRIBE IN DETAIL THE TREATMENT OBJECTIVES/GOALS FOR THIS CLIENT.
PC10	PLEASE DESCRIBE THE FAMILY SITUATION/DYNAMICS. EXPLAIN HOW THE FAMILY WILL BE INCORPORATED INTO THE CLIENTS PLAN OF CARE.
PC12	PLEASE EXPLAIN IF YOUR SERVICE ENCOURAGES THE CLIENT TO ATTEND SELF-HELP GROUPS.
PC13	PLEASE SUPPLY A SPECIFIC SCHEDULE OF ACTIVITIES, INCLUDING DAY, TIME OF DAY, LENGTH OF SESSION, AND SERVICE TO BE RENDERED DURING THAT TIME.
PC15	PLEASE FURNISH DIAGNOSTIC RATIONALE.
PC17	PLEASE DOCUMENT IF THE CLIENT EVER RECEIVED SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT.
PC19	PLEASE FURNISH MORE EXTENSIVE AND IN-DEPTH HISTORICAL AND PSYCHOSOCIAL DATA.
PC20	PLEASE SUPPLY THE DATE THE CLIENT BECAME TOTALLY ENDENTULOUS.
PC23	PLEASE SUBMIT A PHYSICIANS STATEMENT REGARDING THE MEDICAL NECESSITY OF DENTURES FOR THIS CLIENT. THE PHYSICIANS STATEMENT MUST DOCUMENT THE MEDICAL NEED FOR DENTURES.
PC24	THE SERVICE REQUESTED WAS PREVIOUSLY AUTHORIZED. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT INDICATING THIS FACT IS REQUIRED.
PC25	PLEASE SUPPLY SUFFICIENT MITIGATING CIRCUMSTANCES TO WARRANT THE CONSTRUCTION OF NEW DENTURES(S).
PC26	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
PC28	PLEASE SUBMIT A PHYSICIANS STATEMENT INDICATING DENTURES ARE NECESSARY FOR THIS NURSING HOME CLIENT.
PC29	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING LOSS OR DESTRUCTION OF DENTURE(S). INCLUDE SIGNED STATEMENT FROM CLIENT OR FACILITY DIRECTOR REGARDING HOW, WHEN AND WHERE LOST.
PC30	PLEASE PROVIDE COMPLETE INTRAORAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PC31	PLEASE DESCRIBE ANY RELATED DEFORMITIES OF THE FEET.
PC34	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD WITH REQUESTED DME ITEM(S) AND DOCUMENT IF THE CLIENT CAN USE SAFELY AND INDEPENDENTLY.
PC35	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD AND DESCRIBE THE RESULTS AND EFFECTIVENESS OF THE SERVICE REQUESTED.
PC39	PLEASE INDICATE LITER FLOW PER MINUTE, HOURS OF USE PER 24 HOUR PERIOD, AND THE EXPECTED DURATION OF NEED.
PC40	THE ITEM DOES NOT REQUIRE PRIOR AUTHORIZATION UNTIL THE LIFE EXPECTANCY HAS BEEN REACHED.
PC41	PLEASE SUPPLY INFORMATION INDICATING THE NECESSITY OF POSITIONING THE CLIENT'S BODY IN MULTIPLE POSITIONS.
PC42	PLEASE INDICATE IF THE BED HEIGHT MUST BE CHANGED TO ALLOW FOR SAFE TRANSFER OR ADEQUATE BED CARE.

Denial Code	Long Description
PC43	SUPPLY A PHYSICIANS STATEMENT INDICATING TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR UNIT HAS REDUCED PAIN, IMPROVED/INCREASED THE CLIENTS ACTIVITY LEVEL, AND/OR REDUCED CLIENTS USE OF PAIN MEDICATION.
PC44	A CURRENT AUTHORIZATION FOR THIS SERVICE IS ON FILE FOR ANOTHER PROVIDER. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT OF THAT FACT IS REQUIRED BY THE CLIENT OF FIRST PROVIDER.
PC59	DOCUMENT DECLINE OR PROGRESS IN SPECIFIC, MEASURABLE, OBJECTIVE TERMS.
PC60	DOCUMENT IF CLIENT HAS DEMONSTRATED A GOOD APPOINTMENT COMPLIANCE RECORD.
PC61	THE PHYSICIANS SIGNATURE DATE MUST NOT EXCEED 90 DAYS FROM THE DATE OF RECEIPT BY COLORADO MEDICAID.
PC62	REQUESTS FOR A CONTINUATION OF THERAPY SHOULD NOT BE SUBMITTED MORE THAN FOUR WEEKS PRIOR TO THE EXPIRATION DATE OF THE CURRENT AUTHORIZATION.
PC63	PLEASE FURNISH THE STYLE AND MANUFACTURER OF THE FRAME.
PC64	PLEASE FURNISH THE CLIENTS LENS FORMULA.
PC66	ALL REQUESTS FOR TINTS REQUIRE DOCUMENTATION OF THE VISUAL OR MEDICAL CONDITION RELATED TO PHOTOPHOBIA.
PC67	PLEASE DOCUMENT THE REASON AND JUSTIFICATION FOR REPLACEMENT BEYOND THE FIRST LENS/FRAME.
PC68	DOCUMENT IF ALL REMAINING MAXILLARY AND/OR MANDIBULAR TEETH ARE DECAY-FREE, PROPERLY RESTORED, AND PERIODONTICALLY SOUND.
PC72	SUPPLY MORE DETAIL REGARDING PROGRESS (ATTACHMENT OF GOALS, ETC.). CORRELATE PROGRESS TO PREVIOUS GOALS AND IDENTIFIED LIMITATIONS.
PC77	PLEASE SUBMIT A PLAN OF CARE DESCRIBING THE SERVICES THAT WOULD BE PROVIDED.
PC78	PLEASE DOCUMENT SPECIFIC, MEASURABLE GOALS.
PC82	THE PRIOR AUTHORIZATION (PA) SYSTEM CAN PROCESS ONLY 26 DETAILS PER PA REQUEST. PLEASE RESUBMIT YOUR REQUEST WITH NO MORE THAN 26 DETAILS.
PC83	PLEASE SUPPLY A PHYSICIANS PRESCRIPTION DATED WITHIN ONE MONTH OF REQUESTED SUBSTANCE ABUSE DAY TREATMENT.
PC84	PLEASE PROVIDE INFORMATION INDICATING THIS CLIENT IS APPROPRIATELY DETOXIFIED FROM ALCOHOL AND/OR OTHER DRUGS.
PC85	PLEASE PROVIDE INFORMATION TO INDICATE THE CLIENTS ABILITY TO ABSTAIN FROM ALCOHOL OR DRUGS WHILE IN THE SUBSTANCE ABUSE DAY TREATMENT PROGRAM.
PC86	PLEASE INDICATE IF THIS CLIENT IS WILLING TO PARTICIPATE IN AFTERCARE OR CONTINUING CARE SERVICES.
PC87	PROVIDE MORE INFORMATION ON TREATMENT HISTORY; INCLUDE SERVICE PROVIDED, DATES, AND OUTCOME. PROVIDE DETAIL OF PREVIOUS TREATMENT.
PC88	PLEASE PROVIDE MORE RATIONALE FOR THE APPROPRIATENESS AND MEDICAL NECESSITY OF SUBSTANCE ABUSE DAY TREATMENT.
PC89	PROVIDE A TREATMENT PLAN THAT CONTAINS MEASURABLE GOALS AND OBJECTIVES CORRESPONDING TO THE IDENTIFIED DEFICIT.
PC91	PLEASE PROVIDE MORE INFORMATION ON FAMILY INVOLVEMENT TREATMENT.
PC92	PLEASE PROVIDE MORE HISTORY AND EXPLANATION ABOUT THE ISSUE OF ABSTINENCE FOR THIS CLIENT.
PC94	PLEASE PROVIDE THE ANTICIPATED BEGINNING DATE AND/OR THE ESTIMATED SUBSTANCE ABUSE DAY TREATMENT DISCHARGE DATE.
PC95	PLEASE SUPPLY JUSTIFICATION FOR BEGINNING CLIENT IN SERVICE PRIOR TO AUTHORIZATION BEING OBTAINED.
PC96	THE INITIAL THREE HOURS OF SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IN A CALENDAR YEAR DO NOT REQUIRE PRIOR AUTHORIZATION.
PC97	REIMBURSEMENT FOR INITIAL SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IS LIMITED TO THREE HOURS IN A CALENDAR YEAR AND DOES NOT REQUIRE PRIOR AUTHORIZATION.
PC98	THIS DRUG IS CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE BILL USING THE APPROPRIATE NATIONAL DRUG CODE (NDC) OR SUBMIT A COMPLETED DRUG ADDITION REQUEST FORM IF THE NDC IS NOT LISTED IN THE DRUG INDEX.

Denial Code	Long Description
PC99	THIS DRUG IS NOT CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL, CURRENT ADMINISTRATIVE RULE, OR COLORADO DRUG INDEX FOR COVERAGE LIMITATIONS.
PD01	DOCUMENT THAT CLIENT HAS ACHIEVED GOOD ORAL HYGIENE, PERIODONTAL CASE TYPE 1 OR 2, AND IS MOTIVATED TO MAINTAIN SAME.
PD03	PLEASE PROVIDE AN ARTERIAL BLOOD GAS READING OR PULSE OXIMETRY RESULTS DONE ON ROOM AIR SIGNED AND DATED BY A MEDICAL DOCTOR. THIS SHOULD BE DONE WITHIN 60 DAYS OF REQUESTED SERVICE.
PD04	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 30 DAYS OF RECEIPT BY COLORADO MEDICAID.
PD07	SUBMIT A PHOTOCOPY OF A VALID PRESCRIPTION, ISSUED WITHIN THE PAST YEAR, OR COMPLETE SECTION B OF THE PRIOR AUTHORIZATION/DRUG ATTACHMENT (PA/DGA), F-11049.
PD10	BRAND MEDICALLY NECESSARY MUST BE IN THE PRESCRIBERS OWN HANDWRITING AND WRITTEN DIRECTLY ON THE PRESCRIPTION OR A SEPARATE ORDER ATTACHED TO THE ORIGINAL PRESCRIPTION.
PD12	COMPLETE DENTURES, PARTIAL DENTURES, DENTURE RELINES, AND FIXED PROSTHODONTIC SERVICES ARE NOT COVERED SERVICES FOR ADULTS FOR DATES OF SERVICE ON AND AFTER OCTOBER 1, 1995.
PD22	PLEASE COMPLETE ALL REQUIRED ELEMENTS ON THE PERSONAL CARE SCREENING TOOL (PCST), F-11133.
PD24	THIS PRIOR AUTHORIZATION REQUEST IS UNABLE TO BE PROCESSED. PLEASE RESUBMIT WITH ADDITIONAL REQUIRED FORMS, INCLUDING THE ENTIRE PERSONAL CARE SCREENING TOOL (PCST), F-11133; PERSONAL CARE ADDENDUM, F-11136; AND SUPPORTING DOCUMENTATION, AS DIRECTED.
PD25	THERE IS A PERSONAL CARE SCREENING TOOL (PCST), F-11133, COMPLETED BY ANOTHER AGENCY. CONTACT THE AGENCY TO TRANSFER SCREEN.
PD26	THERE IS A LIMITED TERM CARE FUNCTIONAL SCREEN (LTC-FS) COMPLETED BY ANOTHER AGENCY. THE PERSONAL CARE SCREENING TOOL (PCST), F-11133, INFORMATION IS IN CONFLICT WITH LTC-FS.
PD27	ONLY ONE LEVEL OF FUNCTION MAY BE SELECTED FOR ALL ELEMENTS EXCEPT TOILETING. COLORADO MEDICAID IS UNABLE TO PROCESS THE PRIOR AUTHORIZATION REQUEST.
PD28	NO UNITS MAY BE REQUESTED USING THIS PRIOR AUTHORIZATION PROCESS. PLEASE SUBMIT WITH THE APPROPRIATE ATTACHMENTS FOR REQUESTING SPECIFIC PERSONAL CARE WORKER UNITS.
PD29	CLIENT IS NOT ELIGIBLE FOR THE REQUESTED SERVICE(S) AS OF THE REQUESTED START DATE.
PD30	NO TRAVEL TIME MAY BE AUTHORIZED WHEN NO PERSONAL CARE WORKER SERVICE IS AUTHORIZED.
PD32	PROVIDER NOT CERTIFIED TO RENDER THE SERVICE(S) REQUESTED.
PD34	BASED ON THE DOCUMENTATION SUBMITTED, THIS REQUEST CAN NOT BE PRIOR AUTHORIZED. REFER TO THE PA MESSAGES FROM THE CONSULTANT FOR COMPLETE EXPLANATION.
PD98	PLEASE DOCUMENT HOW AND WHEN EACH PREVIOUSLY AUTHORIZED PRO RE NATA VISIT WAS USED.

Durable Medical Equipment (DME) - Wheelchair, Accessories

Denial Code	Long Description
0201	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
0233	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0235	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0237	CLIENT IDENTIFICATION NUMBER DOES NOT MATCH CLIENTS FIRST NAME.
0238	THE CLIENT IDENTIFICATION NUMBER DOES NOT MATCH THE CLIENTS LAST NAME.
0242	SECONDARY DIAGNOSIS CODE IS INVALID.
0248	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0249	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0251	PROCEDURE CODE MODIFIER IN FIRST POSITION IS INVALID.
0252	THE PROCEDURE CODE MODIFIER IN SECOND POSITION IS INVALID FOR REQUESTED START DATE OR DATE OF RECEIPT.

Denial Code	Long Description
0253	THE PROCEDURE CODE MODIFIER IN THIRD POSITION IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
0258	THE PRIMARY DIAGNOSIS CODE IS REQUIRED.
0272	THE PRIMARY DIAGNSOSIS CODE IS INVALID.
0400	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0853	HCPCS - ANNUAL UPDATE
0885	NEVER EVENTS MODIFIERS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
0886	NEVER EVENTS DIAGNOSIS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
1000	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
1002	RENDERING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1003	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1007	RENDERING PROVIDER ID IS NOT ON FILE.
1047	THE RENDERING PROVIDERS CERTIFICATION HAS BEEN CANCELLED.
1048	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1801	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
1804	A CERTIFIED SUBSTANCE ABUSE DAY TREATMENT PROVIDER MUST SUBMIT A SUBSTANCE ABUSE DAY TREATMENT PROCEDURE CODE.
1806	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
1808	THE BILLING PROVIDER DOES NOT HAVE THE REQUIRED CERTIFICATION ADDENDUM ON FILE.
1900	THE BILLING PROVIDERS TAXONOMY CODE IS INVALID.
1901	THE RENDERING PROVIDERS TAXONOMY CODE IS INVALID.
1927	A NATIONAL PROVIDER IDENTIFIER IS REQUIRED FOR THE BILLING PROVIDER.
1934	A NATIONAL PROVIDER INDENTIFIER IS REQUIRED FOR THE RENDERING PROVIDER.
1936	THE BILLING PROVIDER NUMBER IS INVALID.
1937	THE RENDERING PROVIDER NUMBER IS INVALID.
1960	INTERNAL PROCESSING IS REQUIRED.
1963	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.
1964	THE BILLING PROVIDER INDICATED IS NOT ALLOWABLE AS A BILLING PROVIDER.
1965	RENDERING PROVIDER NUMBER IS MISSING/INVALID FOR THIS PROCEDURE PROVIDER.
1974	PRESCRIBING/REFERRING/ORDERING PROVIDER INDICATED IS NOT CERTIFIED AS A PRESCRIBING/REFERRING/ORDERING PROVIDER.
1975	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
1976	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
2001	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2003	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2017	THE CLIENT IS ENROLLED IN A MEDICAID OR OTHER MANAGED CARE PROGRAM.
2037	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2603	CLIENT LOCKED-IN TO A PROVIDER OR ENROLLED IN A HOSPICE. CONTACT CLIENTS HOSPICE FOR PAYMENT OF SERVICES OR RESUBMIT WITH DOCUMENTATION OF UNRELATED NATURE OF CARE.
3324	THE MODIFIER HAS BEEN DISCONTINUED BY THE CENTERS OF MEDICARE AND MEDICAID SERVICES OR THE AMERICAN MEDICAL ASSOCIATION FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
3337	THE PROCEDURE CODE HAS BEEN TERMINATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AMERICAN MEDICAL ASSOCIATION, OR AMERICAN DENTAL ASSOCIATION FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT. RESUBMIT WITH VALID A PROCEDURE CODE.
3339	THE PROCEDURE BILLED IS NOT PAYABLE ACCORDING TO DEFICIT REDUCTION ACT (DEFRA) GUIDELINES.
3351	THE PROCEDURE IS NOT COVERED FOR CLIENTS WITH A NURSING HOME AUTHORIZATION ON THE REQUESTED START DATE OR DATE OF RECEIPT.
3353	THE PROCEDURE IS NOT A COVERED SERVICE FOR HOME AND COMMUNITY-BASED WAIVER CLIENTS.
4021	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4027	THE DIAGNOSIS CODE IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
4031	THE PROCEDURE SUBMITTED IS NOT APPROPRIATE FOR CLIENTS GENDER.
4032	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.

Denial Code	Long Description
4034	THE PROCEDURE CODE HAS AN AGE RESTRICTION.
4036	THE PLACE OF SERVICE CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4040	THE PRIMARY DIAGNOSIS CODE IS NOT ON FILE.
4041	THE SECONDARY DIAGNOSIS IS NOT ON FILE.
4046	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4127	INTERNAL PROCESSING IS REQUIRED.
4131	INTERNAL PROCESSING IS REQUIRED.
4141	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4149	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4150	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4236	ETIOLOGY DIAGNOSIS CODE(S) (E-CODES) ARE INVALID AS THE PRIMARY DIAGNOSIS.
4244	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4245	THE FOURTH POSITION MODIFIER IS INVALID FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT.
4256	THE PROCEDURE CODE AND MODIFIER COMBINATION IS NOT PAYABLE FOR THE CLIENTS BENEFIT PLAN.
4257	THE MODIFIERS SUBMITTED ARE EITHER INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT OR THE MODIFIERS ARE MISSING.
4311	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4315	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4316	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4371	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4372	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4711	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR CLIENTS AGE.
4714	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS AGE.
4731	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS DIAGNOSIS.
4742	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4743	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4744	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4745	DIAGNOSIS AND/OR PROCEDURE AND/OR PLACE OF SERVICE (POS) CODE IS NOT COVERED FOR EXPRESS ENROLLMENT CLIENTS.
4746	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4801	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4802	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
4821	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
4871	PLEASE REFER TO PA MESSAGES FOR RETURN INFORMATION.
4963	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS GENDER.
4990	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
7500	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
7509	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
P001	THE BILLING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THE SERVICES.
P002	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P003	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P005	THE PRIOR AUTHORIZATION CAN NOT BE END DATED. THE PRIOR AUTHORIZATION STATUS IS NOT APPROVED OR APPROVED WITH REVISIONS.
P006	PLEASE FURNISH THE PROCEDURE CODE AND CORRESPONDING DESCRIPTION.
P008	THE BILLING PROVIDER NUMBER IS INVALID.
P009	THE BILLING PROVIDER NUMBER IS INVALID.
P010	THE REQUESTED END DATE IS INVALID.
P011	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.

Denial Code	Long Description
P012	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P013	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P014	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P015	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P016	THE REQUESTED START DATE IS MISSING OR INVALID.
P020	THE RENDERING PROVIDER NUMBER IS INVALID.
P021	THE RENDERING PROVIDER NUMBER IS INVALID.
P022	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P023	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P024	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P026	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P027	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P030	FIRST MODIFIER IS INVALID.
P031	FIRST MODIFIER IS INVALID.
P032	SECOND MODIFIER IS INVALID.
P033	SECOND MODIFIER IS INVALID.
P034	THIRD MODIFIER IS INVALID.
P035	THIRD MODIFIER IS INVALID.
P036	FOURTH MODIFIER IS INVALID.
P037	FOURTH MODIFIER IS INVALID.
P038	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P039	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P040	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P041	CLIENTS FIRST NAME IS MISSING.
P042	CLIENTS LAST NAME IS MISSING.
P043	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P044	BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES REQUESTED.
P045	FIRST MODIFIER IS INVALID.
P046	SECOND MODIFIER IS INVALID.
P047	THIRD MODIFIER IS INVALID.
P048	FOURTH MODIFIER IS INVALID.
P052	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P053	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P054	RENDERING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES FOR THE BENEFIT PLAN.
P055	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P061	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P062	THE CLIENT ID AND/OR NAME INDICATED ON THE PA REQUEST IS INCORRECT. THE CLIENT ID AND/OR NAME HAS BEEN UPDATED. PLEASE VERIFY THE ID AND/OR NAME IS CORRECT.
P064	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
P067	THE FREQUENCY OF HOURS REQUESTED ARE NOT APPROPRIATE FOR THIS CLIENT AND HAVE BEEN MODIFIED ACCORDINGLY.
P079	BILLING PROVIDER IS ON PAYMENT SUSPENSION DUE TO CREDIBLE ALLEGATION OF FRAUD.
P120	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAS BEEN REDUCED.
P121	THE SERVICE/ PROCEDURE REQUESTED IS NOT SUPPORTED BY SUBMITTED DOCUMENTATION.

Denial Code	Long Description
P126	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
P128	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.
P138	SERVICE(S) DO NOT MEET COLORADO MEDICAID GUIDELINES.
P167	REQUESTED DOCUMENTATION HAS NOT BEEN SUBMITTED.
P178	THE SERVICE REQUESTED IS NOT MEDICALLY NECESSARY.
P179	THE MEDICAL NECESSITY FOR THIS SERVICE IS NOT SUPPORTED BY THE SUBMITTED DOCUMENTATION.
P233	THE DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE ADDITIONAL CARE.
P257	THIS CLIENTS FUNCTIONAL ASSESSMENT SCORES PLACE THIS CLIENT OUTSIDE ELIGIBILITY FOR DAY TREATMENT.
P274	OUR RECORDS INDICATE THIS CLIENT IS INVOLVED IN EFFECTIVE AND APPROPRIATE SERVICE ELSEWHERE.
P292	INTENSIVE REHABILITATION HOURS ARE NO LONGER APPROPRIATE AS INDICATED BY HISTORY, DIAGNOSIS, AND/ OR FUNCTIONAL ASSESSMENT SCORES.
P328	THE SERVICES REQUESTED INCLUDE NON-COVERED SERVICES, AND HOURS ARE REDUCED ACCORDINGLY.
P339	THE CLIENTS PAST HISTORY INDICATES REDUCED TREATMENT HOURS ARE WARRANTED.
P342	THE REQUEST DOES NOT MEET GENERALLY ACCEPTED CONDITIONS REQUIRING FLUORIDE TREATMENTS.
P346	SERVICES EXCEED COLORADO MEDICAID LIMITATION AND DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE MEDICAL NECESSITY OF THE SERVICE.
P349	THE SERVICE REQUESTED WAS PERFORMED LESS THAN FIVE YEARS AGO.
P353	THE EXISTING APPLIANCE HAS NOT BEEN WORN FOR THREE YEARS.
P367	THE CLIENT HAS BEEN TOTALLY WITHOUT TEETH AND AN APPLIANCE FOR FIVE YEARS.
P392	THE CLIENT IS MISSING AN ANTERIOR TOOTH AND/OR HAS TWO OR MORE POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P405	THE SERVICE(S) REQUESTED COULD ADEQUATELY BE PERFORMED IN THE DENTAL OFFICE.
P406	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE OF GOOD PERIODONTAL HEALTH (AMERICAN ACADEMY OF PERIODONTOLOGY PERIODONTAL CLASSIFICATION OF TYPE I OR II).
P407	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE VISIBLE ON RADIOGRAPHS THAT AT LEAST 50 PERCENT OF THE CLINICAL CROWN IS INTACT.
P409	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING SIX OR MORE TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED, INCLUDING THIRD MOLARS.
P410	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING ONE OR MORE ANTERIOR TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED.
P411	DOCUMENTATION DOES NOT SUPPORT THE NEED FOR PERIODONTIC SERVICES. POCKETS ARE LESS THAN 4MM AND/OR GREATER THAN 6MM FOR CLIENT AND/OR THE CLIENT IS UNDER THE AGE OF 13.
P412	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA.
P413	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA. THIS PA HAS BEEN GRANTED AS APPROVED NOT APPROVED WITH REVISIONS. THE DURATION REQUESTED MAY HAVE BEEN REDUCED TO REFLECT COVERAGE LIMITATIONS, PRESCRIBER ORDERS, CONFLICTI
P417	THE SERVICE(S) REQUESTED COULD BE ADEQUATELY PERFORMED WITH LOCAL ANESTHESIA.
P437	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO POOR ORAL HYGIENE.
P444	THIS LINE ITEM IS A DUPLICATE OF ANOTHER LINE ITEM ON THIS PRIOR AUTHORIZATION (PA) REQUEST. PLEASE CORRECT.
P446	THIS IS A DUPLICATE OF AN EXISTING PRIOR AUTHORIZATION (PA) REQUEST. YOU MAY CONTACT PROVIDER SERVICES IF YOU REQUIRE ASSISTANCE. DUPLICATE PA REQUEST
P448	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO DECAY HISTORY.
P449	QUESTIONABLE LONG TERM PROGNOSIS DUE TO GUM AND BONE DISEASE.
P456	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO APPARENT ROOT INFECTION.
P457	OUR RECORDS INDICATE THIS CLIENT HAS EXCEEDED ESTABLISHED PROGRAM LIMITATIONS. COLORADO MEDICAID WILL NOT AUTHORIZE NEW DENTURES.
P458	DOCUMENTATION PROVIDED INDICATES A LESS ELABORATE PROCEDURE SHOULD BE CONSIDERED.
P502	RENTAL ONLY ALLOWED; MEDICAL NEED FOR PURCHASE HAS NOT BEEN DOCUMENTED.
P503	PURCHASE ONLY ALLOWED; MEDICAL NEED FOR RENTAL HAS NOT BEEN DOCUMENTED.
P504	OCCUPATIONAL THERAPY GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.

Denial Code	Long Description
P505	THE SERVICE REQUESTED IS INCLUDED IN THE NURSING HOME RATE STRUCTURE.
P511	THIS NATIONAL DRUG CODE IS ONLY BILLABLE AS PART OF A COMPOUND DRUG.
P515	THE PRESENCE OF A HANDICAPPING MALOCCLUSION OR HANDICAPPING DENTOFACIAL DEFORMITY IS NOT SUPPORTED BY THE DOCUMENTATION SUBMITTED.
P521	THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVERED BY COLORADO MEDICAID.
P522	GASTRO-INTESTINAL SURGERY FOR THE PURPOSE OF WEIGHT CONTROL IS COVERED ONLY AS A LIFE THREATENING PROCEDURE.
P523	THE TREATMENT REQUEST IS NOT CONSISTENT WITH THE CLIENT'S DIAGNOSIS.
P524	PSYCHOTHERAPY PROVIDED IN THE CLIENTS HOME IS NOT A COVERED BENEFIT OF COLORADO MEDICAID.
P525	THE INFORMATION PROVIDED IS NOT CONSISTENT WITH THE INTENSITY OF SERVICES REQUESTED.
P526	INTENSIVE MULTIPLE MODALITY TREATMENT IS NOT CONSISTENT WITH THE INFORMATION PROVIDED.
P527	MULTIPLE PROVIDERS OF TREATMENT ARE NOT INDICATED FOR THIS CLIENT.
P528	THE DURATION OF TREATMENT SESSIONS EXCEED CURRENT COLORADO MEDICAID GUIDELINES.
P534	DOCUMENTATION OF POOR PHYSICAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P535	OTHER PHYSICAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P536	THE PHYSICAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P537	USE OF PHYSICAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P538	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF A PHYSICAL THERAPIST.
P539	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS AND LIVING ARRANGEMENT.
P540	GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P541	THE PROCEDURE(S) REQUESTED ARE NOT MEDICAL IN NATURE.
P542	DOCUMENTATION OF POOR OCCUPATIONAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P543	DOCUMENTATION OF POOR SPEECH THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P544	OTHER OCCUPATIONAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P546	THE OCCUPATIONAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P547	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF PHYSICAL THERAPY.
P548	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P549	ACTIVITIES TO PROMOTE DIVERSION OR GENERAL MOTIVATION ARE NONCOVERED COLORADO MEDICAID SERVICES.
P550	REVISIONS OF THE REQUEST IS NECESSITATED BY THE CLIENTS MINIMAL PROGRESS.
P551	RESTORATIVE NURSING INVOLVEMENT COULD BE INCREASED.
P552	CLIENTS DEMONSTRATED RESPONSE TO CURRENT THERAPY DOES NOT WARRANT THE INTENSE FREQUENCY REQUESTED.
P553	MAINTENANCE IS TWO TIMES PER WEEK OR LESS.
P554	THE SPEECH THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P555	USE OF OCCUPATIONAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P556	USE OF SPEECH THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P557	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF AN OCCUPATIONAL THERAPIST.
P558	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
P559	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P560	THE MATERIALS/ SERVICES REQUESTED ARE PRINCIPALLY COSMETIC IN NATURE.

Denial Code	Long Description
P561	THE LENS FORMULA DOES NOT JUSTIFY REPLACEMENT.
P562	THE CHANGE IN THE LENS FORMULA DOES NOT WARRANT MULTIPLE REPLACEMENTS.
P563	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P564	LENSES ONLY ARE APPROVED; PLEASE DISPENSE A CONTRACTED FRAME. THE NON-CONTRACTED FRAME IS NOT MEDICALLY JUSTIFIED.
P565	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P566	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P567	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF OCCUPATIONAL THERAPY.
P568	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF SPEECH THERAPY.
P569	LEVEL, INTENSITY, OR EXTENT OF SERVICE(S) REQUESTED HAS BEEN MODIFIED CONSISTENT WITH MEDICAL NEED AS DEFINED IN THE PLAN OF CARE.
P570	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P571	THE SERVICE ASKED FOR IS NOT COVERED BY COLORADO MEDICAID AS THESE TASKS CAN BE DONE BY NURSES OR ACTIVITY STAFF.
P572	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P573	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.
P574	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P575	MEDICAL NEED FOR EQUIPMENT/ SUPPLY REQUESTED IS NOT SUPPORTED BY DOCUMENTATION SUBMITTED.
P576	OTHER SPEECH THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P577	DOCUMENTATION SUBMITTED IDENTIFIES THAT THE CLIENT HAS FEWER THAN TWO POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P582	LESS EXPENSIVE ALTERNATIVE SERVICES ARE AVAILABLE FOR THIS CLIENT.
P634	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P711	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING PERIODONTAL SCALING AND ROOT PLANNING.
P712	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING GINGIVECTOMY.
P754	AN APPROVED SUBSTANCE ABUSE DAY TREATMENT PROGRAM CANNOT EXCEED A SIX WEEK PERIOD.
P761	THE CLIENT DOES NOT APPEAR TO BE ABLE OR WILLING TO ABSTAIN FROM ALCOHOL/DRUG USAGE WHILE IN TREATMENT. THEREFORE, SUBSTANCE ABUSE DAY TREATMENT SERVICES ARE NOT APPROVED.
P764	THIS CLIENT HAS COMPLETED INTENSIVE SUBSTANCE ABUSE TREATMENT WITHIN THE PAST 12 MONTHS. THE DOCUMENTATION PROVIDED IS NOT ADEQUATE TO JUSTIFY ADDITIONAL INTENSIVE TREATMENT AT THIS TIME.
P785	A LESS THAN SIX-WEEK HEALING PERIOD HAS BEEN SPECIFIED FOR THIS PRIOR AUTHORIZATION. THEREFORE IT IS NOT NECESSARY TO WAIT THE FULL SIX WEEKS AFTER EXTRACTIONS BEFORE TAKING DENTURE IMPRESSIONS.
P818	SIX-WEEK HEALING TIME IS REQUIRED BETWEEN EDENTULATION AND FINAL IMPRESSIONS. PAYMENT FOR DENTURES WILL BE DENIED OR RECOUPED IF HEALING PERIOD IS NOT OBSERVED.
P849	COLORADO MEDICAID HAS DETERMINED THERE WERE (ARE) SEVERAL HOME HEALTH AGENCIES WILLING TO PROVIDE MEDICALLY NECESSARY SKILLED NURSING SERVICES TO THIS CLIENT.
P864	THE DOCUMENTATION YOU HAVE SUBMITTED DOES NOT MEET THE REQUIREMENTS OF COLORADO MEDICAID.
P873	THE MEDICAL NECESSITY FOR THE HOURS REQUESTED IS NOT SUPPORTED BY THE INFORMATION SUBMITTED.
P874	THE DOCUMENTATION SUBMITTED INDICATES THE TASKS SPECIFIED CAN BE COMPLETED DURING THE VISITS APPROVED.
P878	THE DOCUMENTATION SUBMITTED DOES NOT INDICATE THAT MEDICALLY ORIENTED TASKS ARE MEDICALLY NECESSARY; THEREFORE PERSONAL CARE SERVICES HAVE BEEN APPROVED.

Denial Code	Long Description
P880	THE QUANTITY OF SERVICES AUTHORIZED FOR THIS CLIENTS PERSONAL CARE HAS BEEN AMENDED BASED ON INFORMATION RECEIVED FROM ONE OR MORE OF THESE SOURCES: THE CLIENT, THEIR PHYSICIAN, AND/OR THE IN-HOME VISIT BY STAFF OF THE OIG (OFFICE OF INSPECTOR GENERAL).
P885	THE USE OF THIS DRUG FOR THE INTENDED PURPOSE IS NOT COVERED BY COLORADO MEDICAID, CONSISTENT WITH COLORADO ADMINISTRATIVE CODE AND FEDERAL LAW.
P924	THE MEDICAL RECORDS SUBMITTED WITH THE CURRENT REQUEST CONFLICT OR DISAGREE WITH OUR MEDICAL RECORDS ON THIS CLIENT.
P950	INDEPENDENT NURSES, PLEASE NOTE PAYABLE SERVICES MAY NOT EXCEED 12 HOURS/DAY OR 60 HOURS/WEEK.
P951	SERVICES CAN ONLY BE AUTHORIZED THROUGH ONE YEAR FROM THE PRESCRIPTION DATE.
P952	LEAD INSPECTION IS A COVERED COLORADO MEDICAID SERVICE WHEN THE CHILD HAS BEEN SHOWN TO HAVE LEAD POISONING (E.G., CHILD HAS A BLOOD LEAD LEVEL > 19 UG/DL OR TWO CONSECUTIVE BLOOD LEAD LEVELS OF 15-19 UG/DL DONE AT LEAST 90 DAYS APART). THE INSPECTION MUS
P953	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P954	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P956	THE REQUEST CAN ONLY BE BACKDATED A MAXIMUM OF 14 DAYS FROM FIRST DATE RECEIVED BY COLORADO MEDICAID.
P957	COMPLETE PERIODONTAL CHARTING AT TIME OF SERVICE, AND SUBMIT CHARTING, COPY OF OPERATIVE REPORT, TOGETHER WITH A COPY OF THE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF), F-11035, TO PA UNIT ATTENTION DENTAL CONTSULTANT.
P958	NOTE THAT CODE D4341 HAS BEEN CHANGED. REFER TO THE DECISION NOTICE FOR AUTHORIZED QUANTITY.
P960	YOUR PA HAS BEEN APPROVED FOR 90 DAYS. THE 90 DAY APPROVAL DOES NOT IMPLY THE PA REQUEST MEETS PRIOR AUTHORIZATION CRITERIA. AFTER ADDITIONAL INFORMATION IS AVAILABLE IN INTERCHANGE, COLORADO MEDICAID WILL CREATE AN AMENDMENT REQUEST TO EXTEND THE PA FOR
P961	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P962	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
PA10	THE REQUESTED END DATE IS INVALID.
PA12	PLEASE FURNISH A WRITTEN DESCRIPTION OF THE CLIENTS DIAGNOSIS.
PA13	PROVIDE DIAGNOSES WITH DATES OF ONSET.
PA14	IDENTIFY PROBLEMS TO BE TREATED.
PA15	THE AUDIOLOGISTS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1), F-11020, AND PRIOR AUTHORIZATION REQUEST/HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2), F-11021.
PA16	THE PHYSICIANS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION/PHYSICIAN OTOLOGICAL REPORT (PA/POR), F-11019.
PA17	SUBMIT BRIEF HISTORY WITH REFERRAL INFORMATION, LIVING SITUATION, FUNCTIONAL STATUS, AND OTHER PERTINENT INFORMATION. WHAT CHANGE OF STATUS RESULTED IN REFERRAL AT THIS TIME?
PA18	PLEASE FURNISH THE CLIENTS HEIGHT AND WEIGHT.
PA19	PLEASE SUBMIT CLINICAL INFORMATION SUFFICIENT TO VERIFY THE NEED FOR THE REQUESTED SERVICE(S).
PA20	PLEASE RESUBMIT WITH COMPLETE PERIODONTAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PA21	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL EDUCATIONAL PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA22	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL PROGRAM PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA23	REFER TO THE DURABLE MEDICAL EQUIPMENT INDEX FOR APPROPRIATE CODE AND DESCRIPTION. DO NOT USE AN "UNLISTED" CODE.

Denial Code	Long Description
PA24	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUALIZED FAMILY SERVICE PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA25	INFORMATION ON THE REQUEST FORM IS ILLEGIBLE, AND THE REQUEST CANNOT BE PROCESSED.
PA26	RE-EVALUATE YOUR GOALS. EMPHASIS SHOULD BE ON FUNCTIONAL SELF-CARE. GOALS MUST BE RELATED TO FUNCTIONAL OUTCOME.
PA27	PLEASE CLARIFY THE NUMBER OF HOURS PER WEEK REQUESTED.
PA28	PLEASE CLARIFY THE NUMBER OF HOURS PER DAY REQUESTED.
PA29	PLEASE CLARIFY THE NUMBER OF VISITS PER DAY REQUESTED.
PA30	ATTACH SUPPORTIVE DOCUMENTATION; HOME EXERCISE PROGRAM AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA31	THE DIAGNOSIS CODE INDICATED ON THE REQUEST DOES NOT CORRESPOND TO THE DIAGNOSIS CODE DESCRIPTION.
PA32	PLEASE SUBMIT ADDITIONAL INFORMATION SUFFICIENT TO VERIFY APPROPRIATENESS AND NEED FOR TRANSPLANT.
PA33	PLEASE SUBMIT THE INITIAL AND PROGRESSIVE OBJECTIVE FINDINGS.
PA34	ATTACH SUPPORTIVE DOCUMENTATION, FACILITY PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA35	PLEASE SUBMIT THE CLIENTS ORIGINAL COMPLAINTS AND EXAMINATION FINDINGS.
PA36	ATTACH SUPPORTIVE DOCUMENTATION, IN-HOME AUTISM PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA37	PLEASE SUBMIT YOUR TREATMENT PLAN FOR THIS CLIENT.
PA38	ATTACH SUPPORTIVE DOCUMENTATION AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA39	INITIAL EVALUATIONS MUST BE PERFORMED BY AN OCCUPATIONAL THERAPIST REGISTERED (OTR), PER AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA) STANDARDS.
PA41	IDENTIFY THE PLACE OF SERVICE AND ITS EFFECT ON SUPPORTING THE DESIRED TREATMENT OUTCOME.
PA42	PLEASE INDICATE THE HOURS OF USE OF OXYGEN PER 24-HOUR PERIOD.
PA43	PROVIDE BASELINE DOCUMENTATION FOR THIS CLIENTS LIMITATIONS USING UNITS OF MEASUREMENT THAT ARE APPLIED CONSISTENTLY WHEN REPORTING STATUS.
PA44	IDENTIFY FUNCTIONAL LIMITATIONS AS THEY ARE RELATED TO IDENTIFIED CONDITIONS.
PA46	CORRELATE PLAN OF CARE TO REQUESTED PROCEDURE CODES.
PA47	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE FREQUENCY/DURATION REQUESTED.
PA48	PLEASE PROVIDE THE NAME AND CREDENTIALS OF THE RENDERING PROVIDER.
PA50	COLORADO MEDICAID RECORDS INDICATE THE CLIENT OWNS A WHEELCHAIR. DOCUMENT THE REASON AND NEED FOR REPLACEMENT AND COST TO REPAIR CURRENT WHEELCHAIR.
PA51	PLEASE DISTINGUISH PRIMARY AND SUPPORTIVE MODALITIES.
PA52	PLEASE SUBMIT A PROGRESS REPORT.
PA53	MULTIPLE FAMILY CLIENTS TREATMENT BY THE SAME PROVIDER REQUIRES FURTHER INFORMATION DOCUMENTING COORDINATION OF TREATMENT PLAN.
PA54	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE MINUTES REQUESTED.
PA55	MEDICAL NECESSITY OF TREATMENT REQUIRES ADDITIONAL DOCUMENTATION.
PA56	GIVEN AGE, DIAGNOSES, CURRENT LEVEL OF FUNCTION, PAST RESPONSE TO TREATMENT, AND LIVING SITUATION, EXPAND ON POTENTIAL FOR SIGNIFICANT FUNCTIONAL PROGRESS WITHIN THE NEXT SIX MONTHS. EMPHASIZE WHY PROGRESS IS EXPECTED WITH SERVICES AT THIS TIME.
PA57	SUBMIT THE INITIAL FINDINGS. INCLUDE A COMPREHENSIVE EVALUATION.
PA58	SUBMIT PROGRESSIVE, OBJECTIVE FINDINGS. INCLUDE A PERTINENT RE-EVALUATION.
PA59	PLEASE SUPPLY INFORMATION REGARDING THE CLIENTS MEDICATION REQUIREMENTS, IF ANY.
PA60	PLEASE SPECIFY IF THE CLIENT IS IN AN EDUCATIONAL SETTING.
PA61	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA62	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.

Denial Code	Long Description
PA63	THE SKILLS OF A THERAPIST ARE PURPOSEFUL AND SKILLED INTERVENTIONS REQUIRED TO CONTINUALLY DESIGN, IMPLEMENT, REASSESS, MODIFY/GRADE, AND/OR DISCONTINUE A PLAN OF CARE IN A TIMELY MANNER, BASED ON THE COMPLEXITY OF THE CLIENTS MEDICAL CONDITION AND/OR CO
PA64	PLEASE SUBMIT A THERAPY PLAN OF CARE, INCLUDING A CURRENT, DATED EVALUATION.
PA65	A PLAN OF CARE SIGNED AND DATED BY THE PHYSICIAN IS REQUIRED.
PA66	THE SKILLS OF A THERAPIST ARE REQUIRED WHEN ONLY THE THERAPIST CAN SAFELY AND EFFECTIVELY DELIVER THE THERAPEUTIC PROCEDURES BECAUSE OF THEIR UNIQUE KNOWLEDGE, TRAINING, AND EXPERTISE. DESCRIBE THE REASON THAT SOMEONE OTHER THAN A THERAPIST CANNOT SAFELY
PA67	PLEASE SPECIFY IF THE CLIENTS WORK SITE DEMANDS GOOD BINAURAL HEARING.
PA68	DESCRIBE THE REASON, BASED ON THE CLIENTS COGNITIVE, PHYSICAL, COMMUNICATION, OR RESOURCE STATUS, THAT A HOME PROGRAM, EQUIPMENT, OR ENVIRONMENTAL ADAPTATIONS ALONE CANNOT MEET CLIENTS NEEDS.
PA69	PLEASE SPECIFY IF THE CLIENT HAS AN ACCOMPANYING DISABILITY THAT ADDS TO THE HEARING PROBLEM.
PA70	DISTINGUISH REQUESTED PROCEDURES AND GOALS FROM OTHER SERVICES THIS CLIENT RECEIVES. THEY MAY NOT BE DUPLICATIVE.
PA71	PLEASE INDICATE THE NUMBER OF DAYS REQUESTED.
PA73	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA74	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA75	PLEASE DOCUMENT CARRYOVER OF THE THERAPY PROGRAM TO NURSING.
PA76	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA79	PROVIDE EVIDENCE OF SIGNIFICANT FUNCTIONAL PROGRESS IN LAST SIX MONTHS.
PA84	THE GRANT DATE OF THIS REQUEST CANNOT BE PRIOR TO THE SIGNATURE DATE OF THE PRESCRIBING PHYSICIAN.
PA86	PROVIDE EVIDENCE OF SKILLS GAINED IN THERAPY CARRYING OVER TO OTHER SETTINGS WITHIN SIX MONTHS.
PA87	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE NUMBER OF SESSIONS REQUESTED.
PA88	THE REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL SCOPE OF PRACTICE.
PA89	PRIOR AUTHORIZATION IS NOT REQUIRED UNTIL LIMITATION OF SERVICE HAS BEEN REACHED.
PA91	PLEASE SUBMIT REQUIRED X-RAYS.
PA92	PLEASE PROVIDE AN EXPLANATION FOR THE MATERIAL SUBMITTED WITH THE REQUEST.
PA95	PLEASE DESCRIBE HOW THE PROVISION OF THIS SERVICE WOULD PREVENT INSTITUTIONALIZATION OF THE CLIENT.
PA96	COULD THE EXISTING DENTURE(S) BE RELINED OR REBASED? IF NOT, PLEASE EXPLAIN WHY NOT.
PA97	REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL STANDARDS OF PRACTICE.
PA98	PLEASE INDICATE IF THE CLIENT IS CURRENTLY BEING TUBE FED.
PB02	PLEASE PROVIDE THE REQUIRED DATED SIGNATURES ON THE ATTACHMENTS.
PB03	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING THE LOSS/DESTRUCTION/THEFT OF THE HEARING AID.
PB04	DESCRIBE THE CLIENTS ABILITY TO STAND OR AMBULATE SUFFICIENTLY TO ACCOMPLISH SELF-CARE ACTIVITIES.
PB07	PLEASE SUBMIT AN ORTHODONTIC STUDY MODEL OR DIAGNOSTIC CASTS.
PB09	PLEASE PROVIDE A PHOTOGRAPH OF THE INVOLVED AREA(S).
PB10	PLEASE PROVIDE AN ESTIMATION (IN GRAMS) OF THE TOTAL AMOUNT OF TISSUE TO BE RESECTED.
PB11	PLEASE SUBMIT THE PLAN OF CARE FOR CO-TREATMENT.
PB12	FURNISH A DETAILED DESCRIPTION FOR THE PROCEDURE CODE REQUESTED.
PB13	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB15	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB18	PLEASE COMPLETE THE ATTACHED OUT-OF-STATE PROVIDER DATA SHEET, F-11001, AND RESUBMIT.

Denial Code	Long Description
PB20	A SIGNED AND DATED PRESCRIPTION IS REQUIRED WITHIN THREE MONTHS OF RECEIPT BY COLORADO MEDICAID FOR INITIAL REQUESTS AND WITHIN 12 MONTHS OF RECEIPT BY COLORADO MEDICAID FOR SUBSEQUENT REQUESTS.
PB21	PLEASE COMPLETE THE APPROPRIATE PRIOR AUTHORIZATION ATTACHMENT. CONTACT PROVIDER SERVICES OR THE PRIOR AUTHORIZATION UNIT FOR ASSISTANCE.
PB23	PHYSICAL THERAPY ASSISTANT NOTES AND ALL FORMS SUBMITTED MUST BE COSIGNED BY A REGISTERED PHYSICAL THERAPIST.
PB31	ARE YOU REQUESTING A COMPLETE APPLIANCE, OR REPLACEMENT PARTS?
PB32	THE PROCEDURE CODE INDICATED ON THE REQUEST DOES NOT MATCH THE DESCRIPTION OF SERVICE; PLEASE CORRECT AND RESUBMIT.
PB35	THE SERVICE REQUESTED DOES NOT REQUIRE PRIOR AUTHORIZATION.
PB41	PLEASE FURNISH A CURRENT MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT, F-11090 (DATED WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID).
PB45	THE CERTIFICATION PERIOD ON THE PLAN OF CARE (POC) DOES NOT COVER THE REQUESTED GRANT/START DATE. PLEASE RESUBMIT YOUR REQUEST WITH A NEW POC.
PB49	A CERTIFIED OCCUPATIONAL THERAPY ASSISTANTS NOTES MUST BE COSIGNED BY AN OCCUPATIONAL THERAPIST REGISTERED.
PB51	ADDITIONAL INFORMATION IS REQUIRED ON PRIOR AUTHORIZATION TO ENABLE PRICING.
PB54	REQUESTED SERVICES DO NOT MATCH SERVICES ON THE PHYSICIANS ORDERS.
PB59	PLEASE PROVIDE AN INDIVIDUAL EDUCATIONAL PLAN (IEP), WHICH HAS BEEN SIGNED BY THE PROVIDER NO EARLIER THAN NINE MONTHS PRIOR TO RECEIPT AT COLORADO MEDICAID; OTHERWISE, DOCUMENT WHY NO IEP EXISTS.
PB65	PLEASE FURNISH THE ANTICIPATED TOTAL CHARGES FOR THIS REQUEST.
PB66	A PHOTOCOPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED; THE DATE MUST BE WITHIN SIX MONTHS OF RECEIPT BY COLORADO MEDICAID.
PB67	THE PRESCRIPTION DATE MUST INCLUDE MONTH, DAY, AND YEAR.
PB68	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID.
PB73	THE SERVICES IDENTIFIED ON THE PLAN OF CARE DO NOT APPEAR APPROPRIATE FOR THE PROCEDURE CODE(S) REQUESTED ON THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018.
PB74	THE CLIENT/PROVIDER DOES NOT HAVE RETROACTIVE ENROLLMENT.
PB75	THE REQUESTED START DATE IS MORE THAN 14 DAYS BEFORE OR 62 DAYS AFTER RECEIPT.
PB82	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
PB83	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A HOME HEALTH AIDE. PLEASE RESUBMIT AS A PERSONAL CARE WORKER OR PROVIDE ADDITIONAL DOCUMENTATION.
PB86	THE SERVICES REQUESTED ARE NOT BEING PROVIDED IN THE CLIENTS RESIDENCE. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL.
PB87	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A NURSE. PLEASE RESUBMIT AS A HOME HEALTH AIDE OR PROVIDE ADDITIONAL DOCUMENTATION.
PB92	PLEASE FURNISH THE CLIENTS COMPLETE ADDRESS.
PB94	IF THE CLIENT IS A RESIDENT OF A NURSING HOME, SUPPLY THE COMPLETE NAME AND ADDRESS OF THE NURSING HOME.
PB99	THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018, MUST BE SIGNED AND DATED.
PC01	PLEASE SUPPLY THE RENDERING PROVIDERS PROVIDER NUMBER.
PC03	THE DRUG ENFORCEMENT ADMINISTRATION NUMBER IS MISSING OR INVALID.
PC06	PLEASE DESCRIBE YOUR PROGRAM; INCLUDE ENTRY DATE, TERMINATION DATE, HOURS PER WEEK, AND NUMBER OF WEEKS OF PRIMARY INTENSIVE SERVICE REQUESTED.
PC07	PLEASE DESCRIBE YOUR "AFTERCARE/FOLLOW-UP" PLANS FOR THIS CLIENT.
PC08	PLEASE SUPPLY DOCUMENTATION OF PREVIOUS SUBSTANCE ABUSE SERVICES WITH DATE(S) AND OUTCOME.
PC09	PLEASE DESCRIBE IN DETAIL THE TREATMENT OBJECTIVES/GOALS FOR THIS CLIENT.
PC10	PLEASE DESCRIBE THE FAMILY SITUATION/DYNAMICS. EXPLAIN HOW THE FAMILY WILL BE INCORPORATED INTO THE CLIENTS PLAN OF CARE.
PC12	PLEASE EXPLAIN IF YOUR SERVICE ENCOURAGES THE CLIENT TO ATTEND SELF-HELP GROUPS.

Denial Code	Long Description
PC13	PLEASE SUPPLY A SPECIFIC SCHEDULE OF ACTIVITIES, INCLUDING DAY, TIME OF DAY, LENGTH OF SESSION, AND SERVICE TO BE RENDERED DURING THAT TIME.
PC15	PLEASE FURNISH DIAGNOSTIC RATIONALE.
PC17	PLEASE DOCUMENT IF THE CLIENT EVER RECEIVED SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT.
PC19	PLEASE FURNISH MORE EXTENSIVE AND IN-DEPTH HISTORICAL AND PSYCHOSOCIAL DATA.
PC20	PLEASE SUPPLY THE DATE THE CLIENT BECAME TOTALLY ENDENTULOUS.
PC23	PLEASE SUBMIT A PHYSICIANS STATEMENT REGARDING THE MEDICAL NECESSITY OF DENTURES FOR THIS CLIENT. THE PHYSICIANS STATEMENT MUST DOCUMENT THE MEDICAL NEED FOR DENTURES.
PC24	THE SERVICE REQUESTED WAS PREVIOUSLY AUTHORIZED. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT INDICATING THIS FACT IS REQUIRED.
PC25	PLEASE SUPPLY SUFFICIENT MITIGATING CIRCUMSTANCES TO WARRANT THE CONSTRUCTION OF NEW DENTURES(S).
PC26	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
PC28	PLEASE SUBMIT A PHYSICIANS STATEMENT INDICATING DENTURES ARE NECESSARY FOR THIS NURSING HOME CLIENT.
PC29	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING LOSS OR DESTRUCTION OF DENTURE(S). INCLUDE SIGNED STATEMENT FROM CLIENT OR FACILITY DIRECTOR REGARDING HOW, WHEN AND WHERE LOST.
PC30	PLEASE PROVIDE COMPLETE INTRAORAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PC31	PLEASE DESCRIBE ANY RELATED DEFORMITIES OF THE FEET.
PC34	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD WITH REQUESTED DME ITEM(S) AND DOCUMENT IF THE CLIENT CAN USE SAFELY AND INDEPENDENTLY.
PC35	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD AND DESCRIBE THE RESULTS AND EFFECTIVENESS OF THE SERVICE REQUESTED.
PC39	PLEASE INDICATE LITER FLOW PER MINUTE, HOURS OF USE PER 24 HOUR PERIOD, AND THE EXPECTED DURATION OF NEED.
PC40	THE ITEM DOES NOT REQUIRE PRIOR AUTHORIZATION UNTIL THE LIFE EXPECTANCY HAS BEEN REACHED.
PC41	PLEASE SUPPLY INFORMATION INDICATING THE NECESSITY OF POSITIONING THE CLIENT'S BODY IN MULTIPLE POSITIONS.
PC42	PLEASE INDICATE IF THE BED HEIGHT MUST BE CHANGED TO ALLOW FOR SAFE TRANSFER OR ADEQUATE BED CARE.
PC43	SUPPLY A PHYSICIANS STATEMENT INDICATING TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR UNIT HAS REDUCED PAIN, IMPROVED/INCREASED THE CLIENTS ACTIVITY LEVEL, AND/OR REDUCED CLIENTS USE OF PAIN MEDICATION.
PC44	A CURRENT AUTHORIZATION FOR THIS SERVICE IS ON FILE FOR ANOTHER PROVIDER. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT OF THAT FACT IS REQUIRED BY THE CLIENT OF FIRST PROVIDER.
PC59	DOCUMENT DECLINE OR PROGRESS IN SPECIFIC, MEASURABLE, OBJECTIVE TERMS.
PC60	DOCUMENT IF CLIENT HAS DEMONSTRATED A GOOD APPOINTMENT COMPLIANCE RECORD.
PC61	THE PHYSICIANS SIGNATURE DATE MUST NOT EXCEED 90 DAYS FROM THE DATE OF RECEIPT BY COLORADO MEDICAID.
PC62	REQUESTS FOR A CONTINUATION OF THERAPY SHOULD NOT BE SUBMITTED MORE THAN FOUR WEEKS PRIOR TO THE EXPIRATION DATE OF THE CURRENT AUTHORIZATION.
PC63	PLEASE FURNISH THE STYLE AND MANUFACTURER OF THE FRAME.
PC64	PLEASE FURNISH THE CLIENTS LENS FORMULA.
PC66	ALL REQUESTS FOR TINTS REQUIRE DOCUMENTATION OF THE VISUAL OR MEDICAL CONDITION RELATED TO PHOTOPHOBIA.
PC67	PLEASE DOCUMENT THE REASON AND JUSTIFICATION FOR REPLACEMENT BEYOND THE FIRST LENS/FRAME.
PC68	DOCUMENT IF ALL REMAINING MAXILLARY AND/OR MANDIBULAR TEETH ARE DECAY-FREE, PROPERLY RESTORED, AND PERIODONTICALLY SOUND.
PC72	SUPPLY MORE DETAIL REGARDING PROGRESS (ATTACHMENT OF GOALS, ETC.). CORRELATE PROGRESS TO PREVIOUS GOALS AND IDENTIFIED LIMITATIONS.
PC77	PLEASE SUBMIT A PLAN OF CARE DESCRIBING THE SERVICES THAT WOULD BE PROVIDED.

Denial Code	Long Description
PC78	PLEASE DOCUMENT SPECIFIC, MEASURABLE GOALS.
PC82	THE PRIOR AUTHORIZATION (PA) SYSTEM CAN PROCESS ONLY 26 DETAILS PER PA REQUEST. PLEASE RESUBMIT YOUR REQUEST WITH NO MORE THAN 26 DETAILS.
PC83	PLEASE SUPPLY A PHYSICIANS PRESCRIPTION DATED WITHIN ONE MONTH OF REQUESTED SUBSTANCE ABUSE DAY TREATMENT.
PC84	PLEASE PROVIDE INFORMATION INDICATING THIS CLIENT IS APPROPRIATELY DETOXIFIED FROM ALCOHOL AND/OR OTHER DRUGS.
PC85	PLEASE PROVIDE INFORMATION TO INDICATE THE CLIENTS ABILITY TO ABSTAIN FROM ALCOHOL OR DRUGS WHILE IN THE SUBSTANCE ABUSE DAY TREATMENT PROGRAM.
PC86	PLEASE INDICATE IF THIS CLIENT IS WILLING TO PARTICIPATE IN AFTERCARE OR CONTINUING CARE SERVICES.
PC87	PROVIDE MORE INFORMATION ON TREATMENT HISTORY; INCLUDE SERVICE PROVIDED, DATES, AND OUTCOME. PROVIDE DETAIL OF PREVIOUS TREATMENT.
PC88	PLEASE PROVIDE MORE RATIONALE FOR THE APPROPRIATENESS AND MEDICAL NECESSITY OF SUBSTANCE ABUSE DAY TREATMENT.
PC89	PROVIDE A TREATMENT PLAN THAT CONTAINS MEASURABLE GOALS AND OBJECTIVES CORRESPONDING TO THE IDENTIFIED DEFICIT.
PC91	PLEASE PROVIDE MORE INFORMATION ON FAMILY INVOLVEMENT TREATMENT.
PC92	PLEASE PROVIDE MORE HISTORY AND EXPLANATION ABOUT THE ISSUE OF ABSTINENCE FOR THIS CLIENT.
PC94	PLEASE PROVIDE THE ANTICIPATED BEGINNING DATE AND/OR THE ESTIMATED SUBSTANCE ABUSE DAY TREATMENT DISCHARGE DATE.
PC95	PLEASE SUPPLY JUSTIFICATION FOR BEGINNING CLIENT IN SERVICE PRIOR TO AUTHORIZATION BEING OBTAINED.
PC96	THE INITIAL THREE HOURS OF SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IN A CALENDAR YEAR DO NOT REQUIRE PRIOR AUTHORIZATION.
PC97	REIMBURSEMENT FOR INITIAL SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IS LIMITED TO THREE HOURS IN A CALENDAR YEAR AND DOES NOT REQUIRE PRIOR AUTHORIZATION.
PC98	THIS DRUG IS CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE BILL USING THE APPROPRIATE NATIONAL DRUG CODE (NDC) OR SUBMIT A COMPLETED DRUG ADDITION REQUEST FORM IF THE NDC IS NOT LISTED IN THE DRUG INDEX.
PC99	THIS DRUG IS NOT CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL, CURRENT ADMINISTRATIVE RULE, OR COLORADO DRUG INDEX FOR COVERAGE LIMITATIONS.
PD01	DOCUMENT THAT CLIENT HAS ACHIEVED GOOD ORAL HYGIENE, PERIODONTAL CASE TYPE 1 OR 2, AND IS MOTIVATED TO MAINTAIN SAME.
PD03	PLEASE PROVIDE AN ARTERIAL BLOOD GAS READING OR PULSE OXIMETRY RESULTS DONE ON ROOM AIR SIGNED AND DATED BY A MEDICAL DOCTOR. THIS SHOULD BE DONE WITHIN 60 DAYS OF REQUESTED SERVICE.
PD04	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 30 DAYS OF RECEIPT BY COLORADO MEDICAID.
PD07	SUBMIT A PHOTOCOPY OF A VALID PRESCRIPTION, ISSUED WITHIN THE PAST YEAR, OR COMPLETE SECTION B OF THE PRIOR AUTHORIZATION/DRUG ATTACHMENT (PA/DGA), F-11049.
PD10	BRAND MEDICALLY NECESSARY MUST BE IN THE PRESCRIBERS OWN HANDWRITING AND WRITTEN DIRECTLY ON THE PRESCRIPTION OR A SEPARATE ORDER ATTACHED TO THE ORIGINAL PRESCRIPTION.
PD12	COMPLETE DENTURES, PARTIAL DENTURES, DENTURE RELINES, AND FIXED PROSTHODONTIC SERVICES ARE NOT COVERED SERVICES FOR ADULTS FOR DATES OF SERVICE ON AND AFTER OCTOBER 1, 1995.
PD22	PLEASE COMPLETE ALL REQUIRED ELEMENTS ON THE PERSONAL CARE SCREENING TOOL (PCST), F-11133.
PD24	THIS PRIOR AUTHORIZATION REQUEST IS UNABLE TO BE PROCESSED. PLEASE RESUBMIT WITH ADDITIONAL REQUIRED FORMS, INCLUDING THE ENTIRE PERSONAL CARE SCREENING TOOL (PCST), F-11133; PERSONAL CARE ADDENDUM, F-11136; AND SUPPORTING DOCUMENTATION, AS DIRECTED.
PD25	THERE IS A PERSONAL CARE SCREENING TOOL (PCST), F-11133, COMPLETED BY ANOTHER AGENCY. CONTACT THE AGENCY TO TRANSFER SCREEN.

Denial Code	Long Description
PD26	THERE IS A LIMITED TERM CARE FUNCTIONAL SCREEN (LTC-FS) COMPLETED BY ANOTHER AGENCY. THE PERSONAL CARE SCREENING TOOL (PCST), F-11133, INFORMATION IS IN CONFLICT WITH LTC-FS.
PD27	ONLY ONE LEVEL OF FUNCTION MAY BE SELECTED FOR ALL ELEMENTS EXCEPT TOILETING. COLORADO MEDICAID IS UNABLE TO PROCESS THE PRIOR AUTHORIZATION REQUEST.
PD28	NO UNITS MAY BE REQUESTED USING THIS PRIOR AUTHORIZATION PROCESS. PLEASE SUBMIT WITH THE APPROPRIATE ATTACHMENTS FOR REQUESTING SPECIFIC PERSONAL CARE WORKER UNITS.
PD29	CLIENT IS NOT ELIGIBLE FOR THE REQUESTED SERVICE(S) AS OF THE REQUESTED START DATE.
PD30	NO TRAVEL TIME MAY BE AUTHORIZED WHEN NO PERSONAL CARE WORKER SERVICE IS AUTHORIZED.
PD32	PROVIDER NOT CERTIFIED TO RENDER THE SERVICE(S) REQUESTED.
PD34	BASED ON THE DOCUMENTATION SUBMITTED, THIS REQUEST CAN NOT BE PRIOR AUTHORIZED. REFER TO THE PA MESSAGES FROM THE CONSULTANT FOR COMPLETE EXPLANATION.
PD98	PLEASE DOCUMENT HOW AND WHEN EACH PREVIOUSLY AUTHORIZED PRO RE NATA VISIT WAS USED.

Early Intervention EI

Denial Code	Long Description
0201	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
0233	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0235	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0237	CLIENT IDENTIFICATION NUMBER DOES NOT MATCH CLIENTS FIRST NAME.
0238	THE CLIENT IDENTIFICATION NUMBER DOES NOT MATCH THE CLIENTS LAST NAME.
0242	SECONDARY DIAGNOSIS CODE IS INVALID.
0248	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0249	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0251	PROCEDURE CODE MODIFIER IN FIRST POSITION IS INVALID.
0252	THE PROCEDURE CODE MODIFIER IN SECOND POSITION IS INVALID FOR REQUESTED START DATE OR DATE OF RECEIPT.
0253	THE PROCEDURE CODE MODIFIER IN THIRD POSITION IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
0258	THE PRIMARY DIAGNOSIS CODE IS REQUIRED.
0272	THE PRIMARY DIAGNSOSIS CODE IS INVALID.
0400	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0853	HCPCS - ANNUAL UPDATE
0885	NEVER EVENTS MODIFIERS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
0886	NEVER EVENTS DIAGNOSIS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
1000	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
1002	RENDERING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1003	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1007	RENDERING PROVIDER ID IS NOT ON FILE.
1047	THE RENDERING PROVIDERS CERTIFICATION HAS BEEN CANCELLED.
1048	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1801	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
1804	A CERTIFIED SUBSTANCE ABUSE DAY TREATMENT PROVIDER MUST SUBMIT A SUBSTANCE ABUSE DAY TREATMENT PROCEDURE CODE.
1806	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
1808	THE BILLING PROVIDER DOES NOT HAVE THE REQUIRED CERTIFICATION ADDENDUM ON FILE.
1900	THE BILLING PROVIDERS TAXONOMY CODE IS INVALID.
1901	THE RENDERING PROVIDERS TAXONOMY CODE IS INVALID.

Denial Code	Long Description
1927	A NATIONAL PROVIDER IDENTIFIER IS REQUIRED FOR THE BILLING PROVIDER.
1934	A NATIONAL PROVIDER INDENTIFIER IS REQUIRED FOR THE RENDERING PROVIDER.
1936	THE BILLING PROVIDER NUMBER IS INVALID.
1937	THE RENDERING PROVIDER NUMBER IS INVALID.
1960	INTERNAL PROCESSING IS REQUIRED.
1963	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.
1964	THE BILLING PROVIDER INDICATED IS NOT ALLOWABLE AS A BILLING PROVIDER.
1965	RENDERING PROVIDER NUMBER IS MISSING/INVALID FOR THIS PROCEDURE PROVIDER.
1974	PRESCRIBING/REFERRING/ORDERING PROVIDER INDICATED IS NOT CERTIFIED AS A PRESCRIBING/REFERRING/ORDERING PROVIDER.
1975	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
1976	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
2001	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2003	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2017	THE CLIENT IS ENROLLED IN A MEDICAID OR OTHER MANAGED CARE PROGRAM.
2037	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2603	CLIENT LOCKED-IN TO A PROVIDER OR ENROLLED IN A HOSPICE. CONTACT CLIENTS HOSPICE FOR PAYMENT OF SERVICES OR RESUBMIT WITH DOCUMENTATION OF UNRELATED NATURE OF CARE.
3324	THE MODIFIER HAS BEEN DISCONTINUED BY THE CENTERS OF MEDICARE AND MEDICAID SERVICES OR THE AMERICAN MEDICAL ASSOCIATION FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
3337	THE PROCEDURE CODE HAS BEEN TERMINATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AMERICAN MEDICAL ASSOCIATION, OR AMERICAN DENTAL ASSOCIATION FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT. RESUBMIT WITH VALID A PROCEDURE CODE.
3339	THE PROCEDURE BILLED IS NOT PAYABLE ACCORDING TO DEFICIT REDUCTION ACT (DEFRA) GUIDELINES.
3351	THE PROCEDURE IS NOT COVERED FOR CLIENTS WITH A NURSING HOME AUTHORIZATION ON THE REQUESTED START DATE OR DATE OF RECEIPT.
3353	THE PROCEDURE IS NOT A COVERED SERVICE FOR HOME AND COMMUNITY-BASED WAIVER CLIENTS.
4021	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4027	THE DIAGNOSIS CODE IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
4031	THE PROCEDURE SUBMITTED IS NOT APPROPRIATE FOR CLIENTS GENDER.
4032	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4034	THE PROCEDURE CODE HAS AN AGE RESTRICTION.
4036	THE PLACE OF SERVICE CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4040	THE PRIMARY DIAGNOSIS CODE IS NOT ON FILE.
4041	THE SECONDARY DIAGNOSIS IS NOT ON FILE.
4046	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4127	INTERNAL PROCESSING IS REQUIRED.
4131	INTERNAL PROCESSING IS REQUIRED.
4141	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4149	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4150	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4236	ETIOLOGY DIAGNOSIS CODE(S) (E-CODES) ARE INVALID AS THE PRIMARY DIAGNOSIS.
4244	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4245	THE FOURTH POSITION MODIFIER IS INVALID FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT.
4256	THE PROCEDURE CODE AND MODIFIER COMBINATION IS NOT PAYABLE FOR THE CLIENTS BENEFIT PLAN.
4257	THE MODIFIERS SUBMITTED ARE EITHER INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT OR THE MODIFIERS ARE MISSING.
4311	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4315	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4316	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4371	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4372	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.

Denial Code	Long Description
4711	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR CLIENTS AGE.
4714	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS AGE.
4731	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS DIAGNOSIS.
4742	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4743	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4744	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4745	DIAGNOSIS AND/OR PROCEDURE AND/OR PLACE OF SERVICE (POS) CODE IS NOT COVERED FOR EXPRESS ENROLLMENT CLIENTS.
4746	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4801	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4802	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
4821	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
4871	PLEASE REFER TO PA MESSAGES FOR RETURN INFORMATION.
4963	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS GENDER.
4990	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
7500	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
7509	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
P001	THE BILLING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THE SERVICES.
P002	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P003	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P005	THE PRIOR AUTHORIZATION CAN NOT BE END DATED. THE PRIOR AUTHORIZATION STATUS IS NOT APPROVED OR APPROVED WITH REVISIONS.
P006	PLEASE FURNISH THE PROCEDURE CODE AND CORRESPONDING DESCRIPTION.
P008	THE BILLING PROVIDER NUMBER IS INVALID.
P009	THE BILLING PROVIDER NUMBER IS INVALID.
P010	THE REQUESTED END DATE IS INVALID.
P011	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P012	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P013	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P014	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P015	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P016	THE REQUESTED START DATE IS MISSING OR INVALID.
P019	THE REQUESTED START DATE IS MISSING OR INVALID.
P020	THE RENDERING PROVIDER NUMBER IS INVALID.
P021	THE RENDERING PROVIDER NUMBER IS INVALID.
P022	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P023	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P024	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P026	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P027	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P030	FIRST MODIFIER IS INVALID.
P031	FIRST MODIFIER IS INVALID.
P032	SECOND MODIFIER IS INVALID.
P033	SECOND MODIFIER IS INVALID.
P034	THIRD MODIFIER IS INVALID.
P035	THIRD MODIFIER IS INVALID.

Denial Code	Long Description
P036	FOURTH MODIFIER IS INVALID.
P037	FOURTH MODIFIER IS INVALID.
P038	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P039	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P040	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P041	CLIENTS FIRST NAME IS MISSING.
P042	CLIENTS LAST NAME IS MISSING.
P043	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P044	BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES REQUESTED.
P045	FIRST MODIFIER IS INVALID.
P046	SECOND MODIFIER IS INVALID.
P047	THIRD MODIFIER IS INVALID.
P048	FOURTH MODIFIER IS INVALID.
P052	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P053	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P054	RENDERING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES FOR THE BENEFIT PLAN.
P055	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P061	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P062	THE CLIENT ID AND/OR NAME INDICATED ON THE PA REQUEST IS INCORRECT. THE CLIENT ID AND/OR NAME HAS BEEN UPDATED. PLEASE VERIFY THE ID AND/OR NAME IS CORRECT.
P064	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
P067	THE FREQUENCY OF HOURS REQUESTED ARE NOT APPROPRIATE FOR THIS CLIENT AND HAVE BEEN MODIFIED ACCORDINGLY.
P079	BILLING PROVIDER IS ON PAYMENT SUSPENSION DUE TO CREDIBLE ALLEGATION OF FRAUD.
P120	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAS BEEN REDUCED.
P121	THE SERVICE/ PROCEDURE REQUESTED IS NOT SUPPORTED BY SUBMITTED DOCUMENTATION.
P126	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
P128	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.
P138	SERVICE(S) DO NOT MEET COLORADO MEDICAID GUIDELINES.
P167	REQUESTED DOCUMENTATION HAS NOT BEEN SUBMITTED.
P178	THE SERVICE REQUESTED IS NOT MEDICALLY NECESSARY.
P179	THE MEDICAL NECESSITY FOR THIS SERVICE IS NOT SUPPORTED BY THE SUBMITTED DOCUMENTATION.
P233	THE DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE ADDITIONAL CARE.
P257	THIS CLIENTS FUNCTIONAL ASSESSMENT SCORES PLACE THIS CLIENT OUTSIDE ELIGIBILITY FOR DAY TREATMENT.
P274	OUR RECORDS INDICATE THIS CLIENT IS INVOLVED IN EFFECTIVE AND APPROPRIATE SERVICE ELSEWHERE.
P292	INTENSIVE REHABILITATION HOURS ARE NO LONGER APPROPRIATE AS INDICATED BY HISTORY, DIAGNOSIS, AND/ OR FUNCTIONAL ASSESSMENT SCORES.
P328	THE SERVICES REQUESTED INCLUDE NON-COVERED SERVICES, AND HOURS ARE REDUCED ACCORDINGLY.
P339	THE CLIENTS PAST HISTORY INDICATES REDUCED TREATMENT HOURS ARE WARRANTED.
P342	THE REQUEST DOES NOT MEET GENERALLY ACCEPTED CONDITIONS REQUIRING FLUORIDE TREATMENTS.
P346	SERVICES EXCEED COLORADO MEDICAID LIMITATION AND DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE MEDICAL NECESSITY OF THE SERVICE.
P349	THE SERVICE REQUESTED WAS PERFORMED LESS THAN FIVE YEARS AGO.
P353	THE EXISTING APPLIANCE HAS NOT BEEN WORN FOR THREE YEARS.
P367	THE CLIENT HAS BEEN TOTALLY WITHOUT TEETH AND AN APPLIANCE FOR FIVE YEARS.

Denial Code	Long Description
P392	THE CLIENT IS MISSING AN ANTERIOR TOOTH AND/OR HAS TWO OR MORE POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P405	THE SERVICE(S) REQUESTED COULD ADEQUATELY BE PERFORMED IN THE DENTAL OFFICE.
P406	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE OF GOOD PERIODONTAL HEALTH (AMERICAN ACADEMY OF PERIODONTOLOGY PERIODONTAL CLASSIFICATION OF TYPE I OR II).
P407	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE VISIBLE ON RADIOGRAPHS THAT AT LEAST 50 PERCENT OF THE CLINICAL CROWN IS INTACT.
P409	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING SIX OR MORE TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED, INCLUDING THIRD MOLARS.
P410	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING ONE OR MORE ANTERIOR TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED.
P411	DOCUMENTATION DOES NOT SUPPORT THE NEED FOR PERIODONTIC SERVICES. POCKETS ARE LESS THAN 4MM AND/OR GREATER THAN 6MM FOR CLIENT AND/OR THE CLIENT IS UNDER THE AGE OF 13.
P412	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA.
P413	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA. THIS PA HAS BEEN GRANTED AS APPROVED NOT APPROVED WITH REVISIONS. THE DURATION REQUESTED MAY HAVE BEEN REDUCED TO REFLECT COVERAGE LIMITATIONS, PRESCRIBER ORDERS, CONFLICTI
P417	THE SERVICE(S) REQUESTED COULD BE ADEQUATELY PERFORMED WITH LOCAL ANESTHESIA.
P437	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO POOR ORAL HYGIENE.
P444	THIS LINE ITEM IS A DUPLICATE OF ANOTHER LINE ITEM ON THIS PRIOR AUTHORIZATION (PA) REQUEST. PLEASE CORRECT.
P446	THIS IS A DUPLICATE OF AN EXISTING PRIOR AUTHORIZATION (PA) REQUEST. YOU MAY CONTACT PROVIDER SERVICES IF YOU REQUIRE ASSISTANCE. DUPLICATE PA REQUEST
P448	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO DECAY HISTORY.
P449	QUESTIONABLE LONG TERM PROGNOSIS DUE TO GUM AND BONE DISEASE.
P456	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO APPARENT ROOT INFECTION.
P457	OUR RECORDS INDICATE THIS CLIENT HAS EXCEEDED ESTABLISHED PROGRAM LIMITATIONS. COLORADO MEDICAID WILL NOT AUTHORIZE NEW DENTURES.
P458	DOCUMENTATION PROVIDED INDICATES A LESS ELABORATE PROCEDURE SHOULD BE CONSIDERED.
P502	RENTAL ONLY ALLOWED; MEDICAL NEED FOR PURCHASE HAS NOT BEEN DOCUMENTED.
P503	PURCHASE ONLY ALLOWED; MEDICAL NEED FOR RENTAL HAS NOT BEEN DOCUMENTED.
P504	OCCUPATIONAL THERAPY GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P505	THE SERVICE REQUESTED IS INCLUDED IN THE NURSING HOME RATE STRUCTURE.
P511	THIS NATIONAL DRUG CODE IS ONLY BILLABLE AS PART OF A COMPOUND DRUG.
P515	THE PRESENCE OF A HANDICAPPING MALOCCLUSION OR HANDICAPPING DENTOFACIAL DEFORMITY IS NOT SUPPORTED BY THE DOCUMENTATION SUBMITTED.
P521	THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVERED BY COLORADO MEDICAID.
P522	GASTRO-INTESTINAL SURGERY FOR THE PURPOSE OF WEIGHT CONTROL IS COVERED ONLY AS A LIFE THREATENING PROCEDURE.
P523	THE TREATMENT REQUEST IS NOT CONSISTENT WITH THE CLIENT'S DIAGNOSIS.
P524	PSYCHOTHERAPY PROVIDED IN THE CLIENTS HOME IS NOT A COVERED BENEFIT OF COLORADO MEDICAID.
P525	THE INFORMATION PROVIDED IS NOT CONSISTENT WITH THE INTENSITY OF SERVICES REQUESTED.
P526	INTENSIVE MULTIPLE MODALITY TREATMENT IS NOT CONSISTENT WITH THE INFORMATION PROVIDED.
P527	MULTIPLE PROVIDERS OF TREATMENT ARE NOT INDICATED FOR THIS CLIENT.
P528	THE DURATION OF TREATMENT SESSIONS EXCEED CURRENT COLORADO MEDICAID GUIDELINES.
P534	DOCUMENTATION OF POOR PHYSICAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P535	OTHER PHYSICAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P536	THE PHYSICAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P537	USE OF PHYSICAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.

Denial Code	Long Description
P538	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF A PHYSICAL THERAPIST.
P539	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS AND LIVING ARRANGEMENT.
P540	GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P541	THE PROCEDURE(S) REQUESTED ARE NOT MEDICAL IN NATURE.
P542	DOCUMENTATION OF POOR OCCUPATIONAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P543	DOCUMENTATION OF POOR SPEECH THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P544	OTHER OCCUPATIONAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P546	THE OCCUPATIONAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P547	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF PHYSICAL THERAPY.
P548	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P549	ACTIVITIES TO PROMOTE DIVERSION OR GENERAL MOTIVATION ARE NONCOVERED COLORADO MEDICAID SERVICES.
P550	REVISIONS OF THE REQUEST IS NECESSITATED BY THE CLIENTS MINIMAL PROGRESS.
P551	RESTORATIVE NURSING INVOLVEMENT COULD BE INCREASED.
P552	CLIENTS DEMONSTRATED RESPONSE TO CURRENT THERAPY DOES NOT WARRANT THE INTENSE FREQUENCY REQUESTED.
P553	MAINTENANCE IS TWO TIMES PER WEEK OR LESS.
P554	THE SPEECH THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P555	USE OF OCCUPATIONAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P556	USE OF SPEECH THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P557	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF AN OCCUPATIONAL THERAPIST.
P558	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
P559	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P560	THE MATERIALS/ SERVICES REQUESTED ARE PRINCIPALLY COSMETIC IN NATURE.
P561	THE LENS FORMULA DOES NOT JUSTIFY REPLACEMENT.
P562	THE CHANGE IN THE LENS FORMULA DOES NOT WARRANT MULTIPLE REPLACEMENTS.
P563	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P564	LENSES ONLY ARE APPROVED; PLEASE DISPENSE A CONTRACTED FRAME. THE NON-CONTRACTED FRAME IS NOT MEDICALLY JUSTIFIED.
P565	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P566	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P567	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF OCCUPATIONAL THERAPY.
P568	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF SPEECH THERAPY.
P569	LEVEL, INTENSITY, OR EXTENT OF SERVICE(S) REQUESTED HAS BEEN MODIFIED CONSISTENT WITH MEDICAL NEED AS DEFINED IN THE PLAN OF CARE.
P570	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P571	THE SERVICE ASKED FOR IS NOT COVERED BY COLORADO MEDICAID AS THESE TASKS CAN BE DONE BY NURSES OR ACTIVITY STAFF.
P572	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P573	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.

Denial Code	Long Description
P574	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P575	MEDICAL NEED FOR EQUIPMENT/ SUPPLY REQUESTED IS NOT SUPPORTED BY DOCUMENTATION SUBMITTED.
P576	OTHER SPEECH THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P577	DOCUMENTATION SUBMITTED IDENTIFIES THAT THE CLIENT HAS FEWER THAN TWO POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P582	LESS EXPENSIVE ALTERNATIVE SERVICES ARE AVAILABLE FOR THIS CLIENT.
P634	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P711	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING PERIODONTAL SCALING AND ROOT PLANNING.
P712	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING GINGIVECTOMY.
P754	AN APPROVED SUBSTANCE ABUSE DAY TREATMENT PROGRAM CANNOT EXCEED A SIX WEEK PERIOD.
P761	THE CLIENT DOES NOT APPEAR TO BE ABLE OR WILLING TO ABSTAIN FROM ALCOHOL/DRUG USAGE WHILE IN TREATMENT. THEREFORE, SUBSTANCE ABUSE DAY TREATMENT SERVICES ARE NOT APPROVED.
P764	THIS CLIENT HAS COMPLETED INTENSIVE SUBSTANCE ABUSE TREATMENT WITHIN THE PAST 12 MONTHS. THE DOCUMENTATION PROVIDED IS NOT ADEQUATE TO JUSTIFY ADDITIONAL INTENSIVE TREATMENT AT THIS TIME.
P785	A LESS THAN SIX-WEEK HEALING PERIOD HAS BEEN SPECIFIED FOR THIS PRIOR AUTHORIZATION. THEREFORE IT IS NOT NECESSARY TO WAIT THE FULL SIX WEEKS AFTER EXTRACTIONS BEFORE TAKING DENTURE IMPRESSIONS.
P818	SIX-WEEK HEALING TIME IS REQUIRED BETWEEN EDENTULATION AND FINAL IMPRESSIONS. PAYMENT FOR DENTURES WILL BE DENIED OR RECOUPED IF HEALING PERIOD IS NOT OBSERVED.
P849	COLORADO MEDICAID HAS DETERMINED THERE WERE (ARE) SEVERAL HOME HEALTH AGENCIES WILLING TO PROVIDE MEDICALLY NECESSARY SKILLED NURSING SERVICES TO THIS CLIENT.
P864	THE DOCUMENTATION YOU HAVE SUBMITTED DOES NOT MEET THE REQUIREMENTS OF COLORADO MEDICAID.
P873	THE MEDICAL NECESSITY FOR THE HOURS REQUESTED IS NOT SUPPORTED BY THE INFORMATION SUBMITTED.
P874	THE DOCUMENTATION SUBMITTED INDICATES THE TASKS SPECIFIED CAN BE COMPLETED DURING THE VISITS APPROVED.
P878	THE DOCUMENTATION SUBMITTED DOES NOT INDICATE THAT MEDICALLY ORIENTED TASKS ARE MEDICALLY NECESSARY; THEREFORE PERSONAL CARE SERVICES HAVE BEEN APPROVED.
P880	THE QUANTITY OF SERVICES AUTHORIZED FOR THIS CLIENTS PERSONAL CARE HAS BEEN AMENDED BASED ON INFORMATION RECEIVED FROM ONE OR MORE OF THESE SOURCES: THE CLIENT, THEIR PHYSICIAN, AND/OR THE IN-HOME VISIT BY STAFF OF THE OIG (OFFICE OF INSPECTOR GENERAL).
P885	THE USE OF THIS DRUG FOR THE INTENDED PURPOSE IS NOT COVERED BY COLORADO MEDICAID, CONSISTENT WITH COLORADO ADMINISTRATIVE CODE AND FEDERAL LAW.
P924	THE MEDICAL RECORDS SUBMITTED WITH THE CURRENT REQUEST CONFLICT OR DISAGREE WITH OUR MEDICAL RECORDS ON THIS CLIENT.
P950	INDEPENDENT NURSES, PLEASE NOTE PAYABLE SERVICES MAY NOT EXCEED 12 HOURS/DAY OR 60 HOURS/WEEK.
P951	SERVICES CAN ONLY BE AUTHORIZED THROUGH ONE YEAR FROM THE PRESCRIPTION DATE.
P952	LEAD INSPECTION IS A COVERED COLORADO MEDICAID SERVICE WHEN THE CHILD HAS BEEN SHOWN TO HAVE LEAD POISONING (E.G., CHILD HAS A BLOOD LEAD LEVEL > 19 UG/DL OR TWO CONSECUTIVE BLOOD LEAD LEVELS OF 15-19 UG/DL DONE AT LEAST 90 DAYS APART). THE INSPECTION MUS
P953	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P954	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P956	THE REQUEST CAN ONLY BE BACKDATED A MAXIMUM OF 14 DAYS FROM FIRST DATE RECEIVED BY COLORADO MEDICAID.

Denial Code	Long Description
P957	COMPLETE PERIODONTAL CHARTING AT TIME OF SERVICE, AND SUBMIT CHARTING, COPY OF OPERATIVE REPORT, TOGETHER WITH A COPY OF THE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF), F-11035, TO PA UNIT ATTENTION DENTAL CONTSULTANT.
P958	NOTE THAT CODE D4341 HAS BEEN CHANGED. REFER TO THE DECISION NOTICE FOR AUTHORIZED QUANTITY.
P960	YOUR PA HAS BEEN APPROVED FOR 90 DAYS. THE 90 DAY APPROVAL DOES NOT IMPLY THE PA REQUEST MEETS PRIOR AUTHORIZATION CRITERIA. AFTER ADDITIONAL INFORMATION IS AVAILABLE IN INTERCHANGE, COLORADO MEDICAID WILL CREATE AN AMENDMENT REQUEST TO EXTEND THE PA FOR
P961	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P962	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
PA10	THE REQUESTED END DATE IS INVALID.
PA12	PLEASE FURNISH A WRITTEN DESCRIPTION OF THE CLIENTS DIAGNOSIS.
PA13	PROVIDE DIAGNOSES WITH DATES OF ONSET.
PA14	IDENTIFY PROBLEMS TO BE TREATED.
PA15	THE AUDIOLOGISTS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1), F-11020, AND PRIOR AUTHORIZATION REQUEST/HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2), F-11021.
PA16	THE PHYSICIANS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION/PHYSICIAN OTOLOGICAL REPORT (PA/POR), F-11019.
PA17	SUBMIT BRIEF HISTORY WITH REFERRAL INFORMATION, LIVING SITUATION, FUNCTIONAL STATUS, AND OTHER PERTINENT INFORMATION. WHAT CHANGE OF STATUS RESULTED IN REFERRAL AT THIS TIME?
PA18	PLEASE FURNISH THE CLIENTS HEIGHT AND WEIGHT.
PA19	PLEASE SUBMIT CLINICAL INFORMATION SUFFICIENT TO VERIFY THE NEED FOR THE REQUESTED SERVICE(S).
PA20	PLEASE RESUBMIT WITH COMPLETE PERIODONTAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PA21	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL EDUCATIONAL PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA22	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL PROGRAM PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA23	REFER TO THE DURABLE MEDICAL EQUIPMENT INDEX FOR APPROPRIATE CODE AND DESCRIPTION. DO NOT USE AN "UNLISTED" CODE.
PA24	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUALIZED FAMILY SERVICE PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA25	INFORMATION ON THE REQUEST FORM IS ILLEGIBLE, AND THE REQUEST CANNOT BE PROCESSED.
PA26	RE-EVALUATE YOUR GOALS. EMPHASIS SHOULD BE ON FUNCTIONAL SELF-CARE. GOALS MUST BE RELATED TO FUNCTIONAL OUTCOME.
PA27	PLEASE CLARIFY THE NUMBER OF HOURS PER WEEK REQUESTED.
PA28	PLEASE CLARIFY THE NUMBER OF HOURS PER DAY REQUESTED.
PA29	PLEASE CLARIFY THE NUMBER OF VISITS PER DAY REQUESTED.
PA30	ATTACH SUPPORTIVE DOCUMENTATION; HOME EXERCISE PROGRAM AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA31	THE DIAGNOSIS CODE INDICATED ON THE REQUEST DOES NOT CORRESPOND TO THE DIAGNOSIS CODE DESCRIPTION.
PA32	PLEASE SUBMIT ADDITIONAL INFORMATION SUFFICIENT TO VERIFY APPROPRIATENESS AND NEED FOR TRANSPLANT.
PA33	PLEASE SUBMIT THE INITIAL AND PROGRESSIVE OBJECTIVE FINDINGS.
PA34	ATTACH SUPPORTIVE DOCUMENTATION, FACILITY PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA35	PLEASE SUBMIT THE CLIENTS ORIGINAL COMPLAINTS AND EXAMINATION FINDINGS.

Denial Code	Long Description
PA36	ATTACH SUPPORTIVE DOCUMENTATION, IN-HOME AUTISM PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA37	PLEASE SUBMIT YOUR TREATMENT PLAN FOR THIS CLIENT.
PA38	ATTACH SUPPORTIVE DOCUMENTATION AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA39	INITIAL EVALUATIONS MUST BE PERFORMED BY AN OCCUPATIONAL THERAPIST REGISTERED (OTR), PER AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA) STANDARDS.
PA41	IDENTIFY THE PLACE OF SERVICE AND ITS EFFECT ON SUPPORTING THE DESIRED TREATMENT OUTCOME.
PA42	PLEASE INDICATE THE HOURS OF USE OF OXYGEN PER 24-HOUR PERIOD.
PA43	PROVIDE BASELINE DOCUMENTATION FOR THIS CLIENTS LIMITATIONS USING UNITS OF MEASUREMENT THAT ARE APPLIED CONSISTENTLY WHEN REPORTING STATUS.
PA44	IDENTIFY FUNCTIONAL LIMITATIONS AS THEY ARE RELATED TO IDENTIFIED CONDITIONS.
PA46	CORRELATE PLAN OF CARE TO REQUESTED PROCEDURE CODES.
PA47	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE FREQUENCY/DURATION REQUESTED.
PA48	PLEASE PROVIDE THE NAME AND CREDENTIALS OF THE RENDERING PROVIDER.
PA50	COLORADO MEDICAID RECORDS INDICATE THE CLIENT OWNS A WHEELCHAIR. DOCUMENT THE REASON AND NEED FOR REPLACEMENT AND COST TO REPAIR CURRENT WHEELCHAIR.
PA51	PLEASE DISTINGUISH PRIMARY AND SUPPORTIVE MODALITIES.
PA52	PLEASE SUBMIT A PROGRESS REPORT.
PA53	MULTIPLE FAMILY CLIENTS TREATMENT BY THE SAME PROVIDER REQUIRES FURTHER INFORMATION DOCUMENTING COORDINATION OF TREATMENT PLAN.
PA54	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE MINUTES REQUESTED.
PA55	MEDICAL NECESSITY OF TREATMENT REQUIRES ADDITIONAL DOCUMENTATION.
PA56	GIVEN AGE, DIAGNOSES, CURRENT LEVEL OF FUNCTION, PAST RESPONSE TO TREATMENT, AND LIVING SITUATION, EXPAND ON POTENTIAL FOR SIGNIFICANT FUNCTIONAL PROGRESS WITHIN THE NEXT SIX MONTHS. EMPHASIZE WHY PROGRESS IS EXPECTED WITH SERVICES AT THIS TIME.
PA57	SUBMIT THE INITIAL FINDINGS. INCLUDE A COMPREHENSIVE EVALUATION.
PA58	SUBMIT PROGRESSIVE, OBJECTIVE FINDINGS. INCLUDE A PERTINENT RE-EVALUATION.
PA59	PLEASE SUPPLY INFORMATION REGARDING THE CLIENTS MEDICATION REQUIREMENTS, IF ANY.
PA60	PLEASE SPECIFY IF THE CLIENT IS IN AN EDUCATIONAL SETTING.
PA61	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA62	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
PA63	THE SKILLS OF A THERAPIST ARE PURPOSEFUL AND SKILLED INTERVENTIONS REQUIRED TO CONTINUALLY DESIGN, IMPLEMENT, REASSESS, MODIFY/GRADE, AND/OR DISCONTINUE A PLAN OF CARE IN A TIMELY MANNER, BASED ON THE COMPLEXITY OF THE CLIENTS MEDICAL CONDITION AND/OR CO
PA64	PLEASE SUBMIT A THERAPY PLAN OF CARE, INCLUDING A CURRENT, DATED EVALUATION.
PA65	A PLAN OF CARE SIGNED AND DATED BY THE PHYSICIAN IS REQUIRED.
PA66	THE SKILLS OF A THERAPIST ARE REQUIRED WHEN ONLY THE THERAPIST CAN SAFELY AND EFFECTIVELY DELIVER THE THERAPEUTIC PROCEDURES BECAUSE OF THEIR UNIQUE KNOWLEDGE, TRAINING, AND EXPERTISE. DESCRIBE THE REASON THAT SOMEONE OTHER THAN A THERAPIST CANNOT SAFELY
PA67	PLEASE SPECIFY IF THE CLIENTS WORK SITE DEMANDS GOOD BINAURAL HEARING.
PA68	DESCRIBE THE REASON, BASED ON THE CLIENTS COGNITIVE, PHYSICAL, COMMUNICATION, OR RESOURCE STATUS, THAT A HOME PROGRAM, EQUIPMENT, OR ENVIRONMENTAL ADAPTATIONS ALONE CANNOT MEET CLIENTS NEEDS.
PA69	PLEASE SPECIFY IF THE CLIENT HAS AN ACCOMPANYING DISABILITY THAT ADDS TO THE HEARING PROBLEM.
PA70	DISTINGUISH REQUESTED PROCEDURES AND GOALS FROM OTHER SERVICES THIS CLIENT RECEIVES. THEY MAY NOT BE DUPLICATIVE.
PA71	PLEASE INDICATE THE NUMBER OF DAYS REQUESTED.
PA73	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).

Denial Code	Long Description
PA74	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA75	PLEASE DOCUMENT CARRYOVER OF THE THERAPY PROGRAM TO NURSING.
PA76	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA79	PROVIDE EVIDENCE OF SIGNIFICANT FUNCTIONAL PROGRESS IN LAST SIX MONTHS.
PA84	THE GRANT DATE OF THIS REQUEST CANNOT BE PRIOR TO THE SIGNATURE DATE OF THE PRESCRIBING PHYSICIAN.
PA86	PROVIDE EVIDENCE OF SKILLS GAINED IN THERAPY CARRYING OVER TO OTHER SETTINGS WITHIN SIX MONTHS.
PA87	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE NUMBER OF SESSIONS REQUESTED.
PA88	THE REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL SCOPE OF PRACTICE.
PA89	PRIOR AUTHORIZATION IS NOT REQUIRED UNTIL LIMITATION OF SERVICE HAS BEEN REACHED.
PA91	PLEASE SUBMIT REQUIRED X-RAYS.
PA92	PLEASE PROVIDE AN EXPLANATION FOR THE MATERIAL SUBMITTED WITH THE REQUEST.
PA95	PLEASE DESCRIBE HOW THE PROVISION OF THIS SERVICE WOULD PREVENT INSTITUTIONALIZATION OF THE CLIENT.
PA96	COULD THE EXISTING DENTURE(S) BE RELINED OR REBASED? IF NOT, PLEASE EXPLAIN WHY NOT.
PA97	REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL STANDARDS OF PRACTICE.
PA98	PLEASE INDICATE IF THE CLIENT IS CURRENTLY BEING TUBE FED.
PB02	PLEASE PROVIDE THE REQUIRED DATED SIGNATURES ON THE ATTACHMENTS.
PB03	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING THE LOSS/DESTRUCTION/THEFT OF THE HEARING AID.
PB04	DESCRIBE THE CLIENTS ABILITY TO STAND OR AMBULATE SUFFICIENTLY TO ACCOMPLISH SELF-CARE ACTIVITIES.
PB07	PLEASE SUBMIT AN ORTHODONTIC STUDY MODEL OR DIAGNOSTIC CASTS.
PB09	PLEASE PROVIDE A PHOTOGRAPH OF THE INVOLVED AREA(S).
PB10	PLEASE PROVIDE AN ESTIMATION (IN GRAMS) OF THE TOTAL AMOUNT OF TISSUE TO BE RESECTED.
PB11	PLEASE SUBMIT THE PLAN OF CARE FOR CO-TREATMENT.
PB12	FURNISH A DETAILED DESCRIPTION FOR THE PROCEDURE CODE REQUESTED.
PB13	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB15	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB18	PLEASE COMPLETE THE ATTACHED OUT-OF-STATE PROVIDER DATA SHEET, F-11001, AND RESUBMIT.
PB20	A SIGNED AND DATED PRESCRIPTION IS REQUIRED WITHIN THREE MONTHS OF RECEIPT BY COLORADO MEDICAID FOR INITIAL REQUESTS AND WITHIN 12 MONTHS OF RECEIPT BY COLORADO MEDICAID FOR SUBSEQUENT REQUESTS.
PB21	PLEASE COMPLETE THE APPROPRIATE PRIOR AUTHORIZATION ATTACHMENT. CONTACT PROVIDER SERVICES OR THE PRIOR AUTHORIZATION UNIT FOR ASSISTANCE.
PB23	PHYSICAL THERAPY ASSISTANT NOTES AND ALL FORMS SUBMITTED MUST BE COSIGNED BY A REGISTERED PHYSICAL THERAPIST.
PB31	ARE YOU REQUESTING A COMPLETE APPLIANCE, OR REPLACEMENT PARTS?
PB32	THE PROCEDURE CODE INDICATED ON THE REQUEST DOES NOT MATCH THE DESCRIPTION OF SERVICE; PLEASE CORRECT AND RESUBMIT.
PB35	THE SERVICE REQUESTED DOES NOT REQUIRE PRIOR AUTHORIZATION.
PB41	PLEASE FURNISH A CURRENT MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT, F-11090 (DATED WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID).
PB45	THE CERTIFICATION PERIOD ON THE PLAN OF CARE (POC) DOES NOT COVER THE REQUESTED GRANT/START DATE. PLEASE RESUBMIT YOUR REQUEST WITH A NEW POC.
PB49	A CERTIFIED OCCUPATIONAL THERAPY ASSISTANTS NOTES MUST BE COSIGNED BY AN OCCUPATIONAL THERAPIST REGISTERED.
PB51	ADDITIONAL INFORMATION IS REQUIRED ON PRIOR AUTHORIZATION TO ENABLE PRICING.
PB54	REQUESTED SERVICES DO NOT MATCH SERVICES ON THE PHYSICIANS ORDERS.

Denial Code	Long Description
PB59	PLEASE PROVIDE AN INDIVIDUAL EDUCATIONAL PLAN (IEP), WHICH HAS BEEN SIGNED BY THE PROVIDER NO EARLIER THAN NINE MONTHS PRIOR TO RECEIPT AT COLORADO MEDICAID; OTHERWISE, DOCUMENT WHY NO IEP EXISTS.
PB65	PLEASE FURNISH THE ANTICIPATED TOTAL CHARGES FOR THIS REQUEST.
PB66	A PHOTOCOPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED; THE DATE MUST BE WITHIN SIX MONTHS OF RECEIPT BY COLORADO MEDICAID.
PB67	THE PRESCRIPTION DATE MUST INCLUDE MONTH, DAY, AND YEAR.
PB68	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID.
PB73	THE SERVICES IDENTIFIED ON THE PLAN OF CARE DO NOT APPEAR APPROPRIATE FOR THE PROCEDURE CODE(S) REQUESTED ON THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018.
PB74	THE CLIENT/PROVIDER DOES NOT HAVE RETROACTIVE ENROLLMENT.
PB75	THE REQUESTED START DATE IS MORE THAN 14 DAYS BEFORE OR 62 DAYS AFTER RECEIPT.
PB82	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
PB83	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A HOME HEALTH AIDE. PLEASE RESUBMIT AS A PERSONAL CARE WORKER OR PROVIDE ADDITIONAL DOCUMENTATION.
PB86	THE SERVICES REQUESTED ARE NOT BEING PROVIDED IN THE CLIENTS RESIDENCE. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL.
PB87	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A NURSE. PLEASE RESUBMIT AS A HOME HEALTH AIDE OR PROVIDE ADDITIONAL DOCUMENTATION.
PB92	PLEASE FURNISH THE CLIENTS COMPLETE ADDRESS.
PB94	IF THE CLIENT IS A RESIDENT OF A NURSING HOME, SUPPLY THE COMPLETE NAME AND ADDRESS OF THE NURSING HOME.
PB99	THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018, MUST BE SIGNED AND DATED.
PC01	PLEASE SUPPLY THE RENDERING PROVIDERS PROVIDER NUMBER.
PC03	THE DRUG ENFORCEMENT ADMINISTRATION NUMBER IS MISSING OR INVALID.
PC06	PLEASE DESCRIBE YOUR PROGRAM; INCLUDE ENTRY DATE, TERMINATION DATE, HOURS PER WEEK, AND NUMBER OF WEEKS OF PRIMARY INTENSIVE SERVICE REQUESTED.
PC07	PLEASE DESCRIBE YOUR "AFTERCARE/FOLLOW-UP" PLANS FOR THIS CLIENT.
PC08	PLEASE SUPPLY DOCUMENTATION OF PREVIOUS SUBSTANCE ABUSE SERVICES WITH DATE(S) AND OUTCOME.
PC09	PLEASE DESCRIBE IN DETAIL THE TREATMENT OBJECTIVES/GOALS FOR THIS CLIENT.
PC10	PLEASE DESCRIBE THE FAMILY SITUATION/DYNAMICS. EXPLAIN HOW THE FAMILY WILL BE INCORPORATED INTO THE CLIENTS PLAN OF CARE.
PC12	PLEASE EXPLAIN IF YOUR SERVICE ENCOURAGES THE CLIENT TO ATTEND SELF-HELP GROUPS.
PC13	PLEASE SUPPLY A SPECIFIC SCHEDULE OF ACTIVITIES, INCLUDING DAY, TIME OF DAY, LENGTH OF SESSION, AND SERVICE TO BE RENDERED DURING THAT TIME.
PC15	PLEASE FURNISH DIAGNOSTIC RATIONALE.
PC17	PLEASE DOCUMENT IF THE CLIENT EVER RECEIVED SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT.
PC19	PLEASE FURNISH MORE EXTENSIVE AND IN-DEPTH HISTORICAL AND PSYCHOSOCIAL DATA.
PC20	PLEASE SUPPLY THE DATE THE CLIENT BECAME TOTALLY ENDENTULOUS.
PC23	PLEASE SUBMIT A PHYSICIANS STATEMENT REGARDING THE MEDICAL NECESSITY OF DENTURES FOR THIS CLIENT. THE PHYSICIANS STATEMENT MUST DOCUMENT THE MEDICAL NEED FOR DENTURES.
PC24	THE SERVICE REQUESTED WAS PREVIOUSLY AUTHORIZED. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT INDICATING THIS FACT IS REQUIRED.
PC25	PLEASE SUPPLY SUFFICIENT MITIGATING CIRCUMSTANCES TO WARRANT THE CONSTRUCTION OF NEW DENTURES(S).
PC26	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
PC28	PLEASE SUBMIT A PHYSICIANS STATEMENT INDICATING DENTURES ARE NECESSARY FOR THIS NURSING HOME CLIENT.
PC29	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING LOSS OR DESTRUCTION OF DENTURE(S). INCLUDE SIGNED STATEMENT FROM CLIENT OR FACILITY DIRECTOR REGARDING HOW, WHEN AND WHERE LOST.

Denial Code	Long Description
PC30	PLEASE PROVIDE COMPLETE INTRAORAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PC31	PLEASE DESCRIBE ANY RELATED DEFORMITIES OF THE FEET.
PC34	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD WITH REQUESTED DME ITEM(S) AND DOCUMENT IF THE CLIENT CAN USE SAFELY AND INDEPENDENTLY.
PC35	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD AND DESCRIBE THE RESULTS AND EFFECTIVENESS OF THE SERVICE REQUESTED.
PC39	PLEASE INDICATE LITER FLOW PER MINUTE, HOURS OF USE PER 24 HOUR PERIOD, AND THE EXPECTED DURATION OF NEED.
PC40	THE ITEM DOES NOT REQUIRE PRIOR AUTHORIZATION UNTIL THE LIFE EXPECTANCY HAS BEEN REACHED.
PC41	PLEASE SUPPLY INFORMATION INDICATING THE NECESSITY OF POSITIONING THE CLIENT'S BODY IN MULTIPLE POSITIONS.
PC42	PLEASE INDICATE IF THE BED HEIGHT MUST BE CHANGED TO ALLOW FOR SAFE TRANSFER OR ADEQUATE BED CARE.
PC43	SUPPLY A PHYSICIANS STATEMENT INDICATING TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR UNIT HAS REDUCED PAIN, IMPROVED/INCREASED THE CLIENTS ACTIVITY LEVEL, AND/OR REDUCED CLIENTS USE OF PAIN MEDICATION.
PC44	A CURRENT AUTHORIZATION FOR THIS SERVICE IS ON FILE FOR ANOTHER PROVIDER. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT OF THAT FACT IS REQUIRED BY THE CLIENT OF FIRST PROVIDER.
PC59	DOCUMENT DECLINE OR PROGRESS IN SPECIFIC, MEASURABLE, OBJECTIVE TERMS.
PC60	DOCUMENT IF CLIENT HAS DEMONSTRATED A GOOD APPOINTMENT COMPLIANCE RECORD.
PC61	THE PHYSICIANS SIGNATURE DATE MUST NOT EXCEED 90 DAYS FROM THE DATE OF RECEIPT BY COLORADO MEDICAID.
PC62	REQUESTS FOR A CONTINUATION OF THERAPY SHOULD NOT BE SUBMITTED MORE THAN FOUR WEEKS PRIOR TO THE EXPIRATION DATE OF THE CURRENT AUTHORIZATION.
PC63	PLEASE FURNISH THE STYLE AND MANUFACTURER OF THE FRAME.
PC64	PLEASE FURNISH THE CLIENTS LENS FORMULA.
PC66	ALL REQUESTS FOR TINTS REQUIRE DOCUMENTATION OF THE VISUAL OR MEDICAL CONDITION RELATED TO PHOTOPHOBIA.
PC67	PLEASE DOCUMENT THE REASON AND JUSTIFICATION FOR REPLACEMENT BEYOND THE FIRST LENS/FRAME.
PC68	DOCUMENT IF ALL REMAINING MAXILLARY AND/OR MANDIBULAR TEETH ARE DECAY-FREE, PROPERLY RESTORED, AND PERIODONTICALLY SOUND.
PC72	SUPPLY MORE DETAIL REGARDING PROGRESS (ATTACHMENT OF GOALS, ETC.). CORRELATE PROGRESS TO PREVIOUS GOALS AND IDENTIFIED LIMITATIONS.
PC77	PLEASE SUBMIT A PLAN OF CARE DESCRIBING THE SERVICES THAT WOULD BE PROVIDED.
PC78	PLEASE DOCUMENT SPECIFIC, MEASURABLE GOALS.
PC82	THE PRIOR AUTHORIZATION (PA) SYSTEM CAN PROCESS ONLY 26 DETAILS PER PA REQUEST. PLEASE RESUBMIT YOUR REQUEST WITH NO MORE THAN 26 DETAILS.
PC83	PLEASE SUPPLY A PHYSICIANS PRESCRIPTION DATED WITHIN ONE MONTH OF REQUESTED SUBSTANCE ABUSE DAY TREATMENT.
PC84	PLEASE PROVIDE INFORMATION INDICATING THIS CLIENT IS APPROPRIATELY DETOXIFIED FROM ALCOHOL AND/OR OTHER DRUGS.
PC85	PLEASE PROVIDE INFORMATION TO INDICATE THE CLIENTS ABILITY TO ABSTAIN FROM ALCOHOL OR DRUGS WHILE IN THE SUBSTANCE ABUSE DAY TREATMENT PROGRAM.
PC86	PLEASE INDICATE IF THIS CLIENT IS WILLING TO PARTICIPATE IN AFTERCARE OR CONTINUING CARE SERVICES.
PC87	PROVIDE MORE INFORMATION ON TREATMENT HISTORY; INCLUDE SERVICE PROVIDED, DATES, AND OUTCOME. PROVIDE DETAIL OF PREVIOUS TREATMENT.
PC88	PLEASE PROVIDE MORE RATIONALE FOR THE APPROPRIATENESS AND MEDICAL NECESSITY OF SUBSTANCE ABUSE DAY TREATMENT.
PC89	PROVIDE A TREATMENT PLAN THAT CONTAINS MEASURABLE GOALS AND OBJECTIVES CORRESPONDING TO THE IDENTIFIED DEFICIT.
PC91	PLEASE PROVIDE MORE INFORMATION ON FAMILY INVOLVEMENT TREATMENT.

Denial Code	Long Description
PC92	PLEASE PROVIDE MORE HISTORY AND EXPLANATION ABOUT THE ISSUE OF ABSTINENCE FOR THIS CLIENT.
PC94	PLEASE PROVIDE THE ANTICIPATED BEGINNING DATE AND/OR THE ESTIMATED SUBSTANCE ABUSE DAY TREATMENT DISCHARGE DATE.
PC95	PLEASE SUPPLY JUSTIFICATION FOR BEGINNING CLIENT IN SERVICE PRIOR TO AUTHORIZATION BEING OBTAINED.
PC96	THE INITIAL THREE HOURS OF SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IN A CALENDAR YEAR DO NOT REQUIRE PRIOR AUTHORIZATION.
PC97	REIMBURSEMENT FOR INITIAL SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IS LIMITED TO THREE HOURS IN A CALENDAR YEAR AND DOES NOT REQUIRE PRIOR AUTHORIZATION.
PC98	THIS DRUG IS CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE BILL USING THE APPROPRIATE NATIONAL DRUG CODE (NDC) OR SUBMIT A COMPLETED DRUG ADDITION REQUEST FORM IF THE NDC IS NOT LISTED IN THE DRUG INDEX.
PC99	THIS DRUG IS NOT CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL, CURRENT ADMINISTRATIVE RULE, OR COLORADO DRUG INDEX FOR COVERAGE LIMITATIONS.
PD01	DOCUMENT THAT CLIENT HAS ACHIEVED GOOD ORAL HYGIENE, PERIODONTAL CASE TYPE 1 OR 2, AND IS MOTIVATED TO MAINTAIN SAME.
PD03	PLEASE PROVIDE AN ARTERIAL BLOOD GAS READING OR PULSE OXIMETRY RESULTS DONE ON ROOM AIR SIGNED AND DATED BY A MEDICAL DOCTOR. THIS SHOULD BE DONE WITHIN 60 DAYS OF REQUESTED SERVICE.
PD04	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 30 DAYS OF RECEIPT BY COLORADO MEDICAID.
PD07	SUBMIT A PHOTOCOPY OF A VALID PRESCRIPTION, ISSUED WITHIN THE PAST YEAR, OR COMPLETE SECTION B OF THE PRIOR AUTHORIZATION/DRUG ATTACHMENT (PA/DGA), F-11049.
PD10	BRAND MEDICALLY NECESSARY MUST BE IN THE PRESCRIBERS OWN HANDWRITING AND WRITTEN DIRECTLY ON THE PRESCRIPTION OR A SEPARATE ORDER ATTACHED TO THE ORIGINAL PRESCRIPTION.
PD12	COMPLETE DENTURES, PARTIAL DENTURES, DENTURE RELINES, AND FIXED PROSTHODONTIC SERVICES ARE NOT COVERED SERVICES FOR ADULTS FOR DATES OF SERVICE ON AND AFTER OCTOBER 1, 1995.
PD22	PLEASE COMPLETE ALL REQUIRED ELEMENTS ON THE PERSONAL CARE SCREENING TOOL (PCST), F-11133.
PD24	THIS PRIOR AUTHORIZATION REQUEST IS UNABLE TO BE PROCESSED. PLEASE RESUBMIT WITH ADDITIONAL REQUIRED FORMS, INCLUDING THE ENTIRE PERSONAL CARE SCREENING TOOL (PCST), F-11133; PERSONAL CARE ADDENDUM, F-11136; AND SUPPORTING DOCUMENTATION, AS DIRECTED.
PD25	THERE IS A PERSONAL CARE SCREENING TOOL (PCST), F-11133, COMPLETED BY ANOTHER AGENCY. CONTACT THE AGENCY TO TRANSFER SCREEN.
PD26	THERE IS A LIMITED TERM CARE FUNCTIONAL SCREEN (LTC-FS) COMPLETED BY ANOTHER AGENCY. THE PERSONAL CARE SCREENING TOOL (PCST), F-11133, INFORMATION IS IN CONFLICT WITH LTC-FS.
PD27	ONLY ONE LEVEL OF FUNCTION MAY BE SELECTED FOR ALL ELEMENTS EXCEPT TOILETING. COLORADO MEDICAID IS UNABLE TO PROCESS THE PRIOR AUTHORIZATION REQUEST.
PD28	NO UNITS MAY BE REQUESTED USING THIS PRIOR AUTHORIZATION PROCESS. PLEASE SUBMIT WITH THE APPROPRIATE ATTACHMENTS FOR REQUESTING SPECIFIC PERSONAL CARE WORKER UNITS.
PD29	CLIENT IS NOT ELIGIBLE FOR THE REQUESTED SERVICE(S) AS OF THE REQUESTED START DATE.
PD30	NO TRAVEL TIME MAY BE AUTHORIZED WHEN NO PERSONAL CARE WORKER SERVICE IS AUTHORIZED.
PD32	PROVIDER NOT CERTIFIED TO RENDER THE SERVICE(S) REQUESTED.
PD34	BASED ON THE DOCUMENTATION SUBMITTED, THIS REQUEST CAN NOT BE PRIOR AUTHORIZED. REFER TO THE PA MESSAGES FROM THE CONSULTANT FOR COMPLETE EXPLANATION.
PD98	PLEASE DOCUMENT HOW AND WHEN EACH PREVIOUSLY AUTHORIZED PRO RE NATA VISIT WAS USED.

Elderly, Blind, Disabled (EBD)

Denial Code	Long Description
0201	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.

Denial Code	Long Description
0233	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0235	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0237	CLIENT IDENTIFICATION NUMBER DOES NOT MATCH CLIENTS FIRST NAME.
0238	THE CLIENT IDENTIFICATION NUMBER DOES NOT MATCH THE CLIENTS LAST NAME.
0242	SECONDARY DIAGNOSIS CODE IS INVALID.
0248	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0249	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0251	PROCEDURE CODE MODIFIER IN FIRST POSITION IS INVALID.
0252	THE PROCEDURE CODE MODIFIER IN SECOND POSITION IS INVALID FOR REQUESTED START DATE OR DATE OF RECEIPT.
0253	THE PROCEDURE CODE MODIFIER IN THIRD POSITION IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
0258	THE PRIMARY DIAGNOSIS CODE IS REQUIRED.
0272	THE PRIMARY DIAGNSOSIS CODE IS INVALID.
0400	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0853	HCPCS - ANNUAL UPDATE
0885	NEVER EVENTS MODIFIERS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
0886	NEVER EVENTS DIAGNOSIS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
1000	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
1002	RENDERING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1003	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1007	RENDERING PROVIDER ID IS NOT ON FILE.
1047	THE RENDERING PROVIDERS CERTIFICATION HAS BEEN CANCELLED.
1048	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1801	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
1804	A CERTIFIED SUBSTANCE ABUSE DAY TREATMENT PROVIDER MUST SUBMIT A SUBSTANCE ABUSE DAY TREATMENT PROCEDURE CODE.
1806	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
1808	THE BILLING PROVIDER DOES NOT HAVE THE REQUIRED CERTIFICATION ADDENDUM ON FILE.
1900	THE BILLING PROVIDERS TAXONOMY CODE IS INVALID.
1901	THE RENDERING PROVIDERS TAXONOMY CODE IS INVALID.
1927	A NATIONAL PROVIDER IDENTIFIER IS REQUIRED FOR THE BILLING PROVIDER.
1934	A NATIONAL PROVIDER INDENTIFIER IS REQUIRED FOR THE RENDERING PROVIDER.
1936	THE BILLING PROVIDER NUMBER IS INVALID.
1937	THE RENDERING PROVIDER NUMBER IS INVALID.
1960	INTERNAL PROCESSING IS REQUIRED.
1963	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.
1964	THE BILLING PROVIDER INDICATED IS NOT ALLOWABLE AS A BILLING PROVIDER.
1965	RENDERING PROVIDER NUMBER IS MISSING/INVALID FOR THIS PROCEDURE PROVIDER.
1974	PRESCRIBING/REFERRING/ORDERING PROVIDER INDICATED IS NOT CERTIFIED AS A PRESCRIBING/REFERRING/ORDERING PROVIDER.
1975	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
1976	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
2001	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2003	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2017	THE CLIENT IS ENROLLED IN A MEDICAID OR OTHER MANAGED CARE PROGRAM.
2037	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2603	CLIENT LOCKED-IN TO A PROVIDER OR ENROLLED IN A HOSPICE. CONTACT CLIENTS HOSPICE FOR PAYMENT OF SERVICES OR RESUBMIT WITH DOCUMENTATION OF UNRELATED NATURE OF CARE.

Denial Code	Long Description
3324	THE MODIFIER HAS BEEN DISCONTINUED BY THE CENTERS OF MEDICARE AND MEDICAID SERVICES OR THE AMERICAN MEDICAL ASSOCIATION FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
3337	THE PROCEDURE CODE HAS BEEN TERMINATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AMERICAN MEDICAL ASSOCIATION, OR AMERICAN DENTAL ASSOCIATION FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT. RESUBMIT WITH VALID A PROCEDURE CODE.
3339	THE PROCEDURE BILLED IS NOT PAYABLE ACCORDING TO DEFICIT REDUCTION ACT (DEFRA) GUIDELINES.
3351	THE PROCEDURE IS NOT COVERED FOR CLIENTS WITH A NURSING HOME AUTHORIZATION ON THE REQUESTED START DATE OR DATE OF RECEIPT.
3353	THE PROCEDURE IS NOT A COVERED SERVICE FOR HOME AND COMMUNITY-BASED WAIVER CLIENTS.
4021	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4027	THE DIAGNOSIS CODE IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
4031	THE PROCEDURE SUBMITTED IS NOT APPROPRIATE FOR CLIENTS GENDER.
4032	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4034	THE PROCEDURE CODE HAS AN AGE RESTRICTION.
4036	THE PLACE OF SERVICE CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4040	THE PRIMARY DIAGNOSIS CODE IS NOT ON FILE.
4041	THE SECONDARY DIAGNOSIS IS NOT ON FILE.
4046	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4127	INTERNAL PROCESSING IS REQUIRED.
4131	INTERNAL PROCESSING IS REQUIRED.
4141	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4149	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4150	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4236	ETIOLOGY DIAGNOSIS CODE(S) (E-CODES) ARE INVALID AS THE PRIMARY DIAGNOSIS.
4244	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4245	THE FOURTH POSITION MODIFIER IS INVALID FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT.
4256	THE PROCEDURE CODE AND MODIFIER COMBINATION IS NOT PAYABLE FOR THE CLIENTS BENEFIT PLAN.
4257	THE MODIFIERS SUBMITTED ARE EITHER INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT OR THE MODIFIERS ARE MISSING.
4311	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4315	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4316	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4371	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4372	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4711	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR CLIENTS AGE.
4714	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS AGE.
4731	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS DIAGNOSIS.
4742	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4743	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4744	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4745	DIAGNOSIS AND/OR PROCEDURE AND/OR PLACE OF SERVICE (POS) CODE IS NOT COVERED FOR EXPRESS ENROLLMENT CLIENTS.
4746	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4801	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4802	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
4821	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
4871	PLEASE REFER TO PA MESSAGES FOR RETURN INFORMATION.
4963	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS GENDER.
4990	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
7500	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.

Denial Code	Long Description
7509	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
P001	THE BILLING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THE SERVICES.
P002	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P003	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P005	THE PRIOR AUTHORIZATION CAN NOT BE END DATED. THE PRIOR AUTHORIZATION STATUS IS NOT APPROVED OR APPROVED WITH REVISIONS.
P006	PLEASE FURNISH THE PROCEDURE CODE AND CORRESPONDING DESCRIPTION.
P008	THE BILLING PROVIDER NUMBER IS INVALID.
P009	THE BILLING PROVIDER NUMBER IS INVALID.
P010	THE REQUESTED END DATE IS INVALID.
P011	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P012	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P013	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P014	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P015	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P016	THE REQUESTED START DATE IS MISSING OR INVALID.
P019	THE REQUESTED START DATE IS MISSING OR INVALID.
P020	THE RENDERING PROVIDER NUMBER IS INVALID.
P021	THE RENDERING PROVIDER NUMBER IS INVALID.
P022	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P023	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P024	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P026	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P027	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P030	FIRST MODIFIER IS INVALID.
P031	FIRST MODIFIER IS INVALID.
P032	SECOND MODIFIER IS INVALID.
P033	SECOND MODIFIER IS INVALID.
P034	THIRD MODIFIER IS INVALID.
P035	THIRD MODIFIER IS INVALID.
P036	FOURTH MODIFIER IS INVALID.
P037	FOURTH MODIFIER IS INVALID.
P038	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P039	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P040	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P041	CLIENTS FIRST NAME IS MISSING.
P042	CLIENTS LAST NAME IS MISSING.
P043	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P044	BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES REQUESTED.
P045	FIRST MODIFIER IS INVALID.
P046	SECOND MODIFIER IS INVALID.
P047	THIRD MODIFIER IS INVALID.
P048	FOURTH MODIFIER IS INVALID.
P052	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P053	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.

Denial Code	Long Description
P054	RENDERING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES FOR THE BENEFIT PLAN.
P055	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P061	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P062	THE CLIENT ID AND/OR NAME INDICATED ON THE PA REQUEST IS INCORRECT. THE CLIENT ID AND/OR NAME HAS BEEN UPDATED. PLEASE VERIFY THE ID AND/OR NAME IS CORRECT.
P064	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
P067	THE FREQUENCY OF HOURS REQUESTED ARE NOT APPROPRIATE FOR THIS CLIENT AND HAVE BEEN MODIFIED ACCORDINGLY.
P079	BILLING PROVIDER IS ON PAYMENT SUSPENSION DUE TO CREDIBLE ALLEGATION OF FRAUD.
P120	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAS BEEN REDUCED.
P121	THE SERVICE/ PROCEDURE REQUESTED IS NOT SUPPORTED BY SUBMITTED DOCUMENTATION.
P126	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
P128	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.
P138	SERVICE(S) DO NOT MEET COLORADO MEDICAID GUIDELINES.
P167	REQUESTED DOCUMENTATION HAS NOT BEEN SUBMITTED.
P178	THE SERVICE REQUESTED IS NOT MEDICALLY NECESSARY.
P179	THE MEDICAL NECESSITY FOR THIS SERVICE IS NOT SUPPORTED BY THE SUBMITTED DOCUMENTATION.
P233	THE DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE ADDITIONAL CARE.
P257	THIS CLIENTS FUNCTIONAL ASSESSMENT SCORES PLACE THIS CLIENT OUTSIDE ELIGIBILITY FOR DAY TREATMENT.
P274	OUR RECORDS INDICATE THIS CLIENT IS INVOLVED IN EFFECTIVE AND APPROPRIATE SERVICE ELSEWHERE.
P292	INTENSIVE REHABILITATION HOURS ARE NO LONGER APPROPRIATE AS INDICATED BY HISTORY, DIAGNOSIS, AND/ OR FUNCTIONAL ASSESSMENT SCORES.
P328	THE SERVICES REQUESTED INCLUDE NON-COVERED SERVICES, AND HOURS ARE REDUCED ACCORDINGLY.
P339	THE CLIENTS PAST HISTORY INDICATES REDUCED TREATMENT HOURS ARE WARRANTED.
P342	THE REQUEST DOES NOT MEET GENERALLY ACCEPTED CONDITIONS REQUIRING FLUORIDE TREATMENTS.
P346	SERVICES EXCEED COLORADO MEDICAID LIMITATION AND DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE MEDICAL NECESSITY OF THE SERVICE.
P349	THE SERVICE REQUESTED WAS PERFORMED LESS THAN FIVE YEARS AGO.
P353	THE EXISTING APPLIANCE HAS NOT BEEN WORN FOR THREE YEARS.
P367	THE CLIENT HAS BEEN TOTALLY WITHOUT TEETH AND AN APPLIANCE FOR FIVE YEARS.
P392	THE CLIENT IS MISSING AN ANTERIOR TOOTH AND/OR HAS TWO OR MORE POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P405	THE SERVICE(S) REQUESTED COULD ADEQUATELY BE PERFORMED IN THE DENTAL OFFICE.
P406	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE OF GOOD PERIODONTAL HEALTH (AMERICAN ACADEMY OF PERIODONTOLOGY PERIODONTAL CLASSIFICATION OF TYPE I OR II).
P407	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE VISIBLE ON RADIOGRAPHS THAT AT LEAST 50 PERCENT OF THE CLINICAL CROWN IS INTACT.
P409	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING SIX OR MORE TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED, INCLUDING THIRD MOLARS.
P410	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING ONE OR MORE ANTERIOR TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED.
P411	DOCUMENTATION DOES NOT SUPPORT THE NEED FOR PERIODONTIC SERVICES. POCKETS ARE LESS THAN 4MM AND/OR GREATER THAN 6MM FOR CLIENT AND/OR THE CLIENT IS UNDER THE AGE OF 13.
P412	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA.
P413	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA. THIS PA HAS BEEN GRANTED AS APPROVED NOT APPROVED WITH REVISIONS. THE DURATION REQUESTED MAY HAVE BEEN REDUCED TO REFLECT COVERAGE LIMITATIONS, PRESCRIBER ORDERS, CONFLICTI
P417	THE SERVICE(S) REQUESTED COULD BE ADEQUATELY PERFORMED WITH LOCAL ANESTHESIA.
P437	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO POOR ORAL HYGIENE.

Denial Code	Long Description
P444	THIS LINE ITEM IS A DUPLICATE OF ANOTHER LINE ITEM ON THIS PRIOR AUTHORIZATION (PA) REQUEST. PLEASE CORRECT.
P446	THIS IS A DUPLICATE OF AN EXISTING PRIOR AUTHORIZATION (PA) REQUEST. YOU MAY CONTACT PROVIDER SERVICES IF YOU REQUIRE ASSISTANCE. DUPLICATE PA REQUEST
P448	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO DECAY HISTORY.
P449	QUESTIONABLE LONG TERM PROGNOSIS DUE TO GUM AND BONE DISEASE.
P456	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO APPARENT ROOT INFECTION.
P457	OUR RECORDS INDICATE THIS CLIENT HAS EXCEEDED ESTABLISHED PROGRAM LIMITATIONS. COLORADO MEDICAID WILL NOT AUTHORIZE NEW DENTURES.
P458	DOCUMENTATION PROVIDED INDICATES A LESS ELABORATE PROCEDURE SHOULD BE CONSIDERED.
P502	RENTAL ONLY ALLOWED; MEDICAL NEED FOR PURCHASE HAS NOT BEEN DOCUMENTED.
P503	PURCHASE ONLY ALLOWED; MEDICAL NEED FOR RENTAL HAS NOT BEEN DOCUMENTED.
P504	OCCUPATIONAL THERAPY GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P505	THE SERVICE REQUESTED IS INCLUDED IN THE NURSING HOME RATE STRUCTURE.
P511	THIS NATIONAL DRUG CODE IS ONLY BILLABLE AS PART OF A COMPOUND DRUG.
P515	THE PRESENCE OF A HANDICAPPING MALOCCLUSION OR HANDICAPPING DENTOFACIAL DEFORMITY IS NOT SUPPORTED BY THE DOCUMENTATION SUBMITTED.
P521	THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVERED BY COLORADO MEDICAID.
P522	GASTRO-INTESTINAL SURGERY FOR THE PURPOSE OF WEIGHT CONTROL IS COVERED ONLY AS A LIFE THREATENING PROCEDURE.
P523	THE TREATMENT REQUEST IS NOT CONSISTENT WITH THE CLIENT'S DIAGNOSIS.
P524	PSYCHOTHERAPY PROVIDED IN THE CLIENTS HOME IS NOT A COVERED BENEFIT OF COLORADO MEDICAID.
P525	THE INFORMATION PROVIDED IS NOT CONSISTENT WITH THE INTENSITY OF SERVICES REQUESTED.
P526	INTENSIVE MULTIPLE MODALITY TREATMENT IS NOT CONSISTENT WITH THE INFORMATION PROVIDED.
P527	MULTIPLE PROVIDERS OF TREATMENT ARE NOT INDICATED FOR THIS CLIENT.
P528	THE DURATION OF TREATMENT SESSIONS EXCEED CURRENT COLORADO MEDICAID GUIDELINES.
P534	DOCUMENTATION OF POOR PHYSICAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P535	OTHER PHYSICAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P536	THE PHYSICAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P537	USE OF PHYSICAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P538	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF A PHYSICAL THERAPIST.
P539	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS AND LIVING ARRANGEMENT.
P540	GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P541	THE PROCEDURE(S) REQUESTED ARE NOT MEDICAL IN NATURE.
P542	DOCUMENTATION OF POOR OCCUPATIONAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P543	DOCUMENTATION OF POOR SPEECH THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P544	OTHER OCCUPATIONAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P546	THE OCCUPATIONAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P547	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF PHYSICAL THERAPY.
P548	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.

Denial Code	Long Description
P549	ACTIVITIES TO PROMOTE DIVERSION OR GENERAL MOTIVATION ARE NONCOVERED COLORADO MEDICAID SERVICES.
P550	REVISIONS OF THE REQUEST IS NECESSITATED BY THE CLIENTS MINIMAL PROGRESS.
P551	RESTORATIVE NURSING INVOLVEMENT COULD BE INCREASED.
P552	CLIENTS DEMONSTRATED RESPONSE TO CURRENT THERAPY DOES NOT WARRANT THE INTENSE FREQUENCY REQUESTED.
P553	MAINTENANCE IS TWO TIMES PER WEEK OR LESS.
P554	THE SPEECH THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P555	USE OF OCCUPATIONAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P556	USE OF SPEECH THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P557	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF AN OCCUPATIONAL THERAPIST.
P558	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
P559	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P560	THE MATERIALS/ SERVICES REQUESTED ARE PRINCIPALLY COSMETIC IN NATURE.
P561	THE LENS FORMULA DOES NOT JUSTIFY REPLACEMENT.
P562	THE CHANGE IN THE LENS FORMULA DOES NOT WARRANT MULTIPLE REPLACEMENTS.
P563	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P564	LENSES ONLY ARE APPROVED; PLEASE DISPENSE A CONTRACTED FRAME. THE NON-CONTRACTED FRAME IS NOT MEDICALLY JUSTIFIED.
P565	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P566	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P567	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF OCCUPATIONAL THERAPY.
P568	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF SPEECH THERAPY.
P569	LEVEL, INTENSITY, OR EXTENT OF SERVICE(S) REQUESTED HAS BEEN MODIFIED CONSISTENT WITH MEDICAL NEED AS DEFINED IN THE PLAN OF CARE.
P570	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P571	THE SERVICE ASKED FOR IS NOT COVERED BY COLORADO MEDICAID AS THESE TASKS CAN BE DONE BY NURSES OR ACTIVITY STAFF.
P572	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P573	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.
P574	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P575	MEDICAL NEED FOR EQUIPMENT/ SUPPLY REQUESTED IS NOT SUPPORTED BY DOCUMENTATION SUBMITTED.
P576	OTHER SPEECH THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P577	DOCUMENTATION SUBMITTED IDENTIFIES THAT THE CLIENT HAS FEWER THAN TWO POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P582	LESS EXPENSIVE ALTERNATIVE SERVICES ARE AVAILABLE FOR THIS CLIENT.
P634	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P711	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING PERIODONTAL SCALING AND ROOT PLANNING.
P712	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING GINGIVECTOMY.
P754	AN APPROVED SUBSTANCE ABUSE DAY TREATMENT PROGRAM CANNOT EXCEED A SIX WEEK PERIOD.
P761	THE CLIENT DOES NOT APPEAR TO BE ABLE OR WILLING TO ABSTAIN FROM ALCOHOL/DRUG USAGE WHILE IN TREATMENT. THEREFORE, SUBSTANCE ABUSE DAY TREATMENT SERVICES ARE NOT APPROVED.
P764	THIS CLIENT HAS COMPLETED INTENSIVE SUBSTANCE ABUSE TREATMENT WITHIN THE PAST 12 MONTHS. THE DOCUMENTATION PROVIDED IS NOT ADEQUATE TO JUSTIFY ADDITIONAL INTENSIVE TREATMENT AT THIS TIME.

Denial Code	Long Description
P785	A LESS THAN SIX-WEEK HEALING PERIOD HAS BEEN SPECIFIED FOR THIS PRIOR AUTHORIZATION. THEREFORE IT IS NOT NECESSARY TO WAIT THE FULL SIX WEEKS AFTER EXTRACTIONS BEFORE TAKING DENTURE IMPRESSIONS.
P818	SIX-WEEK HEALING TIME IS REQUIRED BETWEEN EDENTULATION AND FINAL IMPRESSIONS. PAYMENT FOR DENTURES WILL BE DENIED OR RECOUPED IF HEALING PERIOD IS NOT OBSERVED.
P849	COLORADO MEDICAID HAS DETERMINED THERE WERE (ARE) SEVERAL HOME HEALTH AGENCIES WILLING TO PROVIDE MEDICALLY NECESSARY SKILLED NURSING SERVICES TO THIS CLIENT.
P864	THE DOCUMENTATION YOU HAVE SUBMITTED DOES NOT MEET THE REQUIREMENTS OF COLORADO MEDICAID.
P873	THE MEDICAL NECESSITY FOR THE HOURS REQUESTED IS NOT SUPPORTED BY THE INFORMATION SUBMITTED.
P874	THE DOCUMENTATION SUBMITTED INDICATES THE TASKS SPECIFIED CAN BE COMPLETED DURING THE VISITS APPROVED.
P878	THE DOCUMENTATION SUBMITTED DOES NOT INDICATE THAT MEDICALLY ORIENTED TASKS ARE MEDICALLY NECESSARY; THEREFORE PERSONAL CARE SERVICES HAVE BEEN APPROVED.
P880	THE QUANTITY OF SERVICES AUTHORIZED FOR THIS CLIENTS PERSONAL CARE HAS BEEN AMENDED BASED ON INFORMATION RECEIVED FROM ONE OR MORE OF THESE SOURCES: THE CLIENT, THEIR PHYSICIAN, AND/OR THE IN-HOME VISIT BY STAFF OF THE OIG (OFFICE OF INSPECTOR GENERAL).
P885	THE USE OF THIS DRUG FOR THE INTENDED PURPOSE IS NOT COVERED BY COLORADO MEDICAID, CONSISTENT WITH COLORADO ADMINISTRATIVE CODE AND FEDERAL LAW.
P924	THE MEDICAL RECORDS SUBMITTED WITH THE CURRENT REQUEST CONFLICT OR DISAGREE WITH OUR MEDICAL RECORDS ON THIS CLIENT.
P950	INDEPENDENT NURSES, PLEASE NOTE PAYABLE SERVICES MAY NOT EXCEED 12 HOURS/DAY OR 60 HOURS/WEEK.
P951	SERVICES CAN ONLY BE AUTHORIZED THROUGH ONE YEAR FROM THE PRESCRIPTION DATE.
P952	LEAD INSPECTION IS A COVERED COLORADO MEDICAID SERVICE WHEN THE CHILD HAS BEEN SHOWN TO HAVE LEAD POISONING (E.G., CHILD HAS A BLOOD LEAD LEVEL > 19 UG/DL OR TWO CONSECUTIVE BLOOD LEAD LEVELS OF 15-19 UG/DL DONE AT LEAST 90 DAYS APART). THE INSPECTION MUS
P953	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P954	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P956	THE REQUEST CAN ONLY BE BACKDATED A MAXIMUM OF 14 DAYS FROM FIRST DATE RECEIVED BY COLORADO MEDICAID.
P957	COMPLETE PERIODONTAL CHARTING AT TIME OF SERVICE, AND SUBMIT CHARTING, COPY OF OPERATIVE REPORT, TOGETHER WITH A COPY OF THE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF), F-11035, TO PA UNIT ATTENTION DENTAL CONTSULTANT.
P958	NOTE THAT CODE D4341 HAS BEEN CHANGED. REFER TO THE DECISION NOTICE FOR AUTHORIZED QUANTITY.
P960	YOUR PA HAS BEEN APPROVED FOR 90 DAYS. THE 90 DAY APPROVAL DOES NOT IMPLY THE PA REQUEST MEETS PRIOR AUTHORIZATION CRITERIA. AFTER ADDITIONAL INFORMATION IS AVAILABLE IN INTERCHANGE, COLORADO MEDICAID WILL CREATE AN AMENDMENT REQUEST TO EXTEND THE PA FOR
P961	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P962	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
PA10	THE REQUESTED END DATE IS INVALID.
PA12	PLEASE FURNISH A WRITTEN DESCRIPTION OF THE CLIENTS DIAGNOSIS.
PA13	PROVIDE DIAGNOSES WITH DATES OF ONSET.
PA14	IDENTIFY PROBLEMS TO BE TREATED.
PA15	THE AUDIOLOGISTS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1), F-11020, AND PRIOR AUTHORIZATION REQUEST/HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2), F-11021.

Denial Code	Long Description
PA16	THE PHYSICIANS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION/PHYSICIAN OTOLOGICAL REPORT (PA/POR), F-11019.
PA17	SUBMIT BRIEF HISTORY WITH REFERRAL INFORMATION, LIVING SITUATION, FUNCTIONAL STATUS, AND OTHER PERTINENT INFORMATION. WHAT CHANGE OF STATUS RESULTED IN REFERRAL AT THIS TIME?
PA18	PLEASE FURNISH THE CLIENTS HEIGHT AND WEIGHT.
PA19	PLEASE SUBMIT CLINICAL INFORMATION SUFFICIENT TO VERIFY THE NEED FOR THE REQUESTED SERVICE(S).
PA20	PLEASE RESUBMIT WITH COMPLETE PERIODONTAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PA21	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL EDUCATIONAL PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA22	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL PROGRAM PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA23	REFER TO THE DURABLE MEDICAL EQUIPMENT INDEX FOR APPROPRIATE CODE AND DESCRIPTION. DO NOT USE AN "UNLISTED" CODE.
PA24	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUALIZED FAMILY SERVICE PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA25	INFORMATION ON THE REQUEST FORM IS ILLEGIBLE, AND THE REQUEST CANNOT BE PROCESSED.
PA26	RE-EVALUATE YOUR GOALS. EMPHASIS SHOULD BE ON FUNCTIONAL SELF-CARE. GOALS MUST BE RELATED TO FUNCTIONAL OUTCOME.
PA27	PLEASE CLARIFY THE NUMBER OF HOURS PER WEEK REQUESTED.
PA28	PLEASE CLARIFY THE NUMBER OF HOURS PER DAY REQUESTED.
PA29	PLEASE CLARIFY THE NUMBER OF VISITS PER DAY REQUESTED.
PA30	ATTACH SUPPORTIVE DOCUMENTATION; HOME EXERCISE PROGRAM AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA31	THE DIAGNOSIS CODE INDICATED ON THE REQUEST DOES NOT CORRESPOND TO THE DIAGNOSIS CODE DESCRIPTION.
PA32	PLEASE SUBMIT ADDITIONAL INFORMATION SUFFICIENT TO VERIFY APPROPRIATENESS AND NEED FOR TRANSPLANT.
PA33	PLEASE SUBMIT THE INITIAL AND PROGRESSIVE OBJECTIVE FINDINGS.
PA34	ATTACH SUPPORTIVE DOCUMENTATION, FACILITY PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA35	PLEASE SUBMIT THE CLIENTS ORIGINAL COMPLAINTS AND EXAMINATION FINDINGS.
PA36	ATTACH SUPPORTIVE DOCUMENTATION, IN-HOME AUTISM PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA37	PLEASE SUBMIT YOUR TREATMENT PLAN FOR THIS CLIENT.
PA38	ATTACH SUPPORTIVE DOCUMENTATION AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA39	INITIAL EVALUATIONS MUST BE PERFORMED BY AN OCCUPATIONAL THERAPIST REGISTERED (OTR), PER AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA) STANDARDS.
PA41	IDENTIFY THE PLACE OF SERVICE AND ITS EFFECT ON SUPPORTING THE DESIRED TREATMENT OUTCOME.
PA42	PLEASE INDICATE THE HOURS OF USE OF OXYGEN PER 24-HOUR PERIOD.
PA43	PROVIDE BASELINE DOCUMENTATION FOR THIS CLIENTS LIMITATIONS USING UNITS OF MEASUREMENT THAT ARE APPLIED CONSISTENTLY WHEN REPORTING STATUS.
PA44	IDENTIFY FUNCTIONAL LIMITATIONS AS THEY ARE RELATED TO IDENTIFIED CONDITIONS.
PA46	CORRELATE PLAN OF CARE TO REQUESTED PROCEDURE CODES.
PA47	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE FREQUENCY/DURATION REQUESTED.
PA48	PLEASE PROVIDE THE NAME AND CREDENTIALS OF THE RENDERING PROVIDER.
PA50	COLORADO MEDICAID RECORDS INDICATE THE CLIENT OWNS A WHEELCHAIR. DOCUMENT THE REASON AND NEED FOR REPLACEMENT AND COST TO REPAIR CURRENT WHEELCHAIR.
PA51	PLEASE DISTINGUISH PRIMARY AND SUPPORTIVE MODALITIES.
PA52	PLEASE SUBMIT A PROGRESS REPORT.

Denial Code	Long Description
PA53	MULTIPLE FAMILY CLIENTS TREATMENT BY THE SAME PROVIDER REQUIRES FURTHER INFORMATION DOCUMENTING COORDINATION OF TREATMENT PLAN.
PA54	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE MINUTES REQUESTED.
PA55	MEDICAL NECESSITY OF TREATMENT REQUIRES ADDITIONAL DOCUMENTATION.
PA56	GIVEN AGE, DIAGNOSES, CURRENT LEVEL OF FUNCTION, PAST RESPONSE TO TREATMENT, AND LIVING SITUATION, EXPAND ON POTENTIAL FOR SIGNIFICANT FUNCTIONAL PROGRESS WITHIN THE NEXT SIX MONTHS. EMPHASIZE WHY PROGRESS IS EXPECTED WITH SERVICES AT THIS TIME.
PA57	SUBMIT THE INITIAL FINDINGS. INCLUDE A COMPREHENSIVE EVALUATION.
PA58	SUBMIT PROGRESSIVE, OBJECTIVE FINDINGS. INCLUDE A PERTINENT RE-EVALUATION.
PA59	PLEASE SUPPLY INFORMATION REGARDING THE CLIENTS MEDICATION REQUIREMENTS, IF ANY.
PA60	PLEASE SPECIFY IF THE CLIENT IS IN AN EDUCATIONAL SETTING.
PA61	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA62	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
PA63	THE SKILLS OF A THERAPIST ARE PURPOSEFUL AND SKILLED INTERVENTIONS REQUIRED TO CONTINUALLY DESIGN, IMPLEMENT, REASSESS, MODIFY/GRADE, AND/OR DISCONTINUE A PLAN OF CARE IN A TIMELY MANNER, BASED ON THE COMPLEXITY OF THE CLIENTS MEDICAL CONDITION AND/OR CO
PA64	PLEASE SUBMIT A THERAPY PLAN OF CARE, INCLUDING A CURRENT, DATED EVALUATION.
PA65	A PLAN OF CARE SIGNED AND DATED BY THE PHYSICIAN IS REQUIRED.
PA66	THE SKILLS OF A THERAPIST ARE REQUIRED WHEN ONLY THE THERAPIST CAN SAFELY AND EFFECTIVELY DELIVER THE THERAPEUTIC PROCEDURES BECAUSE OF THEIR UNIQUE KNOWLEDGE, TRAINING, AND EXPERTISE. DESCRIBE THE REASON THAT SOMEONE OTHER THAN A THERAPIST CANNOT SAFELY
PA67	PLEASE SPECIFY IF THE CLIENTS WORK SITE DEMANDS GOOD BINAURAL HEARING.
PA68	DESCRIBE THE REASON, BASED ON THE CLIENTS COGNITIVE, PHYSICAL, COMMUNICATION, OR RESOURCE STATUS, THAT A HOME PROGRAM, EQUIPMENT, OR ENVIRONMENTAL ADAPTATIONS ALONE CANNOT MEET CLIENTS NEEDS.
PA69	PLEASE SPECIFY IF THE CLIENT HAS AN ACCOMPANYING DISABILITY THAT ADDS TO THE HEARING PROBLEM.
PA70	DISTINGUISH REQUESTED PROCEDURES AND GOALS FROM OTHER SERVICES THIS CLIENT RECEIVES. THEY MAY NOT BE DUPLICATIVE.
PA71	PLEASE INDICATE THE NUMBER OF DAYS REQUESTED.
PA73	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA74	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA75	PLEASE DOCUMENT CARRYOVER OF THE THERAPY PROGRAM TO NURSING.
PA76	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA79	PROVIDE EVIDENCE OF SIGNIFICANT FUNCTIONAL PROGRESS IN LAST SIX MONTHS.
PA84	THE GRANT DATE OF THIS REQUEST CANNOT BE PRIOR TO THE SIGNATURE DATE OF THE PRESCRIBING PHYSICIAN.
PA86	PROVIDE EVIDENCE OF SKILLS GAINED IN THERAPY CARRYING OVER TO OTHER SETTINGS WITHIN SIX MONTHS.
PA87	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE NUMBER OF SESSIONS REQUESTED.
PA88	THE REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL SCOPE OF PRACTICE.
PA89	PRIOR AUTHORIZATION IS NOT REQUIRED UNTIL LIMITATION OF SERVICE HAS BEEN REACHED.
PA91	PLEASE SUBMIT REQUIRED X-RAYS.
PA92	PLEASE PROVIDE AN EXPLANATION FOR THE MATERIAL SUBMITTED WITH THE REQUEST.
PA95	PLEASE DESCRIBE HOW THE PROVISION OF THIS SERVICE WOULD PREVENT INSTITUTIONALIZATION OF THE CLIENT.
PA96	COULD THE EXISTING DENTURE(S) BE RELINED OR REBASED? IF NOT, PLEASE EXPLAIN WHY NOT.
PA97	REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL STANDARDS OF PRACTICE.

Denial Code	Long Description
PA98	PLEASE INDICATE IF THE CLIENT IS CURRENTLY BEING TUBE FED.
PB02	PLEASE PROVIDE THE REQUIRED DATED SIGNATURES ON THE ATTACHMENTS.
PB03	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING THE LOSS/DESTRUCTION/THEFT OF THE HEARING AID.
PB04	DESCRIBE THE CLIENTS ABILITY TO STAND OR AMBULATE SUFFICIENTLY TO ACCOMPLISH SELF-CARE ACTIVITIES.
PB07	PLEASE SUBMIT AN ORTHODONTIC STUDY MODEL OR DIAGNOSTIC CASTS.
PB09	PLEASE PROVIDE A PHOTOGRAPH OF THE INVOLVED AREA(S).
PB10	PLEASE PROVIDE AN ESTIMATION (IN GRAMS) OF THE TOTAL AMOUNT OF TISSUE TO BE RESECTED.
PB11	PLEASE SUBMIT THE PLAN OF CARE FOR CO-TREATMENT.
PB12	FURNISH A DETAILED DESCRIPTION FOR THE PROCEDURE CODE REQUESTED.
PB13	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB15	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB18	PLEASE COMPLETE THE ATTACHED OUT-OF-STATE PROVIDER DATA SHEET, F-11001, AND RESUBMIT.
PB20	A SIGNED AND DATED PRESCRIPTION IS REQUIRED WITHIN THREE MONTHS OF RECEIPT BY COLORADO MEDICAID FOR INITIAL REQUESTS AND WITHIN 12 MONTHS OF RECEIPT BY COLORADO MEDICAID FOR SUBSEQUENT REQUESTS.
PB21	PLEASE COMPLETE THE APPROPRIATE PRIOR AUTHORIZATION ATTACHMENT. CONTACT PROVIDER SERVICES OR THE PRIOR AUTHORIZATION UNIT FOR ASSISTANCE.
PB23	PHYSICAL THERAPY ASSISTANT NOTES AND ALL FORMS SUBMITTED MUST BE COSIGNED BY A REGISTERED PHYSICAL THERAPIST.
PB31	ARE YOU REQUESTING A COMPLETE APPLIANCE, OR REPLACEMENT PARTS?
PB32	THE PROCEDURE CODE INDICATED ON THE REQUEST DOES NOT MATCH THE DESCRIPTION OF SERVICE; PLEASE CORRECT AND RESUBMIT.
PB35	THE SERVICE REQUESTED DOES NOT REQUIRE PRIOR AUTHORIZATION.
PB41	PLEASE FURNISH A CURRENT MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT, F-11090 (DATED WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID).
PB45	THE CERTIFICATION PERIOD ON THE PLAN OF CARE (POC) DOES NOT COVER THE REQUESTED GRANT/START DATE. PLEASE RESUBMIT YOUR REQUEST WITH A NEW POC.
PB49	A CERTIFIED OCCUPATIONAL THERAPY ASSISTANTS NOTES MUST BE COSIGNED BY AN OCCUPATIONAL THERAPIST REGISTERED.
PB51	ADDITIONAL INFORMATION IS REQUIRED ON PRIOR AUTHORIZATION TO ENABLE PRICING.
PB54	REQUESTED SERVICES DO NOT MATCH SERVICES ON THE PHYSICIANS ORDERS.
PB59	PLEASE PROVIDE AN INDIVIDUAL EDUCATIONAL PLAN (IEP), WHICH HAS BEEN SIGNED BY THE PROVIDER NO EARLIER THAN NINE MONTHS PRIOR TO RECEIPT AT COLORADO MEDICAID; OTHERWISE, DOCUMENT WHY NO IEP EXISTS.
PB65	PLEASE FURNISH THE ANTICIPATED TOTAL CHARGES FOR THIS REQUEST.
PB66	A PHOTOCOPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED; THE DATE MUST BE WITHIN SIX MONTHS OF RECEIPT BY COLORADO MEDICAID.
PB67	THE PRESCRIPTION DATE MUST INCLUDE MONTH, DAY, AND YEAR.
PB68	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID.
PB73	THE SERVICES IDENTIFIED ON THE PLAN OF CARE DO NOT APPEAR APPROPRIATE FOR THE PROCEDURE CODE(S) REQUESTED ON THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018.
PB74	THE CLIENT/PROVIDER DOES NOT HAVE RETROACTIVE ENROLLMENT.
PB75	THE REQUESTED START DATE IS MORE THAN 14 DAYS BEFORE OR 62 DAYS AFTER RECEIPT.
PB82	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
PB83	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A HOME HEALTH AIDE. PLEASE RESUBMIT AS A PERSONAL CARE WORKER OR PROVIDE ADDITIONAL DOCUMENTATION.
PB86	THE SERVICES REQUESTED ARE NOT BEING PROVIDED IN THE CLIENTS RESIDENCE. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL.
PB87	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A NURSE. PLEASE RESUBMIT AS A HOME HEALTH AIDE OR PROVIDE ADDITIONAL DOCUMENTATION.
PB92	PLEASE FURNISH THE CLIENTS COMPLETE ADDRESS.

Denial Code	Long Description
PB94	IF THE CLIENT IS A RESIDENT OF A NURSING HOME, SUPPLY THE COMPLETE NAME AND ADDRESS OF THE NURSING HOME.
PB99	THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018, MUST BE SIGNED AND DATED.
PC01	PLEASE SUPPLY THE RENDERING PROVIDERS PROVIDER NUMBER.
PC03	THE DRUG ENFORCEMENT ADMINISTRATION NUMBER IS MISSING OR INVALID.
PC06	PLEASE DESCRIBE YOUR PROGRAM; INCLUDE ENTRY DATE, TERMINATION DATE, HOURS PER WEEK, AND NUMBER OF WEEKS OF PRIMARY INTENSIVE SERVICE REQUESTED.
PC07	PLEASE DESCRIBE YOUR "AFTERCARE/FOLLOW-UP" PLANS FOR THIS CLIENT.
PC08	PLEASE SUPPLY DOCUMENTATION OF PREVIOUS SUBSTANCE ABUSE SERVICES WITH DATE(S) AND OUTCOME.
PC09	PLEASE DESCRIBE IN DETAIL THE TREATMENT OBJECTIVES/GOALS FOR THIS CLIENT.
PC10	PLEASE DESCRIBE THE FAMILY SITUATION/DYNAMICS. EXPLAIN HOW THE FAMILY WILL BE INCORPORATED INTO THE CLIENTS PLAN OF CARE.
PC12	PLEASE EXPLAIN IF YOUR SERVICE ENCOURAGES THE CLIENT TO ATTEND SELF-HELP GROUPS.
PC13	PLEASE SUPPLY A SPECIFIC SCHEDULE OF ACTIVITIES, INCLUDING DAY, TIME OF DAY, LENGTH OF SESSION, AND SERVICE TO BE RENDERED DURING THAT TIME.
PC15	PLEASE FURNISH DIAGNOSTIC RATIONALE.
PC17	PLEASE DOCUMENT IF THE CLIENT EVER RECEIVED SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT.
PC19	PLEASE FURNISH MORE EXTENSIVE AND IN-DEPTH HISTORICAL AND PSYCHOSOCIAL DATA.
PC20	PLEASE SUPPLY THE DATE THE CLIENT BECAME TOTALLY ENDENTULOUS.
PC23	PLEASE SUBMIT A PHYSICIANS STATEMENT REGARDING THE MEDICAL NECESSITY OF DENTURES FOR THIS CLIENT. THE PHYSICIANS STATEMENT MUST DOCUMENT THE MEDICAL NEED FOR DENTURES.
PC24	THE SERVICE REQUESTED WAS PREVIOUSLY AUTHORIZED. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT INDICATING THIS FACT IS REQUIRED.
PC25	PLEASE SUPPLY SUFFICIENT MITIGATING CIRCUMSTANCES TO WARRANT THE CONSTRUCTION OF NEW DENTURES(S).
PC26	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
PC28	PLEASE SUBMIT A PHYSICIANS STATEMENT INDICATING DENTURES ARE NECESSARY FOR THIS NURSING HOME CLIENT.
PC29	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING LOSS OR DESTRUCTION OF DENTURE(S). INCLUDE SIGNED STATEMENT FROM CLIENT OR FACILITY DIRECTOR REGARDING HOW, WHEN AND WHERE LOST.
PC30	PLEASE PROVIDE COMPLETE INTRAORAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PC31	PLEASE DESCRIBE ANY RELATED DEFORMITIES OF THE FEET.
PC34	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD WITH REQUESTED DME ITEM(S) AND DOCUMENT IF THE CLIENT CAN USE SAFELY AND INDEPENDENTLY.
PC35	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD AND DESCRIBE THE RESULTS AND EFFECTIVENESS OF THE SERVICE REQUESTED.
PC39	PLEASE INDICATE LITER FLOW PER MINUTE, HOURS OF USE PER 24 HOUR PERIOD, AND THE EXPECTED DURATION OF NEED.
PC40	THE ITEM DOES NOT REQUIRE PRIOR AUTHORIZATION UNTIL THE LIFE EXPECTANCY HAS BEEN REACHED.
PC41	PLEASE SUPPLY INFORMATION INDICATING THE NECESSITY OF POSITIONING THE CLIENT'S BODY IN MULTIPLE POSITIONS.
PC42	PLEASE INDICATE IF THE BED HEIGHT MUST BE CHANGED TO ALLOW FOR SAFE TRANSFER OR ADEQUATE BED CARE.
PC43	SUPPLY A PHYSICIANS STATEMENT INDICATING TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR UNIT HAS REDUCED PAIN, IMPROVED/INCREASED THE CLIENTS ACTIVITY LEVEL, AND/OR REDUCED CLIENTS USE OF PAIN MEDICATION.
PC44	A CURRENT AUTHORIZATION FOR THIS SERVICE IS ON FILE FOR ANOTHER PROVIDER. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT OF THAT FACT IS REQUIRED BY THE CLIENT OF FIRST PROVIDER.
PC59	DOCUMENT DECLINE OR PROGRESS IN SPECIFIC, MEASURABLE, OBJECTIVE TERMS.
PC60	DOCUMENT IF CLIENT HAS DEMONSTRATED A GOOD APPOINTMENT COMPLIANCE RECORD.

Denial Code	Long Description
PC61	THE PHYSICIANS SIGNATURE DATE MUST NOT EXCEED 90 DAYS FROM THE DATE OF RECEIPT BY COLORADO MEDICAID.
PC62	REQUESTS FOR A CONTINUATION OF THERAPY SHOULD NOT BE SUBMITTED MORE THAN FOUR WEEKS PRIOR TO THE EXPIRATION DATE OF THE CURRENT AUTHORIZATION.
PC63	PLEASE FURNISH THE STYLE AND MANUFACTURER OF THE FRAME.
PC64	PLEASE FURNISH THE CLIENTS LENS FORMULA.
PC66	ALL REQUESTS FOR TINTS REQUIRE DOCUMENTATION OF THE VISUAL OR MEDICAL CONDITION RELATED TO PHOTOPHOBIA.
PC67	PLEASE DOCUMENT THE REASON AND JUSTIFICATION FOR REPLACEMENT BEYOND THE FIRST LENS/FRAME.
PC68	DOCUMENT IF ALL REMAINING MAXILLARY AND/OR MANDIBULAR TEETH ARE DECAY-FREE, PROPERLY RESTORED, AND PERIODONTICALLY SOUND.
PC72	SUPPLY MORE DETAIL REGARDING PROGRESS (ATTACHMENT OF GOALS, ETC.). CORRELATE PROGRESS TO PREVIOUS GOALS AND IDENTIFIED LIMITATIONS.
PC77	PLEASE SUBMIT A PLAN OF CARE DESCRIBING THE SERVICES THAT WOULD BE PROVIDED.
PC78	PLEASE DOCUMENT SPECIFIC, MEASURABLE GOALS.
PC82	THE PRIOR AUTHORIZATION (PA) SYSTEM CAN PROCESS ONLY 26 DETAILS PER PA REQUEST. PLEASE RESUBMIT YOUR REQUEST WITH NO MORE THAN 26 DETAILS.
PC83	PLEASE SUPPLY A PHYSICIANS PRESCRIPTION DATED WITHIN ONE MONTH OF REQUESTED SUBSTANCE ABUSE DAY TREATMENT.
PC84	PLEASE PROVIDE INFORMATION INDICATING THIS CLIENT IS APPROPRIATELY DETOXIFIED FROM ALCOHOL AND/OR OTHER DRUGS.
PC85	PLEASE PROVIDE INFORMATION TO INDICATE THE CLIENTS ABILITY TO ABSTAIN FROM ALCOHOL OR DRUGS WHILE IN THE SUBSTANCE ABUSE DAY TREATMENT PROGRAM.
PC86	PLEASE INDICATE IF THIS CLIENT IS WILLING TO PARTICIPATE IN AFTERCARE OR CONTINUING CARE SERVICES.
PC87	PROVIDE MORE INFORMATION ON TREATMENT HISTORY; INCLUDE SERVICE PROVIDED, DATES, AND OUTCOME. PROVIDE DETAIL OF PREVIOUS TREATMENT.
PC88	PLEASE PROVIDE MORE RATIONALE FOR THE APPROPRIATENESS AND MEDICAL NECESSITY OF SUBSTANCE ABUSE DAY TREATMENT.
PC89	PROVIDE A TREATMENT PLAN THAT CONTAINS MEASURABLE GOALS AND OBJECTIVES CORRESPONDING TO THE IDENTIFIED DEFICIT.
PC91	PLEASE PROVIDE MORE INFORMATION ON FAMILY INVOLVEMENT TREATMENT.
PC92	PLEASE PROVIDE MORE HISTORY AND EXPLANATION ABOUT THE ISSUE OF ABSTINENCE FOR THIS CLIENT.
PC94	PLEASE PROVIDE THE ANTICIPATED BEGINNING DATE AND/OR THE ESTIMATED SUBSTANCE ABUSE DAY TREATMENT DISCHARGE DATE.
PC95	PLEASE SUPPLY JUSTIFICATION FOR BEGINNING CLIENT IN SERVICE PRIOR TO AUTHORIZATION BEING OBTAINED.
PC96	THE INITIAL THREE HOURS OF SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IN A CALENDAR YEAR DO NOT REQUIRE PRIOR AUTHORIZATION.
PC97	REIMBURSEMENT FOR INITIAL SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IS LIMITED TO THREE HOURS IN A CALENDAR YEAR AND DOES NOT REQUIRE PRIOR AUTHORIZATION.
PC98	THIS DRUG IS CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE BILL USING THE APPROPRIATE NATIONAL DRUG CODE (NDC) OR SUBMIT A COMPLETED DRUG ADDITION REQUEST FORM IF THE NDC IS NOT LISTED IN THE DRUG INDEX.
PC99	THIS DRUG IS NOT CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL, CURRENT ADMINISTRATIVE RULE, OR COLORADO DRUG INDEX FOR COVERAGE LIMITATIONS.
PD01	DOCUMENT THAT CLIENT HAS ACHIEVED GOOD ORAL HYGIENE, PERIODONTAL CASE TYPE 1 OR 2, AND IS MOTIVATED TO MAINTAIN SAME.
PD03	PLEASE PROVIDE AN ARTERIAL BLOOD GAS READING OR PULSE OXIMETRY RESULTS DONE ON ROOM AIR SIGNED AND DATED BY A MEDICAL DOCTOR. THIS SHOULD BE DONE WITHIN 60 DAYS OF REQUESTED SERVICE.

Denial Code	Long Description
PD04	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 30 DAYS OF RECEIPT BY COLORADO MEDICAID.
PD07	SUBMIT A PHOTOCOPY OF A VALID PRESCRIPTION, ISSUED WITHIN THE PAST YEAR, OR COMPLETE SECTION B OF THE PRIOR AUTHORIZATION/DRUG ATTACHMENT (PA/DGA), F-11049.
PD10	BRAND MEDICALLY NECESSARY MUST BE IN THE PRESCRIBERS OWN HANDWRITING AND WRITTEN DIRECTLY ON THE PRESCRIPTION OR A SEPARATE ORDER ATTACHED TO THE ORIGINAL PRESCRIPTION.
PD12	COMPLETE DENTURES, PARTIAL DENTURES, DENTURE RELINES, AND FIXED PROSTHODONTIC SERVICES ARE NOT COVERED SERVICES FOR ADULTS FOR DATES OF SERVICE ON AND AFTER OCTOBER 1, 1995.
PD22	PLEASE COMPLETE ALL REQUIRED ELEMENTS ON THE PERSONAL CARE SCREENING TOOL (PCST), F-11133.
PD24	THIS PRIOR AUTHORIZATION REQUEST IS UNABLE TO BE PROCESSED. PLEASE RESUBMIT WITH ADDITIONAL REQUIRED FORMS, INCLUDING THE ENTIRE PERSONAL CARE SCREENING TOOL (PCST), F-11133; PERSONAL CARE ADDENDUM, F-11136; AND SUPPORTING DOCUMENTATION, AS DIRECTED.
PD25	THERE IS A PERSONAL CARE SCREENING TOOL (PCST), F-11133, COMPLETED BY ANOTHER AGENCY. CONTACT THE AGENCY TO TRANSFER SCREEN.
PD26	THERE IS A LIMITED TERM CARE FUNCTIONAL SCREEN (LTC-FS) COMPLETED BY ANOTHER AGENCY. THE PERSONAL CARE SCREENING TOOL (PCST), F-11133, INFORMATION IS IN CONFLICT WITH LTC-FS.
PD27	ONLY ONE LEVEL OF FUNCTION MAY BE SELECTED FOR ALL ELEMENTS EXCEPT TOILETING. COLORADO MEDICAID IS UNABLE TO PROCESS THE PRIOR AUTHORIZATION REQUEST.
PD28	NO UNITS MAY BE REQUESTED USING THIS PRIOR AUTHORIZATION PROCESS. PLEASE SUBMIT WITH THE APPROPRIATE ATTACHMENTS FOR REQUESTING SPECIFIC PERSONAL CARE WORKER UNITS.
PD29	CLIENT IS NOT ELIGIBLE FOR THE REQUESTED SERVICE(S) AS OF THE REQUESTED START DATE.
PD30	NO TRAVEL TIME MAY BE AUTHORIZED WHEN NO PERSONAL CARE WORKER SERVICE IS AUTHORIZED.
PD32	PROVIDER NOT CERTIFIED TO RENDER THE SERVICE(S) REQUESTED.
PD34	BASED ON THE DOCUMENTATION SUBMITTED, THIS REQUEST CAN NOT BE PRIOR AUTHORIZED. REFER TO THE PA MESSAGES FROM THE CONSULTANT FOR COMPLETE EXPLANATION.
PD98	PLEASE DOCUMENT HOW AND WHEN EACH PREVIOUSLY AUTHORIZED PRO RE NATA VISIT WAS USED.

Family Support Services Program (FSSP)

Denial Code	Long Description
0201	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
0233	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0235	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0237	CLIENT IDENTIFICATION NUMBER DOES NOT MATCH CLIENTS FIRST NAME.
0238	THE CLIENT IDENTIFICATION NUMBER DOES NOT MATCH THE CLIENTS LAST NAME.
0242	SECONDARY DIAGNOSIS CODE IS INVALID.
0248	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0249	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0251	PROCEDURE CODE MODIFIER IN FIRST POSITION IS INVALID.
0252	THE PROCEDURE CODE MODIFIER IN SECOND POSITION IS INVALID FOR REQUESTED START DATE OR DATE OF RECEIPT.
0253	THE PROCEDURE CODE MODIFIER IN THIRD POSITION IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
0258	THE PRIMARY DIAGNOSIS CODE IS REQUIRED.
0272	THE PRIMARY DIAGNSOSIS CODE IS INVALID.
0400	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0853	HCPCS - ANNUAL UPDATE
0885	NEVER EVENTS MODIFIERS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
0886	NEVER EVENTS DIAGNOSIS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.

Denial Code	Long Description
1000	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
1002	RENDERING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1003	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1007	RENDERING PROVIDER ID IS NOT ON FILE.
1047	THE RENDERING PROVIDERS CERTIFICATION HAS BEEN CANCELLED.
1048	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1801	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
1804	A CERTIFIED SUBSTANCE ABUSE DAY TREATMENT PROVIDER MUST SUBMIT A SUBSTANCE ABUSE DAY TREATMENT PROCEDURE CODE.
1806	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
1808	THE BILLING PROVIDER DOES NOT HAVE THE REQUIRED CERTIFICATION ADDENDUM ON FILE.
1900	THE BILLING PROVIDERS TAXONOMY CODE IS INVALID.
1901	THE RENDERING PROVIDERS TAXONOMY CODE IS INVALID.
1927	A NATIONAL PROVIDER IDENTIFIER IS REQUIRED FOR THE BILLING PROVIDER.
1934	A NATIONAL PROVIDER INDENTIFIER IS REQUIRED FOR THE RENDERING PROVIDER.
1936	THE BILLING PROVIDER NUMBER IS INVALID.
1937	THE RENDERING PROVIDER NUMBER IS INVALID.
1960	INTERNAL PROCESSING IS REQUIRED.
1963	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.
1964	THE BILLING PROVIDER INDICATED IS NOT ALLOWABLE AS A BILLING PROVIDER.
1965	RENDERING PROVIDER NUMBER IS MISSING/INVALID FOR THIS PROCEDURE PROVIDER.
1974	PRESCRIBING/REFERRING/ORDERING PROVIDER INDICATED IS NOT CERTIFIED AS A PRESCRIBING/REFERRING/ORDERING PROVIDER.
1975	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
1976	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
2001	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2003	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2017	THE CLIENT IS ENROLLED IN A MEDICAID OR OTHER MANAGED CARE PROGRAM.
2037	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2603	CLIENT LOCKED-IN TO A PROVIDER OR ENROLLED IN A HOSPICE. CONTACT CLIENTS HOSPICE FOR PAYMENT OF SERVICES OR RESUBMIT WITH DOCUMENTATION OF UNRELATED NATURE OF CARE.
3324	THE MODIFIER HAS BEEN DISCONTINUED BY THE CENTERS OF MEDICARE AND MEDICAID SERVICES OR THE AMERICAN MEDICAL ASSOCIATION FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
3337	THE PROCEDURE CODE HAS BEEN TERMINATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AMERICAN MEDICAL ASSOCIATION, OR AMERICAN DENTAL ASSOCIATION FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT. RESUBMIT WITH VALID A PROCEDURE CODE.
3339	THE PROCEDURE BILLED IS NOT PAYABLE ACCORDING TO DEFICIT REDUCTION ACT (DEFRA) GUIDELINES.
3351	THE PROCEDURE IS NOT COVERED FOR CLIENTS WITH A NURSING HOME AUTHORIZATION ON THE REQUESTED START DATE OR DATE OF RECEIPT.
3353	THE PROCEDURE IS NOT A COVERED SERVICE FOR HOME AND COMMUNITY-BASED WAIVER CLIENTS.
4021	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4027	THE DIAGNOSIS CODE IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
4031	THE PROCEDURE SUBMITTED IS NOT APPROPRIATE FOR CLIENTS GENDER.
4032	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4034	THE PROCEDURE CODE HAS AN AGE RESTRICTION.
4036	THE PLACE OF SERVICE CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4040	THE PRIMARY DIAGNOSIS CODE IS NOT ON FILE.
4041	THE SECONDARY DIAGNOSIS IS NOT ON FILE.
4046	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4127	INTERNAL PROCESSING IS REQUIRED.
4131	INTERNAL PROCESSING IS REQUIRED.
4141	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.

Denial Code	Long Description
4149	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4150	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4236	ETIOLOGY DIAGNOSIS CODE(S) (E-CODES) ARE INVALID AS THE PRIMARY DIAGNOSIS.
4244	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4245	THE FOURTH POSITION MODIFIER IS INVALID FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT.
4256	THE PROCEDURE CODE AND MODIFIER COMBINATION IS NOT PAYABLE FOR THE CLIENTS BENEFIT PLAN.
4257	THE MODIFIERS SUBMITTED ARE EITHER INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT OR THE MODIFIERS ARE MISSING.
4311	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4315	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4316	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4371	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4372	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4711	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR CLIENTS AGE.
4714	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS AGE.
4731	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS DIAGNOSIS.
4742	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4743	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4744	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4745	DIAGNOSIS AND/OR PROCEDURE AND/OR PLACE OF SERVICE (POS) CODE IS NOT COVERED FOR EXPRESS ENROLLMENT CLIENTS.
4746	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4801	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4802	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
4821	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
4871	PLEASE REFER TO PA MESSAGES FOR RETURN INFORMATION.
4963	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS GENDER.
4990	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
7500	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
7509	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
P001	THE BILLING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THE SERVICES.
P002	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P003	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P005	THE PRIOR AUTHORIZATION CAN NOT BE END DATED. THE PRIOR AUTHORIZATION STATUS IS NOT APPROVED OR APPROVED WITH REVISIONS.
P006	PLEASE FURNISH THE PROCEDURE CODE AND CORRESPONDING DESCRIPTION.
P008	THE BILLING PROVIDER NUMBER IS INVALID.
P009	THE BILLING PROVIDER NUMBER IS INVALID.
P010	THE REQUESTED END DATE IS INVALID.
P011	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P012	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P013	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P014	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P015	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P016	THE REQUESTED START DATE IS MISSING OR INVALID.

Denial Code	Long Description
P019	THE REQUESTED START DATE IS MISSING OR INVALID.
P020	THE RENDERING PROVIDER NUMBER IS INVALID.
P021	THE RENDERING PROVIDER NUMBER IS INVALID.
P022	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P023	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P024	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P026	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P027	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P030	FIRST MODIFIER IS INVALID.
P031	FIRST MODIFIER IS INVALID.
P032	SECOND MODIFIER IS INVALID.
P033	SECOND MODIFIER IS INVALID.
P034	THIRD MODIFIER IS INVALID.
P035	THIRD MODIFIER IS INVALID.
P036	FOURTH MODIFIER IS INVALID.
P037	FOURTH MODIFIER IS INVALID.
P038	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P039	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P040	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P041	CLIENTS FIRST NAME IS MISSING.
P042	CLIENTS LAST NAME IS MISSING.
P043	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P044	BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES REQUESTED.
P045	FIRST MODIFIER IS INVALID.
P046	SECOND MODIFIER IS INVALID.
P047	THIRD MODIFIER IS INVALID.
P048	FOURTH MODIFIER IS INVALID.
P052	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P053	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P054	RENDERING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES FOR THE BENEFIT PLAN.
P055	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P061	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P062	THE CLIENT ID AND/OR NAME INDICATED ON THE PA REQUEST IS INCORRECT. THE CLIENT ID AND/OR NAME HAS BEEN UPDATED. PLEASE VERIFY THE ID AND/OR NAME IS CORRECT.
P064	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
P067	THE FREQUENCY OF HOURS REQUESTED ARE NOT APPROPRIATE FOR THIS CLIENT AND HAVE BEEN MODIFIED ACCORDINGLY.
P079	BILLING PROVIDER IS ON PAYMENT SUSPENSION DUE TO CREDIBLE ALLEGATION OF FRAUD.
P120	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAS BEEN REDUCED.
P121	THE SERVICE/ PROCEDURE REQUESTED IS NOT SUPPORTED BY SUBMITTED DOCUMENTATION.
P126	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
P128	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.
P138	SERVICE(S) DO NOT MEET COLORADO MEDICAID GUIDELINES.
P167	REQUESTED DOCUMENTATION HAS NOT BEEN SUBMITTED.
P178	THE SERVICE REQUESTED IS NOT MEDICALLY NECESSARY.
P179	THE MEDICAL NECESSITY FOR THIS SERVICE IS NOT SUPPORTED BY THE SUBMITTED DOCUMENTATION.
P233	THE DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE ADDITIONAL CARE.

Denial Code	Long Description
P257	THIS CLIENTS FUNCTIONAL ASSESSMENT SCORES PLACE THIS CLIENT OUTSIDE ELIGIBILITY FOR DAY TREATMENT.
P274	OUR RECORDS INDICATE THIS CLIENT IS INVOLVED IN EFFECTIVE AND APPROPRIATE SERVICE ELSEWHERE.
P292	INTENSIVE REHABILITATION HOURS ARE NO LONGER APPROPRIATE AS INDICATED BY HISTORY, DIAGNOSIS, AND/ OR FUNCTIONAL ASSESSMENT SCORES.
P328	THE SERVICES REQUESTED INCLUDE NON-COVERED SERVICES, AND HOURS ARE REDUCED ACCORDINGLY.
P339	THE CLIENTS PAST HISTORY INDICATES REDUCED TREATMENT HOURS ARE WARRANTED.
P342	THE REQUEST DOES NOT MEET GENERALLY ACCEPTED CONDITIONS REQUIRING FLUORIDE TREATMENTS.
P346	SERVICES EXCEED COLORADO MEDICAID LIMITATION AND DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE MEDICAL NECESSITY OF THE SERVICE.
P349	THE SERVICE REQUESTED WAS PERFORMED LESS THAN FIVE YEARS AGO.
P353	THE EXISTING APPLIANCE HAS NOT BEEN WORN FOR THREE YEARS.
P367	THE CLIENT HAS BEEN TOTALLY WITHOUT TEETH AND AN APPLIANCE FOR FIVE YEARS.
P392	THE CLIENT IS MISSING AN ANTERIOR TOOTH AND/OR HAS TWO OR MORE POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P405	THE SERVICE(S) REQUESTED COULD ADEQUATELY BE PERFORMED IN THE DENTAL OFFICE.
P406	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE OF GOOD PERIODONTAL HEALTH (AMERICAN ACADEMY OF PERIODONTOLOGY PERIODONTAL CLASSIFICATION OF TYPE I OR II).
P407	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE VISIBLE ON RADIOGRAPHS THAT AT LEAST 50 PERCENT OF THE CLINICAL CROWN IS INTACT.
P409	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING SIX OR MORE TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED, INCLUDING THIRD MOLARS.
P410	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING ONE OR MORE ANTERIOR TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED.
P411	DOCUMENTATION DOES NOT SUPPORT THE NEED FOR PERIODONTIC SERVICES. POCKETS ARE LESS THAN 4MM AND/OR GREATER THAN 6MM FOR CLIENT AND/OR THE CLIENT IS UNDER THE AGE OF 13.
P412	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA.
P413	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA. THIS PA HAS BEEN GRANTED AS APPROVED NOT APPROVED WITH REVISIONS. THE DURATION REQUESTED MAY HAVE BEEN REDUCED TO REFLECT COVERAGE LIMITATIONS, PRESCRIBER ORDERS, CONFLICTI
P417	THE SERVICE(S) REQUESTED COULD BE ADEQUATELY PERFORMED WITH LOCAL ANESTHESIA.
P437	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO POOR ORAL HYGIENE.
P444	THIS LINE ITEM IS A DUPLICATE OF ANOTHER LINE ITEM ON THIS PRIOR AUTHORIZATION (PA) REQUEST. PLEASE CORRECT.
P446	THIS IS A DUPLICATE OF AN EXISTING PRIOR AUTHORIZATION (PA) REQUEST. YOU MAY CONTACT PROVIDER SERVICES IF YOU REQUIRE ASSISTANCE. DUPLICATE PA REQUEST
P448	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO DECAY HISTORY.
P449	QUESTIONABLE LONG TERM PROGNOSIS DUE TO GUM AND BONE DISEASE.
P456	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO APPARENT ROOT INFECTION.
P457	OUR RECORDS INDICATE THIS CLIENT HAS EXCEEDED ESTABLISHED PROGRAM LIMITATIONS. COLORADO MEDICAID WILL NOT AUTHORIZE NEW DENTURES.
P458	DOCUMENTATION PROVIDED INDICATES A LESS ELABORATE PROCEDURE SHOULD BE CONSIDERED.
P502	RENTAL ONLY ALLOWED; MEDICAL NEED FOR PURCHASE HAS NOT BEEN DOCUMENTED.
P503	PURCHASE ONLY ALLOWED; MEDICAL NEED FOR RENTAL HAS NOT BEEN DOCUMENTED.
P504	OCCUPATIONAL THERAPY GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P505	THE SERVICE REQUESTED IS INCLUDED IN THE NURSING HOME RATE STRUCTURE.
P511	THIS NATIONAL DRUG CODE IS ONLY BILLABLE AS PART OF A COMPOUND DRUG.
P515	THE PRESENCE OF A HANDICAPPING MALOCCLUSION OR HANDICAPPING DENTOFACIAL DEFORMITY IS NOT SUPPORTED BY THE DOCUMENTATION SUBMITTED.
P521	THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVERED BY COLORADO MEDICAID.

Denial Code	Long Description
P522	GASTRO-INTESTINAL SURGERY FOR THE PURPOSE OF WEIGHT CONTROL IS COVERED ONLY AS A LIFE THREATENING PROCEDURE.
P523	THE TREATMENT REQUEST IS NOT CONSISTENT WITH THE CLIENT'S DIAGNOSIS.
P524	PSYCHOTHERAPY PROVIDED IN THE CLIENTS HOME IS NOT A COVERED BENEFIT OF COLORADO MEDICAID.
P525	THE INFORMATION PROVIDED IS NOT CONSISTENT WITH THE INTENSITY OF SERVICES REQUESTED.
P526	INTENSIVE MULTIPLE MODALITY TREATMENT IS NOT CONSISTENT WITH THE INFORMATION PROVIDED.
P527	MULTIPLE PROVIDERS OF TREATMENT ARE NOT INDICATED FOR THIS CLIENT.
P528	THE DURATION OF TREATMENT SESSIONS EXCEED CURRENT COLORADO MEDICAID GUIDELINES.
P534	DOCUMENTATION OF POOR PHYSICAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P535	OTHER PHYSICAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P536	THE PHYSICAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P537	USE OF PHYSICAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P538	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF A PHYSICAL THERAPIST.
P539	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS AND LIVING ARRANGEMENT.
P540	GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P541	THE PROCEDURE(S) REQUESTED ARE NOT MEDICAL IN NATURE.
P542	DOCUMENTATION OF POOR OCCUPATIONAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P543	DOCUMENTATION OF POOR SPEECH THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P544	OTHER OCCUPATIONAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P546	THE OCCUPATIONAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P547	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF PHYSICAL THERAPY.
P548	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P549	ACTIVITIES TO PROMOTE DIVERSION OR GENERAL MOTIVATION ARE NONCOVERED COLORADO MEDICAID SERVICES.
P550	REVISIONS OF THE REQUEST IS NECESSITATED BY THE CLIENTS MINIMAL PROGRESS.
P551	RESTORATIVE NURSING INVOLVEMENT COULD BE INCREASED.
P552	CLIENTS DEMONSTRATED RESPONSE TO CURRENT THERAPY DOES NOT WARRANT THE INTENSE FREQUENCY REQUESTED.
P553	MAINTENANCE IS TWO TIMES PER WEEK OR LESS.
P554	THE SPEECH THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P555	USE OF OCCUPATIONAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P556	USE OF SPEECH THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P557	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF AN OCCUPATIONAL THERAPIST.
P558	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
P559	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P560	THE MATERIALS/ SERVICES REQUESTED ARE PRINCIPALLY COSMETIC IN NATURE.
P561	THE LENS FORMULA DOES NOT JUSTIFY REPLACEMENT.
P562	THE CHANGE IN THE LENS FORMULA DOES NOT WARRANT MULTIPLE REPLACEMENTS.
P563	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P564	LENSES ONLY ARE APPROVED; PLEASE DISPENSE A CONTRACTED FRAME. THE NON-CONTRACTED FRAME IS NOT MEDICALLY JUSTIFIED.
P565	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.

Denial Code	Long Description
P566	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P567	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF OCCUPATIONAL THERAPY.
P568	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF SPEECH THERAPY.
P569	LEVEL, INTENSITY, OR EXTENT OF SERVICE(S) REQUESTED HAS BEEN MODIFIED CONSISTENT WITH MEDICAL NEED AS DEFINED IN THE PLAN OF CARE.
P570	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P571	THE SERVICE ASKED FOR IS NOT COVERED BY COLORADO MEDICAID AS THESE TASKS CAN BE DONE BY NURSES OR ACTIVITY STAFF.
P572	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P573	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.
P574	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P575	MEDICAL NEED FOR EQUIPMENT/ SUPPLY REQUESTED IS NOT SUPPORTED BY DOCUMENTATION SUBMITTED.
P576	OTHER SPEECH THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P577	DOCUMENTATION SUBMITTED IDENTIFIES THAT THE CLIENT HAS FEWER THAN TWO POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P582	LESS EXPENSIVE ALTERNATIVE SERVICES ARE AVAILABLE FOR THIS CLIENT.
P634	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P711	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING PERIODONTAL SCALING AND ROOT PLANNING.
P712	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING GINGIVECTOMY.
P754	AN APPROVED SUBSTANCE ABUSE DAY TREATMENT PROGRAM CANNOT EXCEED A SIX WEEK PERIOD.
P761	THE CLIENT DOES NOT APPEAR TO BE ABLE OR WILLING TO ABSTAIN FROM ALCOHOL/DRUG USAGE WHILE IN TREATMENT. THEREFORE, SUBSTANCE ABUSE DAY TREATMENT SERVICES ARE NOT APPROVED.
P764	THIS CLIENT HAS COMPLETED INTENSIVE SUBSTANCE ABUSE TREATMENT WITHIN THE PAST 12 MONTHS. THE DOCUMENTATION PROVIDED IS NOT ADEQUATE TO JUSTIFY ADDITIONAL INTENSIVE TREATMENT AT THIS TIME.
P785	A LESS THAN SIX-WEEK HEALING PERIOD HAS BEEN SPECIFIED FOR THIS PRIOR AUTHORIZATION. THEREFORE IT IS NOT NECESSARY TO WAIT THE FULL SIX WEEKS AFTER EXTRACTIONS BEFORE TAKING DENTURE IMPRESSIONS.
P818	SIX-WEEK HEALING TIME IS REQUIRED BETWEEN EDENTULATION AND FINAL IMPRESSIONS. PAYMENT FOR DENTURES WILL BE DENIED OR RECOUPED IF HEALING PERIOD IS NOT OBSERVED.
P849	COLORADO MEDICAID HAS DETERMINED THERE WERE (ARE) SEVERAL HOME HEALTH AGENCIES WILLING TO PROVIDE MEDICALLY NECESSARY SKILLED NURSING SERVICES TO THIS CLIENT.
P864	THE DOCUMENTATION YOU HAVE SUBMITTED DOES NOT MEET THE REQUIREMENTS OF COLORADO MEDICAID.
P873	THE MEDICAL NECESSITY FOR THE HOURS REQUESTED IS NOT SUPPORTED BY THE INFORMATION SUBMITTED.
P874	THE DOCUMENTATION SUBMITTED INDICATES THE TASKS SPECIFIED CAN BE COMPLETED DURING THE VISITS APPROVED.
P878	THE DOCUMENTATION SUBMITTED DOES NOT INDICATE THAT MEDICALLY ORIENTED TASKS ARE MEDICALLY NECESSARY; THEREFORE PERSONAL CARE SERVICES HAVE BEEN APPROVED.
P880	THE QUANTITY OF SERVICES AUTHORIZED FOR THIS CLIENTS PERSONAL CARE HAS BEEN AMENDED BASED ON INFORMATION RECEIVED FROM ONE OR MORE OF THESE SOURCES: THE CLIENT, THEIR PHYSICIAN, AND/OR THE IN-HOME VISIT BY STAFF OF THE OIG (OFFICE OF INSPECTOR GENERAL).
P885	THE USE OF THIS DRUG FOR THE INTENDED PURPOSE IS NOT COVERED BY COLORADO MEDICAID, CONSISTENT WITH COLORADO ADMINISTRATIVE CODE AND FEDERAL LAW.

Denial Code	Long Description
P924	THE MEDICAL RECORDS SUBMITTED WITH THE CURRENT REQUEST CONFLICT OR DISAGREE WITH OUR MEDICAL RECORDS ON THIS CLIENT.
P950	INDEPENDENT NURSES, PLEASE NOTE PAYABLE SERVICES MAY NOT EXCEED 12 HOURS/DAY OR 60 HOURS/WEEK.
P951	SERVICES CAN ONLY BE AUTHORIZED THROUGH ONE YEAR FROM THE PRESCRIPTION DATE.
P952	LEAD INSPECTION IS A COVERED COLORADO MEDICAID SERVICE WHEN THE CHILD HAS BEEN SHOWN TO HAVE LEAD POISONING (E.G., CHILD HAS A BLOOD LEAD LEVEL > 19 UG/DL OR TWO CONSECUTIVE BLOOD LEAD LEVELS OF 15-19 UG/DL DONE AT LEAST 90 DAYS APART). THE INSPECTION MUS
P953	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P954	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P956	THE REQUEST CAN ONLY BE BACKDATED A MAXIMUM OF 14 DAYS FROM FIRST DATE RECEIVED BY COLORADO MEDICAID.
P957	COMPLETE PERIODONTAL CHARTING AT TIME OF SERVICE, AND SUBMIT CHARTING, COPY OF OPERATIVE REPORT, TOGETHER WITH A COPY OF THE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF), F-11035, TO PA UNIT ATTENTION DENTAL CONTSULTANT.
P958	NOTE THAT CODE D4341 HAS BEEN CHANGED. REFER TO THE DECISION NOTICE FOR AUTHORIZED QUANTITY.
P960	YOUR PA HAS BEEN APPROVED FOR 90 DAYS. THE 90 DAY APPROVAL DOES NOT IMPLY THE PA REQUEST MEETS PRIOR AUTHORIZATION CRITERIA. AFTER ADDITIONAL INFORMATION IS AVAILABLE IN INTERCHANGE, COLORADO MEDICAID WILL CREATE AN AMENDMENT REQUEST TO EXTEND THE PA FOR
P961	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P962	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
PA10	THE REQUESTED END DATE IS INVALID.
PA12	PLEASE FURNISH A WRITTEN DESCRIPTION OF THE CLIENTS DIAGNOSIS.
PA13	PROVIDE DIAGNOSES WITH DATES OF ONSET.
PA14	IDENTIFY PROBLEMS TO BE TREATED.
PA15	THE AUDIOLOGISTS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1), F-11020, AND PRIOR AUTHORIZATION REQUEST/HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2), F-11021.
PA16	THE PHYSICIANS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION/PHYSICIAN OTOLOGICAL REPORT (PA/POR), F-11019.
PA17	SUBMIT BRIEF HISTORY WITH REFERRAL INFORMATION, LIVING SITUATION, FUNCTIONAL STATUS, AND OTHER PERTINENT INFORMATION. WHAT CHANGE OF STATUS RESULTED IN REFERRAL AT THIS TIME?
PA18	PLEASE FURNISH THE CLIENTS HEIGHT AND WEIGHT.
PA19	PLEASE SUBMIT CLINICAL INFORMATION SUFFICIENT TO VERIFY THE NEED FOR THE REQUESTED SERVICE(S).
PA20	PLEASE RESUBMIT WITH COMPLETE PERIODONTAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PA21	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL EDUCATIONAL PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA22	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL PROGRAM PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA23	REFER TO THE DURABLE MEDICAL EQUIPMENT INDEX FOR APPROPRIATE CODE AND DESCRIPTION. DO NOT USE AN "UNLISTED" CODE.
PA24	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUALIZED FAMILY SERVICE PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA25	INFORMATION ON THE REQUEST FORM IS ILLEGIBLE, AND THE REQUEST CANNOT BE PROCESSED.
PA26	RE-EVALUATE YOUR GOALS. EMPHASIS SHOULD BE ON FUNCTIONAL SELF-CARE. GOALS MUST BE RELATED TO FUNCTIONAL OUTCOME.

Denial Code	Long Description
PA27	PLEASE CLARIFY THE NUMBER OF HOURS PER WEEK REQUESTED.
PA28	PLEASE CLARIFY THE NUMBER OF HOURS PER DAY REQUESTED.
PA29	PLEASE CLARIFY THE NUMBER OF VISITS PER DAY REQUESTED.
PA30	ATTACH SUPPORTIVE DOCUMENTATION; HOME EXERCISE PROGRAM AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA31	THE DIAGNOSIS CODE INDICATED ON THE REQUEST DOES NOT CORRESPOND TO THE DIAGNOSIS CODE DESCRIPTION.
PA32	PLEASE SUBMIT ADDITIONAL INFORMATION SUFFICIENT TO VERIFY APPROPRIATENESS AND NEED FOR TRANSPLANT.
PA33	PLEASE SUBMIT THE INITIAL AND PROGRESSIVE OBJECTIVE FINDINGS.
PA34	ATTACH SUPPORTIVE DOCUMENTATION, FACILITY PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA35	PLEASE SUBMIT THE CLIENTS ORIGINAL COMPLAINTS AND EXAMINATION FINDINGS.
PA36	ATTACH SUPPORTIVE DOCUMENTATION, IN-HOME AUTISM PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA37	PLEASE SUBMIT YOUR TREATMENT PLAN FOR THIS CLIENT.
PA38	ATTACH SUPPORTIVE DOCUMENTATION AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA39	INITIAL EVALUATIONS MUST BE PERFORMED BY AN OCCUPATIONAL THERAPIST REGISTERED (OTR), PER AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA) STANDARDS.
PA41	IDENTIFY THE PLACE OF SERVICE AND ITS EFFECT ON SUPPORTING THE DESIRED TREATMENT OUTCOME.
PA42	PLEASE INDICATE THE HOURS OF USE OF OXYGEN PER 24-HOUR PERIOD.
PA43	PROVIDE BASELINE DOCUMENTATION FOR THIS CLIENTS LIMITATIONS USING UNITS OF MEASUREMENT THAT ARE APPLIED CONSISTENTLY WHEN REPORTING STATUS.
PA44	IDENTIFY FUNCTIONAL LIMITATIONS AS THEY ARE RELATED TO IDENTIFIED CONDITIONS.
PA46	CORRELATE PLAN OF CARE TO REQUESTED PROCEDURE CODES.
PA47	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE FREQUENCY/DURATION REQUESTED.
PA48	PLEASE PROVIDE THE NAME AND CREDENTIALS OF THE RENDERING PROVIDER.
PA50	COLORADO MEDICAID RECORDS INDICATE THE CLIENT OWNS A WHEELCHAIR. DOCUMENT THE REASON AND NEED FOR REPLACEMENT AND COST TO REPAIR CURRENT WHEELCHAIR.
PA51	PLEASE DISTINGUISH PRIMARY AND SUPPORTIVE MODALITIES.
PA52	PLEASE SUBMIT A PROGRESS REPORT.
PA53	MULTIPLE FAMILY CLIENTS TREATMENT BY THE SAME PROVIDER REQUIRES FURTHER INFORMATION DOCUMENTING COORDINATION OF TREATMENT PLAN.
PA54	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE MINUTES REQUESTED.
PA55	MEDICAL NECESSITY OF TREATMENT REQUIRES ADDITIONAL DOCUMENTATION.
PA56	GIVEN AGE, DIAGNOSES, CURRENT LEVEL OF FUNCTION, PAST RESPONSE TO TREATMENT, AND LIVING SITUATION, EXPAND ON POTENTIAL FOR SIGNIFICANT FUNCTIONAL PROGRESS WITHIN THE NEXT SIX MONTHS. EMPHASIZE WHY PROGRESS IS EXPECTED WITH SERVICES AT THIS TIME.
PA57	SUBMIT THE INITIAL FINDINGS. INCLUDE A COMPREHENSIVE EVALUATION.
PA58	SUBMIT PROGRESSIVE, OBJECTIVE FINDINGS. INCLUDE A PERTINENT RE-EVALUATION.
PA59	PLEASE SUPPLY INFORMATION REGARDING THE CLIENTS MEDICATION REQUIREMENTS, IF ANY.
PA60	PLEASE SPECIFY IF THE CLIENT IS IN AN EDUCATIONAL SETTING.
PA61	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA62	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
PA63	THE SKILLS OF A THERAPIST ARE PURPOSEFUL AND SKILLED INTERVENTIONS REQUIRED TO CONTINUALLY DESIGN, IMPLEMENT, REASSESS, MODIFY/GRADE, AND/OR DISCONTINUE A PLAN OF CARE IN A TIMELY MANNER, BASED ON THE COMPLEXITY OF THE CLIENTS MEDICAL CONDITION AND/OR CO
PA64	PLEASE SUBMIT A THERAPY PLAN OF CARE, INCLUDING A CURRENT, DATED EVALUATION.
PA65	A PLAN OF CARE SIGNED AND DATED BY THE PHYSICIAN IS REQUIRED.

Denial Code	Long Description
PA66	THE SKILLS OF A THERAPIST ARE REQUIRED WHEN ONLY THE THERAPIST CAN SAFELY AND EFFECTIVELY DELIVER THE THERAPEUTIC PROCEDURES BECAUSE OF THEIR UNIQUE KNOWLEDGE, TRAINING, AND EXPERTISE. DESCRIBE THE REASON THAT SOMEONE OTHER THAN A THERAPIST CANNOT SAFELY
PA67	PLEASE SPECIFY IF THE CLIENTS WORK SITE DEMANDS GOOD BINAURAL HEARING.
PA68	DESCRIBE THE REASON, BASED ON THE CLIENTS COGNITIVE, PHYSICAL, COMMUNICATION, OR RESOURCE STATUS, THAT A HOME PROGRAM, EQUIPMENT, OR ENVIRONMENTAL ADAPTATIONS ALONE CANNOT MEET CLIENTS NEEDS.
PA69	PLEASE SPECIFY IF THE CLIENT HAS AN ACCOMPANYING DISABILITY THAT ADDS TO THE HEARING PROBLEM.
PA70	DISTINGUISH REQUESTED PROCEDURES AND GOALS FROM OTHER SERVICES THIS CLIENT RECEIVES. THEY MAY NOT BE DUPLICATIVE.
PA71	PLEASE INDICATE THE NUMBER OF DAYS REQUESTED.
PA73	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA74	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA75	PLEASE DOCUMENT CARRYOVER OF THE THERAPY PROGRAM TO NURSING.
PA76	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA79	PROVIDE EVIDENCE OF SIGNIFICANT FUNCTIONAL PROGRESS IN LAST SIX MONTHS.
PA84	THE GRANT DATE OF THIS REQUEST CANNOT BE PRIOR TO THE SIGNATURE DATE OF THE PRESCRIBING PHYSICIAN.
PA86	PROVIDE EVIDENCE OF SKILLS GAINED IN THERAPY CARRYING OVER TO OTHER SETTINGS WITHIN SIX MONTHS.
PA87	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE NUMBER OF SESSIONS REQUESTED.
PA88	THE REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL SCOPE OF PRACTICE.
PA89	PRIOR AUTHORIZATION IS NOT REQUIRED UNTIL LIMITATION OF SERVICE HAS BEEN REACHED.
PA91	PLEASE SUBMIT REQUIRED X-RAYS.
PA92	PLEASE PROVIDE AN EXPLANATION FOR THE MATERIAL SUBMITTED WITH THE REQUEST.
PA95	PLEASE DESCRIBE HOW THE PROVISION OF THIS SERVICE WOULD PREVENT INSTITUTIONALIZATION OF THE CLIENT.
PA96	COULD THE EXISTING DENTURE(S) BE RELINED OR REBASED? IF NOT, PLEASE EXPLAIN WHY NOT.
PA97	REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL STANDARDS OF PRACTICE.
PA98	PLEASE INDICATE IF THE CLIENT IS CURRENTLY BEING TUBE FED.
PB02	PLEASE PROVIDE THE REQUIRED DATED SIGNATURES ON THE ATTACHMENTS.
PB03	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING THE LOSS/DESTRUCTION/THEFT OF THE HEARING AID.
PB04	DESCRIBE THE CLIENTS ABILITY TO STAND OR AMBULATE SUFFICIENTLY TO ACCOMPLISH SELF-CARE ACTIVITIES.
PB07	PLEASE SUBMIT AN ORTHODONTIC STUDY MODEL OR DIAGNOSTIC CASTS.
PB09	PLEASE PROVIDE A PHOTOGRAPH OF THE INVOLVED AREA(S).
PB10	PLEASE PROVIDE AN ESTIMATION (IN GRAMS) OF THE TOTAL AMOUNT OF TISSUE TO BE RESECTED.
PB11	PLEASE SUBMIT THE PLAN OF CARE FOR CO-TREATMENT.
PB12	FURNISH A DETAILED DESCRIPTION FOR THE PROCEDURE CODE REQUESTED.
PB13	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB15	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB18	PLEASE COMPLETE THE ATTACHED OUT-OF-STATE PROVIDER DATA SHEET, F-11001, AND RESUBMIT.
PB20	A SIGNED AND DATED PRESCRIPTION IS REQUIRED WITHIN THREE MONTHS OF RECEIPT BY COLORADO MEDICAID FOR INITIAL REQUESTS AND WITHIN 12 MONTHS OF RECEIPT BY COLORADO MEDICAID FOR SUBSEQUENT REQUESTS.
PB21	PLEASE COMPLETE THE APPROPRIATE PRIOR AUTHORIZATION ATTACHMENT. CONTACT PROVIDER SERVICES OR THE PRIOR AUTHORIZATION UNIT FOR ASSISTANCE.
PB23	PHYSICAL THERAPY ASSISTANT NOTES AND ALL FORMS SUBMITTED MUST BE COSIGNED BY A REGISTERED PHYSICAL THERAPIST.

Denial Code	Long Description
PB31	ARE YOU REQUESTING A COMPLETE APPLIANCE, OR REPLACEMENT PARTS?
PB32	THE PROCEDURE CODE INDICATED ON THE REQUEST DOES NOT MATCH THE DESCRIPTION OF SERVICE; PLEASE CORRECT AND RESUBMIT.
PB35	THE SERVICE REQUESTED DOES NOT REQUIRE PRIOR AUTHORIZATION.
PB41	PLEASE FURNISH A CURRENT MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT, F-11090 (DATED WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID).
PB45	THE CERTIFICATION PERIOD ON THE PLAN OF CARE (POC) DOES NOT COVER THE REQUESTED GRANT/START DATE. PLEASE RESUBMIT YOUR REQUEST WITH A NEW POC.
PB49	A CERTIFIED OCCUPATIONAL THERAPY ASSISTANTS NOTES MUST BE COSIGNED BY AN OCCUPATIONAL THERAPIST REGISTERED.
PB51	ADDITIONAL INFORMATION IS REQUIRED ON PRIOR AUTHORIZATION TO ENABLE PRICING.
PB54	REQUESTED SERVICES DO NOT MATCH SERVICES ON THE PHYSICIANS ORDERS.
PB59	PLEASE PROVIDE AN INDIVIDUAL EDUCATIONAL PLAN (IEP), WHICH HAS BEEN SIGNED BY THE PROVIDER NO EARLIER THAN NINE MONTHS PRIOR TO RECEIPT AT COLORADO MEDICAID; OTHERWISE, DOCUMENT WHY NO IEP EXISTS.
PB65	PLEASE FURNISH THE ANTICIPATED TOTAL CHARGES FOR THIS REQUEST.
PB66	A PHOTOCOPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED; THE DATE MUST BE WITHIN SIX MONTHS OF RECEIPT BY COLORADO MEDICAID.
PB67	THE PRESCRIPTION DATE MUST INCLUDE MONTH, DAY, AND YEAR.
PB68	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID.
PB73	THE SERVICES IDENTIFIED ON THE PLAN OF CARE DO NOT APPEAR APPROPRIATE FOR THE PROCEDURE CODE(S) REQUESTED ON THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018.
PB74	THE CLIENT/PROVIDER DOES NOT HAVE RETROACTIVE ENROLLMENT.
PB75	THE REQUESTED START DATE IS MORE THAN 14 DAYS BEFORE OR 62 DAYS AFTER RECEIPT.
PB82	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
PB83	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A HOME HEALTH AIDE. PLEASE RESUBMIT AS A PERSONAL CARE WORKER OR PROVIDE ADDITIONAL DOCUMENTATION.
PB86	THE SERVICES REQUESTED ARE NOT BEING PROVIDED IN THE CLIENTS RESIDENCE. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL.
PB87	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A NURSE. PLEASE RESUBMIT AS A HOME HEALTH AIDE OR PROVIDE ADDITIONAL DOCUMENTATION.
PB92	PLEASE FURNISH THE CLIENTS COMPLETE ADDRESS.
PB94	IF THE CLIENT IS A RESIDENT OF A NURSING HOME, SUPPLY THE COMPLETE NAME AND ADDRESS OF THE NURSING HOME.
PB99	THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018, MUST BE SIGNED AND DATED.
PC01	PLEASE SUPPLY THE RENDERING PROVIDERS PROVIDER NUMBER.
PC03	THE DRUG ENFORCEMENT ADMINISTRATION NUMBER IS MISSING OR INVALID.
PC06	PLEASE DESCRIBE YOUR PROGRAM; INCLUDE ENTRY DATE, TERMINATION DATE, HOURS PER WEEK, AND NUMBER OF WEEKS OF PRIMARY INTENSIVE SERVICE REQUESTED.
PC07	PLEASE DESCRIBE YOUR "AFTERCARE/FOLLOW-UP" PLANS FOR THIS CLIENT.
PC08	PLEASE SUPPLY DOCUMENTATION OF PREVIOUS SUBSTANCE ABUSE SERVICES WITH DATE(S) AND OUTCOME.
PC09	PLEASE DESCRIBE IN DETAIL THE TREATMENT OBJECTIVES/GOALS FOR THIS CLIENT.
PC10	PLEASE DESCRIBE THE FAMILY SITUATION/DYNAMICS. EXPLAIN HOW THE FAMILY WILL BE INCORPORATED INTO THE CLIENTS PLAN OF CARE.
PC12	PLEASE EXPLAIN IF YOUR SERVICE ENCOURAGES THE CLIENT TO ATTEND SELF-HELP GROUPS.
PC13	PLEASE SUPPLY A SPECIFIC SCHEDULE OF ACTIVITIES, INCLUDING DAY, TIME OF DAY, LENGTH OF SESSION, AND SERVICE TO BE RENDERED DURING THAT TIME.
PC15	PLEASE FURNISH DIAGNOSTIC RATIONALE.
PC17	PLEASE DOCUMENT IF THE CLIENT EVER RECEIVED SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT.
PC19	PLEASE FURNISH MORE EXTENSIVE AND IN-DEPTH HISTORICAL AND PSYCHOSOCIAL DATA.
PC20	PLEASE SUPPLY THE DATE THE CLIENT BECAME TOTALLY ENDENTULOUS.

Denial Code	Long Description
PC23	PLEASE SUBMIT A PHYSICIANS STATEMENT REGARDING THE MEDICAL NECESSITY OF DENTURES FOR THIS CLIENT. THE PHYSICIANS STATEMENT MUST DOCUMENT THE MEDICAL NEED FOR DENTURES.
PC24	THE SERVICE REQUESTED WAS PREVIOUSLY AUTHORIZED. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT INDICATING THIS FACT IS REQUIRED.
PC25	PLEASE SUPPLY SUFFICIENT MITIGATING CIRCUMSTANCES TO WARRANT THE CONSTRUCTION OF NEW DENTURES(S).
PC26	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
PC28	PLEASE SUBMIT A PHYSICIANS STATEMENT INDICATING DENTURES ARE NECESSARY FOR THIS NURSING HOME CLIENT.
PC29	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING LOSS OR DESTRUCTION OF DENTURE(S). INCLUDE SIGNED STATEMENT FROM CLIENT OR FACILITY DIRECTOR REGARDING HOW, WHEN AND WHERE LOST.
PC30	PLEASE PROVIDE COMPLETE INTRAORAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PC31	PLEASE DESCRIBE ANY RELATED DEFORMITIES OF THE FEET.
PC34	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD WITH REQUESTED DME ITEM(S) AND DOCUMENT IF THE CLIENT CAN USE SAFELY AND INDEPENDENTLY.
PC35	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD AND DESCRIBE THE RESULTS AND EFFECTIVENESS OF THE SERVICE REQUESTED.
PC39	PLEASE INDICATE LITER FLOW PER MINUTE, HOURS OF USE PER 24 HOUR PERIOD, AND THE EXPECTED DURATION OF NEED.
PC40	THE ITEM DOES NOT REQUIRE PRIOR AUTHORIZATION UNTIL THE LIFE EXPECTANCY HAS BEEN REACHED.
PC41	PLEASE SUPPLY INFORMATION INDICATING THE NECESSITY OF POSITIONING THE CLIENT'S BODY IN MULTIPLE POSITIONS.
PC42	PLEASE INDICATE IF THE BED HEIGHT MUST BE CHANGED TO ALLOW FOR SAFE TRANSFER OR ADEQUATE BED CARE.
PC43	SUPPLY A PHYSICIANS STATEMENT INDICATING TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR UNIT HAS REDUCED PAIN, IMPROVED/INCREASED THE CLIENTS ACTIVITY LEVEL, AND/OR REDUCED CLIENTS USE OF PAIN MEDICATION.
PC44	A CURRENT AUTHORIZATION FOR THIS SERVICE IS ON FILE FOR ANOTHER PROVIDER. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT OF THAT FACT IS REQUIRED BY THE CLIENT OF FIRST PROVIDER.
PC59	DOCUMENT DECLINE OR PROGRESS IN SPECIFIC, MEASURABLE, OBJECTIVE TERMS.
PC60	DOCUMENT IF CLIENT HAS DEMONSTRATED A GOOD APPOINTMENT COMPLIANCE RECORD.
PC61	THE PHYSICIANS SIGNATURE DATE MUST NOT EXCEED 90 DAYS FROM THE DATE OF RECEIPT BY COLORADO MEDICAID.
PC62	REQUESTS FOR A CONTINUATION OF THERAPY SHOULD NOT BE SUBMITTED MORE THAN FOUR WEEKS PRIOR TO THE EXPIRATION DATE OF THE CURRENT AUTHORIZATION.
PC63	PLEASE FURNISH THE STYLE AND MANUFACTURER OF THE FRAME.
PC64	PLEASE FURNISH THE CLIENTS LENS FORMULA.
PC66	ALL REQUESTS FOR TINTS REQUIRE DOCUMENTATION OF THE VISUAL OR MEDICAL CONDITION RELATED TO PHOTOPHOBIA.
PC67	PLEASE DOCUMENT THE REASON AND JUSTIFICATION FOR REPLACEMENT BEYOND THE FIRST LENS/FRAME.
PC68	DOCUMENT IF ALL REMAINING MAXILLARY AND/OR MANDIBULAR TEETH ARE DECAY-FREE, PROPERLY RESTORED, AND PERIODONTICALLY SOUND.
PC72	SUPPLY MORE DETAIL REGARDING PROGRESS (ATTACHMENT OF GOALS, ETC.). CORRELATE PROGRESS TO PREVIOUS GOALS AND IDENTIFIED LIMITATIONS.
PC77	PLEASE SUBMIT A PLAN OF CARE DESCRIBING THE SERVICES THAT WOULD BE PROVIDED.
PC78	PLEASE DOCUMENT SPECIFIC, MEASURABLE GOALS.
PC82	THE PRIOR AUTHORIZATION (PA) SYSTEM CAN PROCESS ONLY 26 DETAILS PER PA REQUEST. PLEASE RESUBMIT YOUR REQUEST WITH NO MORE THAN 26 DETAILS.
PC83	PLEASE SUPPLY A PHYSICIANS PRESCRIPTION DATED WITHIN ONE MONTH OF REQUESTED SUBSTANCE ABUSE DAY TREATMENT.

Denial Code	Long Description
PC84	PLEASE PROVIDE INFORMATION INDICATING THIS CLIENT IS APPROPRIATELY DETOXIFIED FROM ALCOHOL AND/OR OTHER DRUGS.
PC85	PLEASE PROVIDE INFORMATION TO INDICATE THE CLIENTS ABILITY TO ABSTAIN FROM ALCOHOL OR DRUGS WHILE IN THE SUBSTANCE ABUSE DAY TREATMENT PROGRAM.
PC86	PLEASE INDICATE IF THIS CLIENT IS WILLING TO PARTICIPATE IN AFTERCARE OR CONTINUING CARE SERVICES.
PC87	PROVIDE MORE INFORMATION ON TREATMENT HISTORY; INCLUDE SERVICE PROVIDED, DATES, AND OUTCOME. PROVIDE DETAIL OF PREVIOUS TREATMENT.
PC88	PLEASE PROVIDE MORE RATIONALE FOR THE APPROPRIATENESS AND MEDICAL NECESSITY OF SUBSTANCE ABUSE DAY TREATMENT.
PC89	PROVIDE A TREATMENT PLAN THAT CONTAINS MEASURABLE GOALS AND OBJECTIVES CORRESPONDING TO THE IDENTIFIED DEFICIT.
PC91	PLEASE PROVIDE MORE INFORMATION ON FAMILY INVOLVEMENT TREATMENT.
PC92	PLEASE PROVIDE MORE HISTORY AND EXPLANATION ABOUT THE ISSUE OF ABSTINENCE FOR THIS CLIENT.
PC94	PLEASE PROVIDE THE ANTICIPATED BEGINNING DATE AND/OR THE ESTIMATED SUBSTANCE ABUSE DAY TREATMENT DISCHARGE DATE.
PC95	PLEASE SUPPLY JUSTIFICATION FOR BEGINNING CLIENT IN SERVICE PRIOR TO AUTHORIZATION BEING OBTAINED.
PC96	THE INITIAL THREE HOURS OF SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IN A CALENDAR YEAR DO NOT REQUIRE PRIOR AUTHORIZATION.
PC97	REIMBURSEMENT FOR INITIAL SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IS LIMITED TO THREE HOURS IN A CALENDAR YEAR AND DOES NOT REQUIRE PRIOR AUTHORIZATION.
PC98	THIS DRUG IS CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE BILL USING THE APPROPRIATE NATIONAL DRUG CODE (NDC) OR SUBMIT A COMPLETED DRUG ADDITION REQUEST FORM IF THE NDC IS NOT LISTED IN THE DRUG INDEX.
PC99	THIS DRUG IS NOT CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL, CURRENT ADMINISTRATIVE RULE, OR COLORADO DRUG INDEX FOR COVERAGE LIMITATIONS.
PD01	DOCUMENT THAT CLIENT HAS ACHIEVED GOOD ORAL HYGIENE, PERIODONTAL CASE TYPE 1 OR 2, AND IS MOTIVATED TO MAINTAIN SAME.
PD03	PLEASE PROVIDE AN ARTERIAL BLOOD GAS READING OR PULSE OXIMETRY RESULTS DONE ON ROOM AIR SIGNED AND DATED BY A MEDICAL DOCTOR. THIS SHOULD BE DONE WITHIN 60 DAYS OF REQUESTED SERVICE.
PD04	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 30 DAYS OF RECEIPT BY COLORADO MEDICAID.
PD07	SUBMIT A PHOTOCOPY OF A VALID PRESCRIPTION, ISSUED WITHIN THE PAST YEAR, OR COMPLETE SECTION B OF THE PRIOR AUTHORIZATION/DRUG ATTACHMENT (PA/DGA), F-11049.
PD10	BRAND MEDICALLY NECESSARY MUST BE IN THE PRESCRIBERS OWN HANDWRITING AND WRITTEN DIRECTLY ON THE PRESCRIPTION OR A SEPARATE ORDER ATTACHED TO THE ORIGINAL PRESCRIPTION.
PD12	COMPLETE DENTURES, PARTIAL DENTURES, DENTURE RELINES, AND FIXED PROSTHODONTIC SERVICES ARE NOT COVERED SERVICES FOR ADULTS FOR DATES OF SERVICE ON AND AFTER OCTOBER 1, 1995.
PD22	PLEASE COMPLETE ALL REQUIRED ELEMENTS ON THE PERSONAL CARE SCREENING TOOL (PCST), F-11133.
PD24	THIS PRIOR AUTHORIZATION REQUEST IS UNABLE TO BE PROCESSED. PLEASE RESUBMIT WITH ADDITIONAL REQUIRED FORMS, INCLUDING THE ENTIRE PERSONAL CARE SCREENING TOOL (PCST), F-11133; PERSONAL CARE ADDENDUM, F-11136; AND SUPPORTING DOCUMENTATION, AS DIRECTED.
PD25	THERE IS A PERSONAL CARE SCREENING TOOL (PCST), F-11133, COMPLETED BY ANOTHER AGENCY. CONTACT THE AGENCY TO TRANSFER SCREEN.
PD26	THERE IS A LIMITED TERM CARE FUNCTIONAL SCREEN (LTC-FS) COMPLETED BY ANOTHER AGENCY. THE PERSONAL CARE SCREENING TOOL (PCST), F-11133, INFORMATION IS IN CONFLICT WITH LTC-FS.
PD27	ONLY ONE LEVEL OF FUNCTION MAY BE SELECTED FOR ALL ELEMENTS EXCEPT TOILETING. COLORADO MEDICAID IS UNABLE TO PROCESS THE PRIOR AUTHORIZATION REQUEST.
PD28	NO UNITS MAY BE REQUESTED USING THIS PRIOR AUTHORIZATION PROCESS. PLEASE SUBMIT WITH THE APPROPRIATE ATTACHMENTS FOR REQUESTING SPECIFIC PERSONAL CARE WORKER UNITS.

Denial Code	Long Description
PD29	CLIENT IS NOT ELIGIBLE FOR THE REQUESTED SERVICE(S) AS OF THE REQUESTED START DATE.
PD30	NO TRAVEL TIME MAY BE AUTHORIZED WHEN NO PERSONAL CARE WORKER SERVICE IS AUTHORIZED.
PD32	PROVIDER NOT CERTIFIED TO RENDER THE SERVICE(S) REQUESTED.
PD34	BASED ON THE DOCUMENTATION SUBMITTED, THIS REQUEST CAN NOT BE PRIOR AUTHORIZED. REFER TO THE PA MESSAGES FROM THE CONSULTANT FOR COMPLETE EXPLANATION.
PD98	PLEASE DOCUMENT HOW AND WHEN EACH PREVIOUSLY AUTHORIZED PRO RE NATA VISIT WAS USED.

Home Health Adult

Denial Code	Long Description
0201	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
0233	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0235	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0237	CLIENT IDENTIFICATION NUMBER DOES NOT MATCH CLIENTS FIRST NAME.
0238	THE CLIENT IDENTIFICATION NUMBER DOES NOT MATCH THE CLIENTS LAST NAME.
0242	SECONDARY DIAGNOSIS CODE IS INVALID.
0248	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0249	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0251	PROCEDURE CODE MODIFIER IN FIRST POSITION IS INVALID.
0252	THE PROCEDURE CODE MODIFIER IN SECOND POSITION IS INVALID FOR REQUESTED START DATE OR DATE OF RECEIPT.
0253	THE PROCEDURE CODE MODIFIER IN THIRD POSITION IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
0258	THE PRIMARY DIAGNOSIS CODE IS REQUIRED.
0272	THE PRIMARY DIAGNSOSIS CODE IS INVALID.
0339	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0340	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0400	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0853	HCPCS - ANNUAL UPDATE
0885	NEVER EVENTS MODIFIERS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
0886	NEVER EVENTS DIAGNOSIS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
1000	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
1002	RENDERING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1003	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1007	RENDERING PROVIDER ID IS NOT ON FILE.
1047	THE RENDERING PROVIDERS CERTIFICATION HAS BEEN CANCELLED.
1048	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1801	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
1804	A CERTIFIED SUBSTANCE ABUSE DAY TREATMENT PROVIDER MUST SUBMIT A SUBSTANCE ABUSE DAY TREATMENT PROCEDURE CODE.
1806	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
1808	THE BILLING PROVIDER DOES NOT HAVE THE REQUIRED CERTIFICATION ADDENDUM ON FILE.
1900	THE BILLING PROVIDERS TAXONOMY CODE IS INVALID.
1901	THE RENDERING PROVIDERS TAXONOMY CODE IS INVALID.
1927	A NATIONAL PROVIDER IDENTIFIER IS REQUIRED FOR THE BILLING PROVIDER.
1934	A NATIONAL PROVIDER INDENTIFIER IS REQUIRED FOR THE RENDERING PROVIDER.
1936	THE BILLING PROVIDER NUMBER IS INVALID.
1937	THE RENDERING PROVIDER NUMBER IS INVALID.

Denial Code	Long Description
1960	INTERNAL PROCESSING IS REQUIRED.
1963	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.
1964	THE BILLING PROVIDER INDICATED IS NOT ALLOWABLE AS A BILLING PROVIDER.
1965	RENDERING PROVIDER NUMBER IS MISSING/INVALID FOR THIS PROCEDURE PROVIDER.
1974	PRESCRIBING/REFERRING/ORDERING PROVIDER INDICATED IS NOT CERTIFIED AS A PRESCRIBING/REFERRING/ORDERING PROVIDER.
1975	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
1976	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
2001	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2003	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2017	THE CLIENT IS ENROLLED IN A MEDICAID OR OTHER MANAGED CARE PROGRAM.
2037	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2603	CLIENT LOCKED-IN TO A PROVIDER OR ENROLLED IN A HOSPICE. CONTACT CLIENTS HOSPICE FOR PAYMENT OF SERVICES OR RESUBMIT WITH DOCUMENTATION OF UNRELATED NATURE OF CARE.
3324	THE MODIFIER HAS BEEN DISCONTINUED BY THE CENTERS OF MEDICARE AND MEDICAID SERVICES OR THE AMERICAN MEDICAL ASSOCIATION FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
3337	THE PROCEDURE CODE HAS BEEN TERMINATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AMERICAN MEDICAL ASSOCIATION, OR AMERICAN DENTAL ASSOCIATION FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT. RESUBMIT WITH VALID A PROCEDURE CODE.
3339	THE PROCEDURE BILLED IS NOT PAYABLE ACCORDING TO DEFICIT REDUCTION ACT (DEFRA) GUIDELINES.
3351	THE PROCEDURE IS NOT COVERED FOR CLIENTS WITH A NURSING HOME AUTHORIZATION ON THE REQUESTED START DATE OR DATE OF RECEIPT.
3353	THE PROCEDURE IS NOT A COVERED SERVICE FOR HOME AND COMMUNITY-BASED WAIVER CLIENTS.
4021	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4027	THE DIAGNOSIS CODE IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
4031	THE PROCEDURE SUBMITTED IS NOT APPROPRIATE FOR CLIENTS GENDER.
4032	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4034	THE PROCEDURE CODE HAS AN AGE RESTRICTION.
4036	THE PLACE OF SERVICE CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4040	THE PRIMARY DIAGNOSIS CODE IS NOT ON FILE.
4041	THE SECONDARY DIAGNOSIS IS NOT ON FILE.
4046	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4059	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4077	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4127	INTERNAL PROCESSING IS REQUIRED.
4131	INTERNAL PROCESSING IS REQUIRED.
4141	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4149	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4150	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4236	ETIOLOGY DIAGNOSIS CODE(S) (E-CODES) ARE INVALID AS THE PRIMARY DIAGNOSIS.
4244	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4245	THE FOURTH POSITION MODIFIER IS INVALID FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT.
4256	THE PROCEDURE CODE AND MODIFIER COMBINATION IS NOT PAYABLE FOR THE CLIENTS BENEFIT PLAN.
4257	THE MODIFIERS SUBMITTED ARE EITHER INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT OR THE MODIFIERS ARE MISSING.
4311	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4315	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4316	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4371	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4372	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4711	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR CLIENTS AGE.
4714	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS AGE.

Denial Code	Long Description
4731	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS DIAGNOSIS.
4742	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4743	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4744	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4745	DIAGNOSIS AND/OR PROCEDURE AND/OR PLACE OF SERVICE (POS) CODE IS NOT COVERED FOR EXPRESS ENROLLMENT CLIENTS.
4746	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4801	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4802	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
4821	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
4871	PLEASE REFER TO PA MESSAGES FOR RETURN INFORMATION.
4963	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS GENDER.
4990	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
7500	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
7509	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
P001	THE BILLING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THE SERVICES.
P002	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P003	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P005	THE PRIOR AUTHORIZATION CAN NOT BE END DATED. THE PRIOR AUTHORIZATION STATUS IS NOT APPROVED OR APPROVED WITH REVISIONS.
P006	PLEASE FURNISH THE PROCEDURE CODE AND CORRESPONDING DESCRIPTION.
P008	THE BILLING PROVIDER NUMBER IS INVALID.
P009	THE BILLING PROVIDER NUMBER IS INVALID.
P010	THE REQUESTED END DATE IS INVALID.
P011	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P012	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P013	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P014	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P015	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P016	THE REQUESTED START DATE IS MISSING OR INVALID.
P019	THE REQUESTED START DATE IS MISSING OR INVALID.
P020	THE RENDERING PROVIDER NUMBER IS INVALID.
P021	THE RENDERING PROVIDER NUMBER IS INVALID.
P022	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P023	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P024	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P026	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P027	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P030	FIRST MODIFIER IS INVALID.
P031	FIRST MODIFIER IS INVALID.
P032	SECOND MODIFIER IS INVALID.
P033	SECOND MODIFIER IS INVALID.
P034	THIRD MODIFIER IS INVALID.
P035	THIRD MODIFIER IS INVALID.
P036	FOURTH MODIFIER IS INVALID.
P037	FOURTH MODIFIER IS INVALID.

Denial Code	Long Description
P038	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P039	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P040	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P041	CLIENTS FIRST NAME IS MISSING.
P042	CLIENTS LAST NAME IS MISSING.
P043	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P044	BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES REQUESTED.
P045	FIRST MODIFIER IS INVALID.
P046	SECOND MODIFIER IS INVALID.
P047	THIRD MODIFIER IS INVALID.
P048	FOURTH MODIFIER IS INVALID.
P050	PLEASE SUPPLY THE LICENSE NUMBER OF THE CASE COORDINATOR. THE LICENSE NUMBER OF THE CASE COORDINATOR MUST BE NUMERIC, PLEASE CORRECT.
P052	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P053	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P054	RENDERING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES FOR THE BENEFIT PLAN.
P055	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P061	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P062	THE CLIENT ID AND/OR NAME INDICATED ON THE PA REQUEST IS INCORRECT. THE CLIENT ID AND/OR NAME HAS BEEN UPDATED. PLEASE VERIFY THE ID AND/OR NAME IS CORRECT.
P064	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
P067	THE FREQUENCY OF HOURS REQUESTED ARE NOT APPROPRIATE FOR THIS CLIENT AND HAVE BEEN MODIFIED ACCORDINGLY.
P079	BILLING PROVIDER IS ON PAYMENT SUSPENSION DUE TO CREDIBLE ALLEGATION OF FRAUD.
P120	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAS BEEN REDUCED.
P121	THE SERVICE/ PROCEDURE REQUESTED IS NOT SUPPORTED BY SUBMITTED DOCUMENTATION.
P126	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
P128	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.
P138	SERVICE(S) DO NOT MEET COLORADO MEDICAID GUIDELINES.
P167	REQUESTED DOCUMENTATION HAS NOT BEEN SUBMITTED.
P178	THE SERVICE REQUESTED IS NOT MEDICALLY NECESSARY.
P179	THE MEDICAL NECESSITY FOR THIS SERVICE IS NOT SUPPORTED BY THE SUBMITTED DOCUMENTATION.
P233	THE DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE ADDITIONAL CARE.
P257	THIS CLIENTS FUNCTIONAL ASSESSMENT SCORES PLACE THIS CLIENT OUTSIDE ELIGIBILITY FOR DAY TREATMENT.
P274	OUR RECORDS INDICATE THIS CLIENT IS INVOLVED IN EFFECTIVE AND APPROPRIATE SERVICE ELSEWHERE.
P292	INTENSIVE REHABILITATION HOURS ARE NO LONGER APPROPRIATE AS INDICATED BY HISTORY, DIAGNOSIS, AND/ OR FUNCTIONAL ASSESSMENT SCORES.
P328	THE SERVICES REQUESTED INCLUDE NON-COVERED SERVICES, AND HOURS ARE REDUCED ACCORDINGLY.
P339	THE CLIENTS PAST HISTORY INDICATES REDUCED TREATMENT HOURS ARE WARRANTED.
P342	THE REQUEST DOES NOT MEET GENERALLY ACCEPTED CONDITIONS REQUIRING FLUORIDE TREATMENTS.
P346	SERVICES EXCEED COLORADO MEDICAID LIMITATION AND DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE MEDICAL NECESSITY OF THE SERVICE.
P349	THE SERVICE REQUESTED WAS PERFORMED LESS THAN FIVE YEARS AGO.
P353	THE EXISTING APPLIANCE HAS NOT BEEN WORN FOR THREE YEARS.
P367	THE CLIENT HAS BEEN TOTALLY WITHOUT TEETH AND AN APPLIANCE FOR FIVE YEARS.

Denial Code	Long Description
P392	THE CLIENT IS MISSING AN ANTERIOR TOOTH AND/OR HAS TWO OR MORE POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P405	THE SERVICE(S) REQUESTED COULD ADEQUATELY BE PERFORMED IN THE DENTAL OFFICE.
P406	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE OF GOOD PERIODONTAL HEALTH (AMERICAN ACADEMY OF PERIODONTOLOGY PERIODONTAL CLASSIFICATION OF TYPE I OR II).
P407	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE VISIBLE ON RADIOGRAPHS THAT AT LEAST 50 PERCENT OF THE CLINICAL CROWN IS INTACT.
P409	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING SIX OR MORE TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED, INCLUDING THIRD MOLARS.
P410	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING ONE OR MORE ANTERIOR TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED.
P411	DOCUMENTATION DOES NOT SUPPORT THE NEED FOR PERIODONTIC SERVICES. POCKETS ARE LESS THAN 4MM AND/OR GREATER THAN 6MM FOR CLIENT AND/OR THE CLIENT IS UNDER THE AGE OF 13.
P412	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA.
P413	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA. THIS PA HAS BEEN GRANTED AS APPROVED NOT APPROVED WITH REVISIONS. THE DURATION REQUESTED MAY HAVE BEEN REDUCED TO REFLECT COVERAGE LIMITATIONS, PRESCRIBER ORDERS, CONFLICTI
P417	THE SERVICE(S) REQUESTED COULD BE ADEQUATELY PERFORMED WITH LOCAL ANESTHESIA.
P437	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO POOR ORAL HYGIENE.
P444	THIS LINE ITEM IS A DUPLICATE OF ANOTHER LINE ITEM ON THIS PRIOR AUTHORIZATION (PA) REQUEST. PLEASE CORRECT.
P446	THIS IS A DUPLICATE OF AN EXISTING PRIOR AUTHORIZATION (PA) REQUEST. YOU MAY CONTACT PROVIDER SERVICES IF YOU REQUIRE ASSISTANCE. DUPLICATE PA REQUEST
P448	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO DECAY HISTORY.
P449	QUESTIONABLE LONG TERM PROGNOSIS DUE TO GUM AND BONE DISEASE.
P456	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO APPARENT ROOT INFECTION.
P457	OUR RECORDS INDICATE THIS CLIENT HAS EXCEEDED ESTABLISHED PROGRAM LIMITATIONS. COLORADO MEDICAID WILL NOT AUTHORIZE NEW DENTURES.
P458	DOCUMENTATION PROVIDED INDICATES A LESS ELABORATE PROCEDURE SHOULD BE CONSIDERED.
P502	RENTAL ONLY ALLOWED; MEDICAL NEED FOR PURCHASE HAS NOT BEEN DOCUMENTED.
P503	PURCHASE ONLY ALLOWED; MEDICAL NEED FOR RENTAL HAS NOT BEEN DOCUMENTED.
P504	OCCUPATIONAL THERAPY GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P505	THE SERVICE REQUESTED IS INCLUDED IN THE NURSING HOME RATE STRUCTURE.
P511	THIS NATIONAL DRUG CODE IS ONLY BILLABLE AS PART OF A COMPOUND DRUG.
P515	THE PRESENCE OF A HANDICAPPING MALOCCLUSION OR HANDICAPPING DENTOFACIAL DEFORMITY IS NOT SUPPORTED BY THE DOCUMENTATION SUBMITTED.
P521	THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVERED BY COLORADO MEDICAID.
P522	GASTRO-INTESTINAL SURGERY FOR THE PURPOSE OF WEIGHT CONTROL IS COVERED ONLY AS A LIFE THREATENING PROCEDURE.
P523	THE TREATMENT REQUEST IS NOT CONSISTENT WITH THE CLIENT'S DIAGNOSIS.
P524	PSYCHOTHERAPY PROVIDED IN THE CLIENTS HOME IS NOT A COVERED BENEFIT OF COLORADO MEDICAID.
P525	THE INFORMATION PROVIDED IS NOT CONSISTENT WITH THE INTENSITY OF SERVICES REQUESTED.
P526	INTENSIVE MULTIPLE MODALITY TREATMENT IS NOT CONSISTENT WITH THE INFORMATION PROVIDED.
P527	MULTIPLE PROVIDERS OF TREATMENT ARE NOT INDICATED FOR THIS CLIENT.
P528	THE DURATION OF TREATMENT SESSIONS EXCEED CURRENT COLORADO MEDICAID GUIDELINES.
P534	DOCUMENTATION OF POOR PHYSICAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P535	OTHER PHYSICAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P536	THE PHYSICAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P537	USE OF PHYSICAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.

Denial Code	Long Description
P538	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF A PHYSICAL THERAPIST.
P539	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS AND LIVING ARRANGEMENT.
P540	GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P541	THE PROCEDURE(S) REQUESTED ARE NOT MEDICAL IN NATURE.
P542	DOCUMENTATION OF POOR OCCUPATIONAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P543	DOCUMENTATION OF POOR SPEECH THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P544	OTHER OCCUPATIONAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P546	THE OCCUPATIONAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P547	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF PHYSICAL THERAPY.
P548	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P549	ACTIVITIES TO PROMOTE DIVERSION OR GENERAL MOTIVATION ARE NONCOVERED COLORADO MEDICAID SERVICES.
P550	REVISIONS OF THE REQUEST IS NECESSITATED BY THE CLIENTS MINIMAL PROGRESS.
P551	RESTORATIVE NURSING INVOLVEMENT COULD BE INCREASED.
P552	CLIENTS DEMONSTRATED RESPONSE TO CURRENT THERAPY DOES NOT WARRANT THE INTENSE FREQUENCY REQUESTED.
P553	MAINTENANCE IS TWO TIMES PER WEEK OR LESS.
P554	THE SPEECH THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P555	USE OF OCCUPATIONAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P556	USE OF SPEECH THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P557	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF AN OCCUPATIONAL THERAPIST.
P558	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
P559	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P560	THE MATERIALS/ SERVICES REQUESTED ARE PRINCIPALLY COSMETIC IN NATURE.
P561	THE LENS FORMULA DOES NOT JUSTIFY REPLACEMENT.
P562	THE CHANGE IN THE LENS FORMULA DOES NOT WARRANT MULTIPLE REPLACEMENTS.
P563	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P564	LENSES ONLY ARE APPROVED; PLEASE DISPENSE A CONTRACTED FRAME. THE NON-CONTRACTED FRAME IS NOT MEDICALLY JUSTIFIED.
P565	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P566	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P567	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF OCCUPATIONAL THERAPY.
P568	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF SPEECH THERAPY.
P569	LEVEL, INTENSITY, OR EXTENT OF SERVICE(S) REQUESTED HAS BEEN MODIFIED CONSISTENT WITH MEDICAL NEED AS DEFINED IN THE PLAN OF CARE.
P570	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P571	THE SERVICE ASKED FOR IS NOT COVERED BY COLORADO MEDICAID AS THESE TASKS CAN BE DONE BY NURSES OR ACTIVITY STAFF.
P572	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P573	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.

Denial Code	Long Description
P574	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P575	MEDICAL NEED FOR EQUIPMENT/ SUPPLY REQUESTED IS NOT SUPPORTED BY DOCUMENTATION SUBMITTED.
P576	OTHER SPEECH THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P577	DOCUMENTATION SUBMITTED IDENTIFIES THAT THE CLIENT HAS FEWER THAN TWO POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P582	LESS EXPENSIVE ALTERNATIVE SERVICES ARE AVAILABLE FOR THIS CLIENT.
P634	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P711	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING PERIODONTAL SCALING AND ROOT PLANNING.
P712	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING GINGIVECTOMY.
P754	AN APPROVED SUBSTANCE ABUSE DAY TREATMENT PROGRAM CANNOT EXCEED A SIX WEEK PERIOD.
P761	THE CLIENT DOES NOT APPEAR TO BE ABLE OR WILLING TO ABSTAIN FROM ALCOHOL/DRUG USAGE WHILE IN TREATMENT. THEREFORE, SUBSTANCE ABUSE DAY TREATMENT SERVICES ARE NOT APPROVED.
P764	THIS CLIENT HAS COMPLETED INTENSIVE SUBSTANCE ABUSE TREATMENT WITHIN THE PAST 12 MONTHS. THE DOCUMENTATION PROVIDED IS NOT ADEQUATE TO JUSTIFY ADDITIONAL INTENSIVE TREATMENT AT THIS TIME.
P785	A LESS THAN SIX-WEEK HEALING PERIOD HAS BEEN SPECIFIED FOR THIS PRIOR AUTHORIZATION. THEREFORE IT IS NOT NECESSARY TO WAIT THE FULL SIX WEEKS AFTER EXTRACTIONS BEFORE TAKING DENTURE IMPRESSIONS.
P818	SIX-WEEK HEALING TIME IS REQUIRED BETWEEN EDENTULATION AND FINAL IMPRESSIONS. PAYMENT FOR DENTURES WILL BE DENIED OR RECOUPED IF HEALING PERIOD IS NOT OBSERVED.
P849	COLORADO MEDICAID HAS DETERMINED THERE WERE (ARE) SEVERAL HOME HEALTH AGENCIES WILLING TO PROVIDE MEDICALLY NECESSARY SKILLED NURSING SERVICES TO THIS CLIENT.
P864	THE DOCUMENTATION YOU HAVE SUBMITTED DOES NOT MEET THE REQUIREMENTS OF COLORADO MEDICAID.
P873	THE MEDICAL NECESSITY FOR THE HOURS REQUESTED IS NOT SUPPORTED BY THE INFORMATION SUBMITTED.
P874	THE DOCUMENTATION SUBMITTED INDICATES THE TASKS SPECIFIED CAN BE COMPLETED DURING THE VISITS APPROVED.
P878	THE DOCUMENTATION SUBMITTED DOES NOT INDICATE THAT MEDICALLY ORIENTED TASKS ARE MEDICALLY NECESSARY; THEREFORE PERSONAL CARE SERVICES HAVE BEEN APPROVED.
P880	THE QUANTITY OF SERVICES AUTHORIZED FOR THIS CLIENTS PERSONAL CARE HAS BEEN AMENDED BASED ON INFORMATION RECEIVED FROM ONE OR MORE OF THESE SOURCES: THE CLIENT, THEIR PHYSICIAN, AND/OR THE IN-HOME VISIT BY STAFF OF THE OIG (OFFICE OF INSPECTOR GENERAL).
P885	THE USE OF THIS DRUG FOR THE INTENDED PURPOSE IS NOT COVERED BY COLORADO MEDICAID, CONSISTENT WITH COLORADO ADMINISTRATIVE CODE AND FEDERAL LAW.
P924	THE MEDICAL RECORDS SUBMITTED WITH THE CURRENT REQUEST CONFLICT OR DISAGREE WITH OUR MEDICAL RECORDS ON THIS CLIENT.
P950	INDEPENDENT NURSES, PLEASE NOTE PAYABLE SERVICES MAY NOT EXCEED 12 HOURS/DAY OR 60 HOURS/WEEK.
P951	SERVICES CAN ONLY BE AUTHORIZED THROUGH ONE YEAR FROM THE PRESCRIPTION DATE.
P952	LEAD INSPECTION IS A COVERED COLORADO MEDICAID SERVICE WHEN THE CHILD HAS BEEN SHOWN TO HAVE LEAD POISONING (E.G., CHILD HAS A BLOOD LEAD LEVEL > 19 UG/DL OR TWO CONSECUTIVE BLOOD LEAD LEVELS OF 15-19 UG/DL DONE AT LEAST 90 DAYS APART). THE INSPECTION MUS
P953	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P954	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P956	THE REQUEST CAN ONLY BE BACKDATED A MAXIMUM OF 14 DAYS FROM FIRST DATE RECEIVED BY COLORADO MEDICAID.

Denial Code	Long Description
P957	COMPLETE PERIODONTAL CHARTING AT TIME OF SERVICE, AND SUBMIT CHARTING, COPY OF OPERATIVE REPORT, TOGETHER WITH A COPY OF THE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF), F-11035, TO PA UNIT ATTENTION DENTAL CONTSULTANT.
P958	NOTE THAT CODE D4341 HAS BEEN CHANGED. REFER TO THE DECISION NOTICE FOR AUTHORIZED QUANTITY.
P960	YOUR PA HAS BEEN APPROVED FOR 90 DAYS. THE 90 DAY APPROVAL DOES NOT IMPLY THE PA REQUEST MEETS PRIOR AUTHORIZATION CRITERIA. AFTER ADDITIONAL INFORMATION IS AVAILABLE IN INTERCHANGE, COLORADO MEDICAID WILL CREATE AN AMENDMENT REQUEST TO EXTEND THE PA FOR
P961	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P962	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P963	PA AUTHORIZED FOR PRIVATE DUTY NURSING SERVICES TO A VENTILATOR DEPENDENT CLIENT (99504 [TD] AND 99504 [TE]).
P964	PA AUTHORIZED FOR PRIVATE DUTY NURSING SERVICES (S9123 AND S9124).
P965	PA AUTHORIZED FOR SERVICES AT A PEDIATRIC COMMUNITY CARE CENTER (T1026 [59]).
P989	YOUR PRIOR AUTHORIZATION REQUEST FOR PERSONAL CARE SERVICES HAS BEEN APPROVED AS REQUESTED, WHICH IS EQUAL TO OR LESS THAN THE TOTAL ANNUAL UNITS ALLOCATED ON THE PERSONAL CARE SCREENING TOOL SUMMARY SHEET.
PA10	THE REQUESTED END DATE IS INVALID.
PA12	PLEASE FURNISH A WRITTEN DESCRIPTION OF THE CLIENTS DIAGNOSIS.
PA13	PROVIDE DIAGNOSES WITH DATES OF ONSET.
PA14	IDENTIFY PROBLEMS TO BE TREATED.
PA15	THE AUDIOLOGISTS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1), F-11020, AND PRIOR AUTHORIZATION REQUEST/HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2), F-11021.
PA16	THE PHYSICIANS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION/PHYSICIAN OTOLOGICAL REPORT (PA/POR), F-11019.
PA17	SUBMIT BRIEF HISTORY WITH REFERRAL INFORMATION, LIVING SITUATION, FUNCTIONAL STATUS, AND OTHER PERTINENT INFORMATION. WHAT CHANGE OF STATUS RESULTED IN REFERRAL AT THIS TIME?
PA18	PLEASE FURNISH THE CLIENTS HEIGHT AND WEIGHT.
PA19	PLEASE SUBMIT CLINICAL INFORMATION SUFFICIENT TO VERIFY THE NEED FOR THE REQUESTED SERVICE(S).
PA20	PLEASE RESUBMIT WITH COMPLETE PERIODONTAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PA21	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL EDUCATIONAL PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA22	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL PROGRAM PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA23	REFER TO THE DURABLE MEDICAL EQUIPMENT INDEX FOR APPROPRIATE CODE AND DESCRIPTION. DO NOT USE AN "UNLISTED" CODE.
PA24	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUALIZED FAMILY SERVICE PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA25	INFORMATION ON THE REQUEST FORM IS ILLEGIBLE, AND THE REQUEST CANNOT BE PROCESSED.
PA26	RE-EVALUATE YOUR GOALS. EMPHASIS SHOULD BE ON FUNCTIONAL SELF-CARE. GOALS MUST BE RELATED TO FUNCTIONAL OUTCOME.
PA27	PLEASE CLARIFY THE NUMBER OF HOURS PER WEEK REQUESTED.
PA28	PLEASE CLARIFY THE NUMBER OF HOURS PER DAY REQUESTED.
PA29	PLEASE CLARIFY THE NUMBER OF VISITS PER DAY REQUESTED.
PA30	ATTACH SUPPORTIVE DOCUMENTATION; HOME EXERCISE PROGRAM AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA31	THE DIAGNOSIS CODE INDICATED ON THE REQUEST DOES NOT CORRESPOND TO THE DIAGNOSIS CODE DESCRIPTION.

Denial Code	Long Description
PA32	PLEASE SUBMIT ADDITIONAL INFORMATION SUFFICIENT TO VERIFY APPROPRIATENESS AND NEED FOR TRANSPLANT.
PA33	PLEASE SUBMIT THE INITIAL AND PROGRESSIVE OBJECTIVE FINDINGS.
PA34	ATTACH SUPPORTIVE DOCUMENTATION, FACILITY PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA35	PLEASE SUBMIT THE CLIENTS ORIGINAL COMPLAINTS AND EXAMINATION FINDINGS.
PA36	ATTACH SUPPORTIVE DOCUMENTATION, IN-HOME AUTISM PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA37	PLEASE SUBMIT YOUR TREATMENT PLAN FOR THIS CLIENT.
PA38	ATTACH SUPPORTIVE DOCUMENTATION AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA39	INITIAL EVALUATIONS MUST BE PERFORMED BY AN OCCUPATIONAL THERAPIST REGISTERED (OTR), PER AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA) STANDARDS.
PA41	IDENTIFY THE PLACE OF SERVICE AND ITS EFFECT ON SUPPORTING THE DESIRED TREATMENT OUTCOME.
PA42	PLEASE INDICATE THE HOURS OF USE OF OXYGEN PER 24-HOUR PERIOD.
PA43	PROVIDE BASELINE DOCUMENTATION FOR THIS CLIENTS LIMITATIONS USING UNITS OF MEASUREMENT THAT ARE APPLIED CONSISTENTLY WHEN REPORTING STATUS.
PA44	IDENTIFY FUNCTIONAL LIMITATIONS AS THEY ARE RELATED TO IDENTIFIED CONDITIONS.
PA46	CORRELATE PLAN OF CARE TO REQUESTED PROCEDURE CODES.
PA47	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE FREQUENCY/DURATION REQUESTED.
PA48	PLEASE PROVIDE THE NAME AND CREDENTIALS OF THE RENDERING PROVIDER.
PA50	COLORADO MEDICAID RECORDS INDICATE THE CLIENT OWNS A WHEELCHAIR. DOCUMENT THE REASON AND NEED FOR REPLACEMENT AND COST TO REPAIR CURRENT WHEELCHAIR.
PA51	PLEASE DISTINGUISH PRIMARY AND SUPPORTIVE MODALITIES.
PA52	PLEASE SUBMIT A PROGRESS REPORT.
PA53	MULTIPLE FAMILY CLIENTS TREATMENT BY THE SAME PROVIDER REQUIRES FURTHER INFORMATION DOCUMENTING COORDINATION OF TREATMENT PLAN.
PA54	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE MINUTES REQUESTED.
PA55	MEDICAL NECESSITY OF TREATMENT REQUIRES ADDITIONAL DOCUMENTATION.
PA56	GIVEN AGE, DIAGNOSES, CURRENT LEVEL OF FUNCTION, PAST RESPONSE TO TREATMENT, AND LIVING SITUATION, EXPAND ON POTENTIAL FOR SIGNIFICANT FUNCTIONAL PROGRESS WITHIN THE NEXT SIX MONTHS. EMPHASIZE WHY PROGRESS IS EXPECTED WITH SERVICES AT THIS TIME.
PA57	SUBMIT THE INITIAL FINDINGS. INCLUDE A COMPREHENSIVE EVALUATION.
PA58	SUBMIT PROGRESSIVE, OBJECTIVE FINDINGS. INCLUDE A PERTINENT RE-EVALUATION.
PA59	PLEASE SUPPLY INFORMATION REGARDING THE CLIENTS MEDICATION REQUIREMENTS, IF ANY.
PA60	PLEASE SPECIFY IF THE CLIENT IS IN AN EDUCATIONAL SETTING.
PA61	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA62	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
PA63	THE SKILLS OF A THERAPIST ARE PURPOSEFUL AND SKILLED INTERVENTIONS REQUIRED TO CONTINUALLY DESIGN, IMPLEMENT, REASSESS, MODIFY/GRADE, AND/OR DISCONTINUE A PLAN OF CARE IN A TIMELY MANNER, BASED ON THE COMPLEXITY OF THE CLIENTS MEDICAL CONDITION AND/OR CO
PA64	PLEASE SUBMIT A THERAPY PLAN OF CARE, INCLUDING A CURRENT, DATED EVALUATION.
PA65	A PLAN OF CARE SIGNED AND DATED BY THE PHYSICIAN IS REQUIRED.
PA66	THE SKILLS OF A THERAPIST ARE REQUIRED WHEN ONLY THE THERAPIST CAN SAFELY AND EFFECTIVELY DELIVER THE THERAPEUTIC PROCEDURES BECAUSE OF THEIR UNIQUE KNOWLEDGE, TRAINING, AND EXPERTISE. DESCRIBE THE REASON THAT SOMEONE OTHER THAN A THERAPIST CANNOT SAFELY
PA67	PLEASE SPECIFY IF THE CLIENTS WORK SITE DEMANDS GOOD BINAURAL HEARING.
PA68	DESCRIBE THE REASON, BASED ON THE CLIENTS COGNITIVE, PHYSICAL, COMMUNICATION, OR RESOURCE STATUS, THAT A HOME PROGRAM, EQUIPMENT, OR ENVIRONMENTAL ADAPTATIONS ALONE CANNOT MEET CLIENTS NEEDS.

Denial Code	Long Description
PA69	PLEASE SPECIFY IF THE CLIENT HAS AN ACCOMPANYING DISABILITY THAT ADDS TO THE HEARING PROBLEM.
PA70	DISTINGUISH REQUESTED PROCEDURES AND GOALS FROM OTHER SERVICES THIS CLIENT RECEIVES. THEY MAY NOT BE DUPLICATIVE.
PA71	PLEASE INDICATE THE NUMBER OF DAYS REQUESTED.
PA73	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA74	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA75	PLEASE DOCUMENT CARRYOVER OF THE THERAPY PROGRAM TO NURSING.
PA76	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA79	PROVIDE EVIDENCE OF SIGNIFICANT FUNCTIONAL PROGRESS IN LAST SIX MONTHS.
PA80	PA REQUESTS FOR PRIVATE DUTY NURSING CANNOT BE SUBMITTED WITH OTHER SERVICES. PLEASE SUBMIT SEPARATE PA REQUESTS.
PA81	THE PA AMENDMENT REQUEST MUST BE SUBMITTED BY THE BILLING PROVIDER INDICATED ON THE PA.
PA82	PA REQUESTS FOR PRIVATE DUTY NURSING MUST BE SUBMITTED BY A REGISTERED NURSE IN INDEPENDENT PRACTICE, HOME HEALTH AGENCY, OR PEDIATRIC COMMUNITY CARE PROVIDER.
PA84	THE GRANT DATE OF THIS REQUEST CANNOT BE PRIOR TO THE SIGNATURE DATE OF THE PRESCRIBING PHYSICIAN.
PA86	PROVIDE EVIDENCE OF SKILLS GAINED IN THERAPY CARRYING OVER TO OTHER SETTINGS WITHIN SIX MONTHS.
PA87	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE NUMBER OF SESSIONS REQUESTED.
PA88	THE REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL SCOPE OF PRACTICE.
PA89	PRIOR AUTHORIZATION IS NOT REQUIRED UNTIL LIMITATION OF SERVICE HAS BEEN REACHED.
PA91	PLEASE SUBMIT REQUIRED X-RAYS.
PA92	PLEASE PROVIDE AN EXPLANATION FOR THE MATERIAL SUBMITTED WITH THE REQUEST.
PA95	PLEASE DESCRIBE HOW THE PROVISION OF THIS SERVICE WOULD PREVENT INSTITUTIONALIZATION OF THE CLIENT.
PA96	COULD THE EXISTING DENTURE(S) BE RELINED OR REBASED? IF NOT, PLEASE EXPLAIN WHY NOT.
PA97	REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL STANDARDS OF PRACTICE.
PA98	PLEASE INDICATE IF THE CLIENT IS CURRENTLY BEING TUBE FED.
PB02	PLEASE PROVIDE THE REQUIRED DATED SIGNATURES ON THE ATTACHMENTS.
PB03	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING THE LOSS/DESTRUCTION/THEFT OF THE HEARING AID.
PB04	DESCRIBE THE CLIENTS ABILITY TO STAND OR AMBULATE SUFFICIENTLY TO ACCOMPLISH SELF-CARE ACTIVITIES.
PB07	PLEASE SUBMIT AN ORTHODONTIC STUDY MODEL OR DIAGNOSTIC CASTS.
PB09	PLEASE PROVIDE A PHOTOGRAPH OF THE INVOLVED AREA(S).
PB10	PLEASE PROVIDE AN ESTIMATION (IN GRAMS) OF THE TOTAL AMOUNT OF TISSUE TO BE RESECTED.
PB11	PLEASE SUBMIT THE PLAN OF CARE FOR CO-TREATMENT.
PB12	FURNISH A DETAILED DESCRIPTION FOR THE PROCEDURE CODE REQUESTED.
PB13	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB15	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB18	PLEASE COMPLETE THE ATTACHED OUT-OF-STATE PROVIDER DATA SHEET, F-11001, AND RESUBMIT.
PB20	A SIGNED AND DATED PRESCRIPTION IS REQUIRED WITHIN THREE MONTHS OF RECEIPT BY COLORADO MEDICAID FOR INITIAL REQUESTS AND WITHIN 12 MONTHS OF RECEIPT BY COLORADO MEDICAID FOR SUBSEQUENT REQUESTS.
PB21	PLEASE COMPLETE THE APPROPRIATE PRIOR AUTHORIZATION ATTACHMENT. CONTACT PROVIDER SERVICES OR THE PRIOR AUTHORIZATION UNIT FOR ASSISTANCE.
PB23	PHYSICAL THERAPY ASSISTANT NOTES AND ALL FORMS SUBMITTED MUST BE COSIGNED BY A REGISTERED PHYSICAL THERAPIST.
PB31	ARE YOU REQUESTING A COMPLETE APPLIANCE, OR REPLACEMENT PARTS?

Denial Code	Long Description
PB32	THE PROCEDURE CODE INDICATED ON THE REQUEST DOES NOT MATCH THE DESCRIPTION OF SERVICE; PLEASE CORRECT AND RESUBMIT.
PB35	THE SERVICE REQUESTED DOES NOT REQUIRE PRIOR AUTHORIZATION.
PB41	PLEASE FURNISH A CURRENT MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT, F-11090 (DATED WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID).
PB45	THE CERTIFICATION PERIOD ON THE PLAN OF CARE (POC) DOES NOT COVER THE REQUESTED GRANT/START DATE. PLEASE RESUBMIT YOUR REQUEST WITH A NEW POC.
PB49	A CERTIFIED OCCUPATIONAL THERAPY ASSISTANTS NOTES MUST BE COSIGNED BY AN OCCUPATIONAL THERAPIST REGISTERED.
PB51	ADDITIONAL INFORMATION IS REQUIRED ON PRIOR AUTHORIZATION TO ENABLE PRICING.
PB54	REQUESTED SERVICES DO NOT MATCH SERVICES ON THE PHYSICIANS ORDERS.
PB59	PLEASE PROVIDE AN INDIVIDUAL EDUCATIONAL PLAN (IEP), WHICH HAS BEEN SIGNED BY THE PROVIDER NO EARLIER THAN NINE MONTHS PRIOR TO RECEIPT AT COLORADO MEDICAID; OTHERWISE, DOCUMENT WHY NO IEP EXISTS.
PB65	PLEASE FURNISH THE ANTICIPATED TOTAL CHARGES FOR THIS REQUEST.
PB66	A PHOTOCOPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED; THE DATE MUST BE WITHIN SIX MONTHS OF RECEIPT BY COLORADO MEDICAID.
PB67	THE PRESCRIPTION DATE MUST INCLUDE MONTH, DAY, AND YEAR.
PB68	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID.
PB73	THE SERVICES IDENTIFIED ON THE PLAN OF CARE DO NOT APPEAR APPROPRIATE FOR THE PROCEDURE CODE(S) REQUESTED ON THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018.
PB74	THE CLIENT/PROVIDER DOES NOT HAVE RETROACTIVE ENROLLMENT.
PB75	THE REQUESTED START DATE IS MORE THAN 14 DAYS BEFORE OR 62 DAYS AFTER RECEIPT.
PB82	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
PB83	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A HOME HEALTH AIDE. PLEASE RESUBMIT AS A PERSONAL CARE WORKER OR PROVIDE ADDITIONAL DOCUMENTATION.
PB86	THE SERVICES REQUESTED ARE NOT BEING PROVIDED IN THE CLIENTS RESIDENCE. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL.
PB87	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A NURSE. PLEASE RESUBMIT AS A HOME HEALTH AIDE OR PROVIDE ADDITIONAL DOCUMENTATION.
PB92	PLEASE FURNISH THE CLIENTS COMPLETE ADDRESS.
PB94	IF THE CLIENT IS A RESIDENT OF A NURSING HOME, SUPPLY THE COMPLETE NAME AND ADDRESS OF THE NURSING HOME.
PB99	THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018, MUST BE SIGNED AND DATED.
PC01	PLEASE SUPPLY THE RENDERING PROVIDERS PROVIDER NUMBER.
PC03	THE DRUG ENFORCEMENT ADMINISTRATION NUMBER IS MISSING OR INVALID.
PC06	PLEASE DESCRIBE YOUR PROGRAM; INCLUDE ENTRY DATE, TERMINATION DATE, HOURS PER WEEK, AND NUMBER OF WEEKS OF PRIMARY INTENSIVE SERVICE REQUESTED.
PC07	PLEASE DESCRIBE YOUR "AFTERCARE/FOLLOW-UP" PLANS FOR THIS CLIENT.
PC08	PLEASE SUPPLY DOCUMENTATION OF PREVIOUS SUBSTANCE ABUSE SERVICES WITH DATE(S) AND OUTCOME.
PC09	PLEASE DESCRIBE IN DETAIL THE TREATMENT OBJECTIVES/GOALS FOR THIS CLIENT.
PC10	PLEASE DESCRIBE THE FAMILY SITUATION/DYNAMICS. EXPLAIN HOW THE FAMILY WILL BE INCORPORATED INTO THE CLIENTS PLAN OF CARE.
PC12	PLEASE EXPLAIN IF YOUR SERVICE ENCOURAGES THE CLIENT TO ATTEND SELF-HELP GROUPS.
PC13	PLEASE SUPPLY A SPECIFIC SCHEDULE OF ACTIVITIES, INCLUDING DAY, TIME OF DAY, LENGTH OF SESSION, AND SERVICE TO BE RENDERED DURING THAT TIME.
PC15	PLEASE FURNISH DIAGNOSTIC RATIONALE.
PC17	PLEASE DOCUMENT IF THE CLIENT EVER RECEIVED SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT.
PC19	PLEASE FURNISH MORE EXTENSIVE AND IN-DEPTH HISTORICAL AND PSYCHOSOCIAL DATA.
PC20	PLEASE SUPPLY THE DATE THE CLIENT BECAME TOTALLY ENDENTULOUS.
PC23	PLEASE SUBMIT A PHYSICIANS STATEMENT REGARDING THE MEDICAL NECESSITY OF DENTURES FOR THIS CLIENT. THE PHYSICIANS STATEMENT MUST DOCUMENT THE MEDICAL NEED FOR DENTURES.

Denial Code	Long Description
PC24	THE SERVICE REQUESTED WAS PREVIOUSLY AUTHORIZED. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT INDICATING THIS FACT IS REQUIRED.
PC25	PLEASE SUPPLY SUFFICIENT MITIGATING CIRCUMSTANCES TO WARRANT THE CONSTRUCTION OF NEW DENTURES(S).
PC26	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
PC28	PLEASE SUBMIT A PHYSICIANS STATEMENT INDICATING DENTURES ARE NECESSARY FOR THIS NURSING HOME CLIENT.
PC29	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING LOSS OR DESTRUCTION OF DENTURE(S). INCLUDE SIGNED STATEMENT FROM CLIENT OR FACILITY DIRECTOR REGARDING HOW, WHEN AND WHERE LOST.
PC30	PLEASE PROVIDE COMPLETE INTRAORAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PC31	PLEASE DESCRIBE ANY RELATED DEFORMITIES OF THE FEET.
PC34	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD WITH REQUESTED DME ITEM(S) AND DOCUMENT IF THE CLIENT CAN USE SAFELY AND INDEPENDENTLY.
PC35	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD AND DESCRIBE THE RESULTS AND EFFECTIVENESS OF THE SERVICE REQUESTED.
PC39	PLEASE INDICATE LITER FLOW PER MINUTE, HOURS OF USE PER 24 HOUR PERIOD, AND THE EXPECTED DURATION OF NEED.
PC40	THE ITEM DOES NOT REQUIRE PRIOR AUTHORIZATION UNTIL THE LIFE EXPECTANCY HAS BEEN REACHED.
PC41	PLEASE SUPPLY INFORMATION INDICATING THE NECESSITY OF POSITIONING THE CLIENT'S BODY IN MULTIPLE POSITIONS.
PC42	PLEASE INDICATE IF THE BED HEIGHT MUST BE CHANGED TO ALLOW FOR SAFE TRANSFER OR ADEQUATE BED CARE.
PC43	SUPPLY A PHYSICIANS STATEMENT INDICATING TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR UNIT HAS REDUCED PAIN, IMPROVED/INCREASED THE CLIENTS ACTIVITY LEVEL, AND/OR REDUCED CLIENTS USE OF PAIN MEDICATION.
PC44	A CURRENT AUTHORIZATION FOR THIS SERVICE IS ON FILE FOR ANOTHER PROVIDER. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT OF THAT FACT IS REQUIRED BY THE CLIENT OF FIRST PROVIDER.
PC59	DOCUMENT DECLINE OR PROGRESS IN SPECIFIC, MEASURABLE, OBJECTIVE TERMS.
PC60	DOCUMENT IF CLIENT HAS DEMONSTRATED A GOOD APPOINTMENT COMPLIANCE RECORD.
PC61	THE PHYSICIANS SIGNATURE DATE MUST NOT EXCEED 90 DAYS FROM THE DATE OF RECEIPT BY COLORADO MEDICAID.
PC62	REQUESTS FOR A CONTINUATION OF THERAPY SHOULD NOT BE SUBMITTED MORE THAN FOUR WEEKS PRIOR TO THE EXPIRATION DATE OF THE CURRENT AUTHORIZATION.
PC63	PLEASE FURNISH THE STYLE AND MANUFACTURER OF THE FRAME.
PC64	PLEASE FURNISH THE CLIENTS LENS FORMULA.
PC66	ALL REQUESTS FOR TINTS REQUIRE DOCUMENTATION OF THE VISUAL OR MEDICAL CONDITION RELATED TO PHOTOPHOBIA.
PC67	PLEASE DOCUMENT THE REASON AND JUSTIFICATION FOR REPLACEMENT BEYOND THE FIRST LENS/FRAME.
PC68	DOCUMENT IF ALL REMAINING MAXILLARY AND/OR MANDIBULAR TEETH ARE DECAY-FREE, PROPERLY RESTORED, AND PERIODONTICALLY SOUND.
PC72	SUPPLY MORE DETAIL REGARDING PROGRESS (ATTACHMENT OF GOALS, ETC.). CORRELATE PROGRESS TO PREVIOUS GOALS AND IDENTIFIED LIMITATIONS.
PC77	PLEASE SUBMIT A PLAN OF CARE DESCRIBING THE SERVICES THAT WOULD BE PROVIDED.
PC78	PLEASE DOCUMENT SPECIFIC, MEASURABLE GOALS.
PC82	THE PRIOR AUTHORIZATION (PA) SYSTEM CAN PROCESS ONLY 26 DETAILS PER PA REQUEST. PLEASE RESUBMIT YOUR REQUEST WITH NO MORE THAN 26 DETAILS.
PC83	PLEASE SUPPLY A PHYSICIANS PRESCRIPTION DATED WITHIN ONE MONTH OF REQUESTED SUBSTANCE ABUSE DAY TREATMENT.
PC84	PLEASE PROVIDE INFORMATION INDICATING THIS CLIENT IS APPROPRIATELY DETOXIFIED FROM ALCOHOL AND/OR OTHER DRUGS.

Denial Code	Long Description
PC85	PLEASE PROVIDE INFORMATION TO INDICATE THE CLIENTS ABILITY TO ABSTAIN FROM ALCOHOL OR DRUGS WHILE IN THE SUBSTANCE ABUSE DAY TREATMENT PROGRAM.
PC86	PLEASE INDICATE IF THIS CLIENT IS WILLING TO PARTICIPATE IN AFTERCARE OR CONTINUING CARE SERVICES.
PC87	PROVIDE MORE INFORMATION ON TREATMENT HISTORY; INCLUDE SERVICE PROVIDED, DATES, AND OUTCOME. PROVIDE DETAIL OF PREVIOUS TREATMENT.
PC88	PLEASE PROVIDE MORE RATIONALE FOR THE APPROPRIATENESS AND MEDICAL NECESSITY OF SUBSTANCE ABUSE DAY TREATMENT.
PC89	PROVIDE A TREATMENT PLAN THAT CONTAINS MEASURABLE GOALS AND OBJECTIVES CORRESPONDING TO THE IDENTIFIED DEFICIT.
PC91	PLEASE PROVIDE MORE INFORMATION ON FAMILY INVOLVEMENT TREATMENT.
PC92	PLEASE PROVIDE MORE HISTORY AND EXPLANATION ABOUT THE ISSUE OF ABSTINENCE FOR THIS CLIENT.
PC94	PLEASE PROVIDE THE ANTICIPATED BEGINNING DATE AND/OR THE ESTIMATED SUBSTANCE ABUSE DAY TREATMENT DISCHARGE DATE.
PC95	PLEASE SUPPLY JUSTIFICATION FOR BEGINNING CLIENT IN SERVICE PRIOR TO AUTHORIZATION BEING OBTAINED.
PC96	THE INITIAL THREE HOURS OF SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IN A CALENDAR YEAR DO NOT REQUIRE PRIOR AUTHORIZATION.
PC97	REIMBURSEMENT FOR INITIAL SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IS LIMITED TO THREE HOURS IN A CALENDAR YEAR AND DOES NOT REQUIRE PRIOR AUTHORIZATION.
PC98	THIS DRUG IS CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE BILL USING THE APPROPRIATE NATIONAL DRUG CODE (NDC) OR SUBMIT A COMPLETED DRUG ADDITION REQUEST FORM IF THE NDC IS NOT LISTED IN THE DRUG INDEX.
PC99	THIS DRUG IS NOT CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL, CURRENT ADMINISTRATIVE RULE, OR COLORADO DRUG INDEX FOR COVERAGE LIMITATIONS.
PD01	DOCUMENT THAT CLIENT HAS ACHIEVED GOOD ORAL HYGIENE, PERIODONTAL CASE TYPE 1 OR 2, AND IS MOTIVATED TO MAINTAIN SAME.
PD03	PLEASE PROVIDE AN ARTERIAL BLOOD GAS READING OR PULSE OXIMETRY RESULTS DONE ON ROOM AIR SIGNED AND DATED BY A MEDICAL DOCTOR. THIS SHOULD BE DONE WITHIN 60 DAYS OF REQUESTED SERVICE.
PD04	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 30 DAYS OF RECEIPT BY COLORADO MEDICAID.
PD07	SUBMIT A PHOTOCOPY OF A VALID PRESCRIPTION, ISSUED WITHIN THE PAST YEAR, OR COMPLETE SECTION B OF THE PRIOR AUTHORIZATION/DRUG ATTACHMENT (PA/DGA), F-11049.
PD10	BRAND MEDICALLY NECESSARY MUST BE IN THE PRESCRIBERS OWN HANDWRITING AND WRITTEN DIRECTLY ON THE PRESCRIPTION OR A SEPARATE ORDER ATTACHED TO THE ORIGINAL PRESCRIPTION.
PD12	COMPLETE DENTURES, PARTIAL DENTURES, DENTURE RELINES, AND FIXED PROSTHODONTIC SERVICES ARE NOT COVERED SERVICES FOR ADULTS FOR DATES OF SERVICE ON AND AFTER OCTOBER 1, 1995.
PD22	PLEASE COMPLETE ALL REQUIRED ELEMENTS ON THE PERSONAL CARE SCREENING TOOL (PCST), F-11133.
PD24	THIS PRIOR AUTHORIZATION REQUEST IS UNABLE TO BE PROCESSED. PLEASE RESUBMIT WITH ADDITIONAL REQUIRED FORMS, INCLUDING THE ENTIRE PERSONAL CARE SCREENING TOOL (PCST), F-11133; PERSONAL CARE ADDENDUM, F-11136; AND SUPPORTING DOCUMENTATION, AS DIRECTED.
PD25	THERE IS A PERSONAL CARE SCREENING TOOL (PCST), F-11133, COMPLETED BY ANOTHER AGENCY. CONTACT THE AGENCY TO TRANSFER SCREEN.
PD26	THERE IS A LIMITED TERM CARE FUNCTIONAL SCREEN (LTC-FS) COMPLETED BY ANOTHER AGENCY. THE PERSONAL CARE SCREENING TOOL (PCST), F-11133, INFORMATION IS IN CONFLICT WITH LTC-FS.
PD27	ONLY ONE LEVEL OF FUNCTION MAY BE SELECTED FOR ALL ELEMENTS EXCEPT TOILETING. COLORADO MEDICAID IS UNABLE TO PROCESS THE PRIOR AUTHORIZATION REQUEST.
PD28	NO UNITS MAY BE REQUESTED USING THIS PRIOR AUTHORIZATION PROCESS. PLEASE SUBMIT WITH THE APPROPRIATE ATTACHMENTS FOR REQUESTING SPECIFIC PERSONAL CARE WORKER UNITS.
PD29	CLIENT IS NOT ELIGIBLE FOR THE REQUESTED SERVICE(S) AS OF THE REQUESTED START DATE.
PD30	NO TRAVEL TIME MAY BE AUTHORIZED WHEN NO PERSONAL CARE WORKER SERVICE IS AUTHORIZED.

Denial Code	Long Description
PD32	PROVIDER NOT CERTIFIED TO RENDER THE SERVICE(S) REQUESTED.
PD34	BASED ON THE DOCUMENTATION SUBMITTED, THIS REQUEST CAN NOT BE PRIOR AUTHORIZED. REFER TO THE PA MESSAGES FROM THE CONSULTANT FOR COMPLETE EXPLANATION.
PD98	PLEASE DOCUMENT HOW AND WHEN EACH PREVIOUSLY AUTHORIZED PRO RE NATA VISIT WAS USED.

Home Health Pediatric

Denial Code	Long Description
0201	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
0233	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0235	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0237	CLIENT IDENTIFICATION NUMBER DOES NOT MATCH CLIENTS FIRST NAME.
0238	THE CLIENT IDENTIFICATION NUMBER DOES NOT MATCH THE CLIENTS LAST NAME.
0242	SECONDARY DIAGNOSIS CODE IS INVALID.
0248	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0249	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0251	PROCEDURE CODE MODIFIER IN FIRST POSITION IS INVALID.
0252	THE PROCEDURE CODE MODIFIER IN SECOND POSITION IS INVALID FOR REQUESTED START DATE OR DATE OF RECEIPT.
0253	THE PROCEDURE CODE MODIFIER IN THIRD POSITION IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
0258	THE PRIMARY DIAGNOSIS CODE IS REQUIRED.
0272	THE PRIMARY DIAGNSOSIS CODE IS INVALID.
0339	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0340	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0400	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0853	HCPCS - ANNUAL UPDATE
0885	NEVER EVENTS MODIFIERS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
0886	NEVER EVENTS DIAGNOSIS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
1000	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
1002	RENDERING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1003	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1007	RENDERING PROVIDER ID IS NOT ON FILE.
1047	THE RENDERING PROVIDERS CERTIFICATION HAS BEEN CANCELLED.
1048	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1801	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
1804	A CERTIFIED SUBSTANCE ABUSE DAY TREATMENT PROVIDER MUST SUBMIT A SUBSTANCE ABUSE DAY TREATMENT PROCEDURE CODE.
1806	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
1808	THE BILLING PROVIDER DOES NOT HAVE THE REQUIRED CERTIFICATION ADDENDUM ON FILE.
1900	THE BILLING PROVIDERS TAXONOMY CODE IS INVALID.
1901	THE RENDERING PROVIDERS TAXONOMY CODE IS INVALID.
1927	A NATIONAL PROVIDER IDENTIFIER IS REQUIRED FOR THE BILLING PROVIDER.
1934	A NATIONAL PROVIDER INDENTIFIER IS REQUIRED FOR THE RENDERING PROVIDER.
1936	THE BILLING PROVIDER NUMBER IS INVALID.
1937	THE RENDERING PROVIDER NUMBER IS INVALID.
1960	INTERNAL PROCESSING IS REQUIRED.
1963	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.

Denial Code	Long Description
1964	THE BILLING PROVIDER INDICATED IS NOT ALLOWABLE AS A BILLING PROVIDER.
1965	RENDERING PROVIDER NUMBER IS MISSING/INVALID FOR THIS PROCEDURE PROVIDER.
1974	PRESCRIBING/REFERRING/ORDERING PROVIDER INDICATED IS NOT CERTIFIED AS A PRESCRIBING/REFERRING/ORDERING PROVIDER.
1975	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
1976	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
2001	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2003	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2017	THE CLIENT IS ENROLLED IN A MEDICAID OR OTHER MANAGED CARE PROGRAM.
2037	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2603	CLIENT LOCKED-IN TO A PROVIDER OR ENROLLED IN A HOSPICE. CONTACT CLIENTS HOSPICE FOR PAYMENT OF SERVICES OR RESUBMIT WITH DOCUMENTATION OF UNRELATED NATURE OF CARE.
3324	THE MODIFIER HAS BEEN DISCONTINUED BY THE CENTERS OF MEDICARE AND MEDICAID SERVICES OR THE AMERICAN MEDICAL ASSOCIATION FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
3337	THE PROCEDURE CODE HAS BEEN TERMINATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AMERICAN MEDICAL ASSOCIATION, OR AMERICAN DENTAL ASSOCIATION FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT. RESUBMIT WITH VALID A PROCEDURE CODE.
3339	THE PROCEDURE BILLED IS NOT PAYABLE ACCORDING TO DEFICIT REDUCTION ACT (DEFRA) GUIDELINES.
3351	THE PROCEDURE IS NOT COVERED FOR CLIENTS WITH A NURSING HOME AUTHORIZATION ON THE REQUESTED START DATE OR DATE OF RECEIPT.
3353	THE PROCEDURE IS NOT A COVERED SERVICE FOR HOME AND COMMUNITY-BASED WAIVER CLIENTS.
4021	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4027	THE DIAGNOSIS CODE IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
4031	THE PROCEDURE SUBMITTED IS NOT APPROPRIATE FOR CLIENTS GENDER.
4032	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4034	THE PROCEDURE CODE HAS AN AGE RESTRICTION.
4036	THE PLACE OF SERVICE CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4040	THE PRIMARY DIAGNOSIS CODE IS NOT ON FILE.
4041	THE SECONDARY DIAGNOSIS IS NOT ON FILE.
4046	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4059	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4077	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4127	INTERNAL PROCESSING IS REQUIRED.
4131	INTERNAL PROCESSING IS REQUIRED.
4141	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4149	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4150	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4236	ETIOLOGY DIAGNOSIS CODE(S) (E-CODES) ARE INVALID AS THE PRIMARY DIAGNOSIS.
4244	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4245	THE FOURTH POSITION MODIFIER IS INVALID FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT.
4256	THE PROCEDURE CODE AND MODIFIER COMBINATION IS NOT PAYABLE FOR THE CLIENTS BENEFIT PLAN.
4257	THE MODIFIERS SUBMITTED ARE EITHER INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT OR THE MODIFIERS ARE MISSING.
4311	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4315	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4316	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4371	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4372	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4711	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR CLIENTS AGE.
4714	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS AGE.
4731	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS DIAGNOSIS.
4742	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.

Denial Code	Long Description
4743	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4744	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4745	DIAGNOSIS AND/OR PROCEDURE AND/OR PLACE OF SERVICE (POS) CODE IS NOT COVERED FOR EXPRESS ENROLLMENT CLIENTS.
4746	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4801	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4802	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
4821	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
4871	PLEASE REFER TO PA MESSAGES FOR RETURN INFORMATION.
4963	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS GENDER.
4990	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
7500	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
7509	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
P001	THE BILLING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THE SERVICES.
P002	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P003	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P005	THE PRIOR AUTHORIZATION CAN NOT BE END DATED. THE PRIOR AUTHORIZATION STATUS IS NOT APPROVED OR APPROVED WITH REVISIONS.
P006	PLEASE FURNISH THE PROCEDURE CODE AND CORRESPONDING DESCRIPTION.
P008	THE BILLING PROVIDER NUMBER IS INVALID.
P009	THE BILLING PROVIDER NUMBER IS INVALID.
P010	THE REQUESTED END DATE IS INVALID.
P011	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P012	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P013	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P014	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P015	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P016	THE REQUESTED START DATE IS MISSING OR INVALID.
P019	THE REQUESTED START DATE IS MISSING OR INVALID.
P020	THE RENDERING PROVIDER NUMBER IS INVALID.
P021	THE RENDERING PROVIDER NUMBER IS INVALID.
P022	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P023	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P024	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P026	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P027	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P030	FIRST MODIFIER IS INVALID.
P031	FIRST MODIFIER IS INVALID.
P032	SECOND MODIFIER IS INVALID.
P033	SECOND MODIFIER IS INVALID.
P034	THIRD MODIFIER IS INVALID.
P035	THIRD MODIFIER IS INVALID.
P036	FOURTH MODIFIER IS INVALID.
P037	FOURTH MODIFIER IS INVALID.
P038	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.

Denial Code	Long Description
P039	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P040	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P041	CLIENTS FIRST NAME IS MISSING.
P042	CLIENTS LAST NAME IS MISSING.
P043	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P044	BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES REQUESTED.
P045	FIRST MODIFIER IS INVALID.
P046	SECOND MODIFIER IS INVALID.
P047	THIRD MODIFIER IS INVALID.
P048	FOURTH MODIFIER IS INVALID.
P050	PLEASE SUPPLY THE LICENSE NUMBER OF THE CASE COORDINATOR. THE LICENSE NUMBER OF THE CASE COORDINATOR MUST BE NUMERIC, PLEASE CORRECT.
P052	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P053	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P054	RENDERING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES FOR THE BENEFIT PLAN.
P055	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P061	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P062	THE CLIENT ID AND/OR NAME INDICATED ON THE PA REQUEST IS INCORRECT. THE CLIENT ID AND/OR NAME HAS BEEN UPDATED. PLEASE VERIFY THE ID AND/OR NAME IS CORRECT.
P064	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
P067	THE FREQUENCY OF HOURS REQUESTED ARE NOT APPROPRIATE FOR THIS CLIENT AND HAVE BEEN MODIFIED ACCORDINGLY.
P079	BILLING PROVIDER IS ON PAYMENT SUSPENSION DUE TO CREDIBLE ALLEGATION OF FRAUD.
P120	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAS BEEN REDUCED.
P121	THE SERVICE/ PROCEDURE REQUESTED IS NOT SUPPORTED BY SUBMITTED DOCUMENTATION.
P126	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
P128	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.
P138	SERVICE(S) DO NOT MEET COLORADO MEDICAID GUIDELINES.
P167	REQUESTED DOCUMENTATION HAS NOT BEEN SUBMITTED.
P178	THE SERVICE REQUESTED IS NOT MEDICALLY NECESSARY.
P179	THE MEDICAL NECESSITY FOR THIS SERVICE IS NOT SUPPORTED BY THE SUBMITTED DOCUMENTATION.
P233	THE DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE ADDITIONAL CARE.
P257	THIS CLIENTS FUNCTIONAL ASSESSMENT SCORES PLACE THIS CLIENT OUTSIDE ELIGIBILITY FOR DAY TREATMENT.
P274	OUR RECORDS INDICATE THIS CLIENT IS INVOLVED IN EFFECTIVE AND APPROPRIATE SERVICE ELSEWHERE.
P292	INTENSIVE REHABILITATION HOURS ARE NO LONGER APPROPRIATE AS INDICATED BY HISTORY, DIAGNOSIS, AND/ OR FUNCTIONAL ASSESSMENT SCORES.
P328	THE SERVICES REQUESTED INCLUDE NON-COVERED SERVICES, AND HOURS ARE REDUCED ACCORDINGLY.
P339	THE CLIENTS PAST HISTORY INDICATES REDUCED TREATMENT HOURS ARE WARRANTED.
P342	THE REQUEST DOES NOT MEET GENERALLY ACCEPTED CONDITIONS REQUIRING FLUORIDE TREATMENTS.
P346	SERVICES EXCEED COLORADO MEDICAID LIMITATION AND DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE MEDICAL NECESSITY OF THE SERVICE.
P349	THE SERVICE REQUESTED WAS PERFORMED LESS THAN FIVE YEARS AGO.
P353	THE EXISTING APPLIANCE HAS NOT BEEN WORN FOR THREE YEARS.
P367	THE CLIENT HAS BEEN TOTALLY WITHOUT TEETH AND AN APPLIANCE FOR FIVE YEARS.
P392	THE CLIENT IS MISSING AN ANTERIOR TOOTH AND/OR HAS TWO OR MORE POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P405	THE SERVICE(S) REQUESTED COULD ADEQUATELY BE PERFORMED IN THE DENTAL OFFICE.

Denial Code	Long Description
P406	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE OF GOOD PERIODONTAL HEALTH (AMERICAN ACADEMY OF PERIODONTOLOGY PERIODONTAL CLASSIFICATION OF TYPE I OR II).
P407	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE VISIBLE ON RADIOGRAPHS THAT AT LEAST 50 PERCENT OF THE CLINICAL CROWN IS INTACT.
P409	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING SIX OR MORE TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED, INCLUDING THIRD MOLARS.
P410	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING ONE OR MORE ANTERIOR TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED.
P411	DOCUMENTATION DOES NOT SUPPORT THE NEED FOR PERIODONTIC SERVICES. POCKETS ARE LESS THAN 4MM AND/OR GREATER THAN 6MM FOR CLIENT AND/OR THE CLIENT IS UNDER THE AGE OF 13.
P412	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA.
P413	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA. THIS PA HAS BEEN GRANTED AS APPROVED NOT APPROVED WITH REVISIONS. THE DURATION REQUESTED MAY HAVE BEEN REDUCED TO REFLECT COVERAGE LIMITATIONS, PRESCRIBER ORDERS, CONFLICTI
P417	THE SERVICE(S) REQUESTED COULD BE ADEQUATELY PERFORMED WITH LOCAL ANESTHESIA.
P437	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO POOR ORAL HYGIENE.
P444	THIS LINE ITEM IS A DUPLICATE OF ANOTHER LINE ITEM ON THIS PRIOR AUTHORIZATION (PA) REQUEST. PLEASE CORRECT.
P446	THIS IS A DUPLICATE OF AN EXISTING PRIOR AUTHORIZATION (PA) REQUEST. YOU MAY CONTACT PROVIDER SERVICES IF YOU REQUIRE ASSISTANCE. DUPLICATE PA REQUEST
P448	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO DECAY HISTORY.
P449	QUESTIONABLE LONG TERM PROGNOSIS DUE TO GUM AND BONE DISEASE.
P456	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO APPARENT ROOT INFECTION.
P457	OUR RECORDS INDICATE THIS CLIENT HAS EXCEEDED ESTABLISHED PROGRAM LIMITATIONS. COLORADO MEDICAID WILL NOT AUTHORIZE NEW DENTURES.
P458	DOCUMENTATION PROVIDED INDICATES A LESS ELABORATE PROCEDURE SHOULD BE CONSIDERED.
P502	RENTAL ONLY ALLOWED; MEDICAL NEED FOR PURCHASE HAS NOT BEEN DOCUMENTED.
P503	PURCHASE ONLY ALLOWED; MEDICAL NEED FOR RENTAL HAS NOT BEEN DOCUMENTED.
P504	OCCUPATIONAL THERAPY GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P505	THE SERVICE REQUESTED IS INCLUDED IN THE NURSING HOME RATE STRUCTURE.
P511	THIS NATIONAL DRUG CODE IS ONLY BILLABLE AS PART OF A COMPOUND DRUG.
P515	THE PRESENCE OF A HANDICAPPING MALOCCLUSION OR HANDICAPPING DENTOFACIAL DEFORMITY IS NOT SUPPORTED BY THE DOCUMENTATION SUBMITTED.
P521	THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVERED BY COLORADO MEDICAID.
P522	GASTRO-INTESTINAL SURGERY FOR THE PURPOSE OF WEIGHT CONTROL IS COVERED ONLY AS A LIFE THREATENING PROCEDURE.
P523	THE TREATMENT REQUEST IS NOT CONSISTENT WITH THE CLIENT'S DIAGNOSIS.
P524	PSYCHOTHERAPY PROVIDED IN THE CLIENTS HOME IS NOT A COVERED BENEFIT OF COLORADO MEDICAID.
P525	THE INFORMATION PROVIDED IS NOT CONSISTENT WITH THE INTENSITY OF SERVICES REQUESTED.
P526	INTENSIVE MULTIPLE MODALITY TREATMENT IS NOT CONSISTENT WITH THE INFORMATION PROVIDED.
P527	MULTIPLE PROVIDERS OF TREATMENT ARE NOT INDICATED FOR THIS CLIENT.
P528	THE DURATION OF TREATMENT SESSIONS EXCEED CURRENT COLORADO MEDICAID GUIDELINES.
P534	DOCUMENTATION OF POOR PHYSICAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P535	OTHER PHYSICAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P536	THE PHYSICAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P537	USE OF PHYSICAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P538	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF A PHYSICAL THERAPIST.
P539	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS AND LIVING ARRANGEMENT.

Denial Code	Long Description
P540	GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P541	THE PROCEDURE(S) REQUESTED ARE NOT MEDICAL IN NATURE.
P542	DOCUMENTATION OF POOR OCCUPATIONAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P543	DOCUMENTATION OF POOR SPEECH THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P544	OTHER OCCUPATIONAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P546	THE OCCUPATIONAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P547	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF PHYSICAL THERAPY.
P548	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P549	ACTIVITIES TO PROMOTE DIVERSION OR GENERAL MOTIVATION ARE NONCOVERED COLORADO MEDICAID SERVICES.
P550	REVISIONS OF THE REQUEST IS NECESSITATED BY THE CLIENTS MINIMAL PROGRESS.
P551	RESTORATIVE NURSING INVOLVEMENT COULD BE INCREASED.
P552	CLIENTS DEMONSTRATED RESPONSE TO CURRENT THERAPY DOES NOT WARRANT THE INTENSE FREQUENCY REQUESTED.
P553	MAINTENANCE IS TWO TIMES PER WEEK OR LESS.
P554	THE SPEECH THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P555	USE OF OCCUPATIONAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P556	USE OF SPEECH THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P557	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF AN OCCUPATIONAL THERAPIST.
P558	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
P559	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P560	THE MATERIALS/ SERVICES REQUESTED ARE PRINCIPALLY COSMETIC IN NATURE.
P561	THE LENS FORMULA DOES NOT JUSTIFY REPLACEMENT.
P562	THE CHANGE IN THE LENS FORMULA DOES NOT WARRANT MULTIPLE REPLACEMENTS.
P563	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P564	LENSES ONLY ARE APPROVED; PLEASE DISPENSE A CONTRACTED FRAME. THE NON-CONTRACTED FRAME IS NOT MEDICALLY JUSTIFIED.
P565	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P566	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P567	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF OCCUPATIONAL THERAPY.
P568	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF SPEECH THERAPY.
P569	LEVEL, INTENSITY, OR EXTENT OF SERVICE(S) REQUESTED HAS BEEN MODIFIED CONSISTENT WITH MEDICAL NEED AS DEFINED IN THE PLAN OF CARE.
P570	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P571	THE SERVICE ASKED FOR IS NOT COVERED BY COLORADO MEDICAID AS THESE TASKS CAN BE DONE BY NURSES OR ACTIVITY STAFF.
P572	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P573	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.
P574	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.

Denial Code	Long Description
P575	MEDICAL NEED FOR EQUIPMENT/ SUPPLY REQUESTED IS NOT SUPPORTED BY DOCUMENTATION SUBMITTED.
P576	OTHER SPEECH THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P577	DOCUMENTATION SUBMITTED IDENTIFIES THAT THE CLIENT HAS FEWER THAN TWO POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P582	LESS EXPENSIVE ALTERNATIVE SERVICES ARE AVAILABLE FOR THIS CLIENT.
P634	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P711	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING PERIODONTAL SCALING AND ROOT PLANNING.
P712	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING GINGIVECTOMY.
P754	AN APPROVED SUBSTANCE ABUSE DAY TREATMENT PROGRAM CANNOT EXCEED A SIX WEEK PERIOD.
P761	THE CLIENT DOES NOT APPEAR TO BE ABLE OR WILLING TO ABSTAIN FROM ALCOHOL/DRUG USAGE WHILE IN TREATMENT. THEREFORE, SUBSTANCE ABUSE DAY TREATMENT SERVICES ARE NOT APPROVED.
P764	THIS CLIENT HAS COMPLETED INTENSIVE SUBSTANCE ABUSE TREATMENT WITHIN THE PAST 12 MONTHS. THE DOCUMENTATION PROVIDED IS NOT ADEQUATE TO JUSTIFY ADDITIONAL INTENSIVE TREATMENT AT THIS TIME.
P785	A LESS THAN SIX-WEEK HEALING PERIOD HAS BEEN SPECIFIED FOR THIS PRIOR AUTHORIZATION. THEREFORE IT IS NOT NECESSARY TO WAIT THE FULL SIX WEEKS AFTER EXTRACTIONS BEFORE TAKING DENTURE IMPRESSIONS.
P818	SIX-WEEK HEALING TIME IS REQUIRED BETWEEN EDENTULATION AND FINAL IMPRESSIONS. PAYMENT FOR DENTURES WILL BE DENIED OR RECOUPED IF HEALING PERIOD IS NOT OBSERVED.
P849	COLORADO MEDICAID HAS DETERMINED THERE WERE (ARE) SEVERAL HOME HEALTH AGENCIES WILLING TO PROVIDE MEDICALLY NECESSARY SKILLED NURSING SERVICES TO THIS CLIENT.
P864	THE DOCUMENTATION YOU HAVE SUBMITTED DOES NOT MEET THE REQUIREMENTS OF COLORADO MEDICAID.
P873	THE MEDICAL NECESSITY FOR THE HOURS REQUESTED IS NOT SUPPORTED BY THE INFORMATION SUBMITTED.
P874	THE DOCUMENTATION SUBMITTED INDICATES THE TASKS SPECIFIED CAN BE COMPLETED DURING THE VISITS APPROVED.
P878	THE DOCUMENTATION SUBMITTED DOES NOT INDICATE THAT MEDICALLY ORIENTED TASKS ARE MEDICALLY NECESSARY; THEREFORE PERSONAL CARE SERVICES HAVE BEEN APPROVED.
P880	THE QUANTITY OF SERVICES AUTHORIZED FOR THIS CLIENTS PERSONAL CARE HAS BEEN AMENDED BASED ON INFORMATION RECEIVED FROM ONE OR MORE OF THESE SOURCES: THE CLIENT, THEIR PHYSICIAN, AND/OR THE IN-HOME VISIT BY STAFF OF THE OIG (OFFICE OF INSPECTOR GENERAL).
P885	THE USE OF THIS DRUG FOR THE INTENDED PURPOSE IS NOT COVERED BY COLORADO MEDICAID, CONSISTENT WITH COLORADO ADMINISTRATIVE CODE AND FEDERAL LAW.
P924	THE MEDICAL RECORDS SUBMITTED WITH THE CURRENT REQUEST CONFLICT OR DISAGREE WITH OUR MEDICAL RECORDS ON THIS CLIENT.
P950	INDEPENDENT NURSES, PLEASE NOTE PAYABLE SERVICES MAY NOT EXCEED 12 HOURS/DAY OR 60 HOURS/WEEK.
P951	SERVICES CAN ONLY BE AUTHORIZED THROUGH ONE YEAR FROM THE PRESCRIPTION DATE.
P952	LEAD INSPECTION IS A COVERED COLORADO MEDICAID SERVICE WHEN THE CHILD HAS BEEN SHOWN TO HAVE LEAD POISONING (E.G., CHILD HAS A BLOOD LEAD LEVEL > 19 UG/DL OR TWO CONSECUTIVE BLOOD LEAD LEVELS OF 15-19 UG/DL DONE AT LEAST 90 DAYS APART). THE INSPECTION MUS
P953	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P954	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P956	THE REQUEST CAN ONLY BE BACKDATED A MAXIMUM OF 14 DAYS FROM FIRST DATE RECEIVED BY COLORADO MEDICAID.
P957	COMPLETE PERIODONTAL CHARTING AT TIME OF SERVICE, AND SUBMIT CHARTING, COPY OF OPERATIVE REPORT, TOGETHER WITH A COPY OF THE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF), F-11035, TO PA UNIT ATTENTION DENTAL CONTSULTANT.

Denial Code	Long Description
P958	NOTE THAT CODE D4341 HAS BEEN CHANGED. REFER TO THE DECISION NOTICE FOR AUTHORIZED QUANTITY.
P960	YOUR PA HAS BEEN APPROVED FOR 90 DAYS. THE 90 DAY APPROVAL DOES NOT IMPLY THE PA REQUEST MEETS PRIOR AUTHORIZATION CRITERIA. AFTER ADDITIONAL INFORMATION IS AVAILABLE IN INTERCHANGE, COLORADO MEDICAID WILL CREATE AN AMENDMENT REQUEST TO EXTEND THE PA FOR
P961	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P962	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P963	PA AUTHORIZED FOR PRIVATE DUTY NURSING SERVICES TO A VENTILATOR DEPENDENT CLIENT (99504 [TD] AND 99504 [TE]).
P964	PA AUTHORIZED FOR PRIVATE DUTY NURSING SERVICES (S9123 AND S9124).
P965	PA AUTHORIZED FOR SERVICES AT A PEDIATRIC COMMUNITY CARE CENTER (T1026 [59]).
P989	YOUR PRIOR AUTHORIZATION REQUEST FOR PERSONAL CARE SERVICES HAS BEEN APPROVED AS REQUESTED, WHICH IS EQUAL TO OR LESS THAN THE TOTAL ANNUAL UNITS ALLOCATED ON THE PERSONAL CARE SCREENING TOOL SUMMARY SHEET.
PA10	THE REQUESTED END DATE IS INVALID.
PA12	PLEASE FURNISH A WRITTEN DESCRIPTION OF THE CLIENTS DIAGNOSIS.
PA13	PROVIDE DIAGNOSES WITH DATES OF ONSET.
PA14	IDENTIFY PROBLEMS TO BE TREATED.
PA15	THE AUDIOLOGISTS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1), F-11020, AND PRIOR AUTHORIZATION REQUEST/HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2), F-11021.
PA16	THE PHYSICIANS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION/PHYSICIAN OTOLOGICAL REPORT (PA/POR), F-11019.
PA17	SUBMIT BRIEF HISTORY WITH REFERRAL INFORMATION, LIVING SITUATION, FUNCTIONAL STATUS, AND OTHER PERTINENT INFORMATION. WHAT CHANGE OF STATUS RESULTED IN REFERRAL AT THIS TIME?
PA18	PLEASE FURNISH THE CLIENTS HEIGHT AND WEIGHT.
PA19	PLEASE SUBMIT CLINICAL INFORMATION SUFFICIENT TO VERIFY THE NEED FOR THE REQUESTED SERVICE(S).
PA20	PLEASE RESUBMIT WITH COMPLETE PERIODONTAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PA21	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL EDUCATIONAL PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA22	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL PROGRAM PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA23	REFER TO THE DURABLE MEDICAL EQUIPMENT INDEX FOR APPROPRIATE CODE AND DESCRIPTION. DO NOT USE AN "UNLISTED" CODE.
PA24	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUALIZED FAMILY SERVICE PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA25	INFORMATION ON THE REQUEST FORM IS ILLEGIBLE, AND THE REQUEST CANNOT BE PROCESSED.
PA26	RE-EVALUATE YOUR GOALS. EMPHASIS SHOULD BE ON FUNCTIONAL SELF-CARE. GOALS MUST BE RELATED TO FUNCTIONAL OUTCOME.
PA27	PLEASE CLARIFY THE NUMBER OF HOURS PER WEEK REQUESTED.
PA28	PLEASE CLARIFY THE NUMBER OF HOURS PER DAY REQUESTED.
PA29	PLEASE CLARIFY THE NUMBER OF VISITS PER DAY REQUESTED.
PA30	ATTACH SUPPORTIVE DOCUMENTATION; HOME EXERCISE PROGRAM AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA31	THE DIAGNOSIS CODE INDICATED ON THE REQUEST DOES NOT CORRESPOND TO THE DIAGNOSIS CODE DESCRIPTION.
PA32	PLEASE SUBMIT ADDITIONAL INFORMATION SUFFICIENT TO VERIFY APPROPRIATENESS AND NEED FOR TRANSPLANT.
PA33	PLEASE SUBMIT THE INITIAL AND PROGRESSIVE OBJECTIVE FINDINGS.

Denial Code	Long Description
PA34	ATTACH SUPPORTIVE DOCUMENTATION, FACILITY PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA35	PLEASE SUBMIT THE CLIENTS ORIGINAL COMPLAINTS AND EXAMINATION FINDINGS.
PA36	ATTACH SUPPORTIVE DOCUMENTATION, IN-HOME AUTISM PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA37	PLEASE SUBMIT YOUR TREATMENT PLAN FOR THIS CLIENT.
PA38	ATTACH SUPPORTIVE DOCUMENTATION AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA39	INITIAL EVALUATIONS MUST BE PERFORMED BY AN OCCUPATIONAL THERAPIST REGISTERED (OTR), PER AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA) STANDARDS.
PA41	IDENTIFY THE PLACE OF SERVICE AND ITS EFFECT ON SUPPORTING THE DESIRED TREATMENT OUTCOME.
PA42	PLEASE INDICATE THE HOURS OF USE OF OXYGEN PER 24-HOUR PERIOD.
PA43	PROVIDE BASELINE DOCUMENTATION FOR THIS CLIENTS LIMITATIONS USING UNITS OF MEASUREMENT THAT ARE APPLIED CONSISTENTLY WHEN REPORTING STATUS.
PA44	IDENTIFY FUNCTIONAL LIMITATIONS AS THEY ARE RELATED TO IDENTIFIED CONDITIONS.
PA46	CORRELATE PLAN OF CARE TO REQUESTED PROCEDURE CODES.
PA47	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE FREQUENCY/DURATION REQUESTED.
PA48	PLEASE PROVIDE THE NAME AND CREDENTIALS OF THE RENDERING PROVIDER.
PA50	COLORADO MEDICAID RECORDS INDICATE THE CLIENT OWNS A WHEELCHAIR. DOCUMENT THE REASON AND NEED FOR REPLACEMENT AND COST TO REPAIR CURRENT WHEELCHAIR.
PA51	PLEASE DISTINGUISH PRIMARY AND SUPPORTIVE MODALITIES.
PA52	PLEASE SUBMIT A PROGRESS REPORT.
PA53	MULTIPLE FAMILY CLIENTS TREATMENT BY THE SAME PROVIDER REQUIRES FURTHER INFORMATION DOCUMENTING COORDINATION OF TREATMENT PLAN.
PA54	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE MINUTES REQUESTED.
PA55	MEDICAL NECESSITY OF TREATMENT REQUIRES ADDITIONAL DOCUMENTATION.
PA56	GIVEN AGE, DIAGNOSES, CURRENT LEVEL OF FUNCTION, PAST RESPONSE TO TREATMENT, AND LIVING SITUATION, EXPAND ON POTENTIAL FOR SIGNIFICANT FUNCTIONAL PROGRESS WITHIN THE NEXT SIX MONTHS. EMPHASIZE WHY PROGRESS IS EXPECTED WITH SERVICES AT THIS TIME.
PA57	SUBMIT THE INITIAL FINDINGS. INCLUDE A COMPREHENSIVE EVALUATION.
PA58	SUBMIT PROGRESSIVE, OBJECTIVE FINDINGS. INCLUDE A PERTINENT RE-EVALUATION.
PA59	PLEASE SUPPLY INFORMATION REGARDING THE CLIENTS MEDICATION REQUIREMENTS, IF ANY.
PA60	PLEASE SPECIFY IF THE CLIENT IS IN AN EDUCATIONAL SETTING.
PA61	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA62	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
PA63	THE SKILLS OF A THERAPIST ARE PURPOSEFUL AND SKILLED INTERVENTIONS REQUIRED TO CONTINUALLY DESIGN, IMPLEMENT, REASSESS, MODIFY/GRADE, AND/OR DISCONTINUE A PLAN OF CARE IN A TIMELY MANNER, BASED ON THE COMPLEXITY OF THE CLIENTS MEDICAL CONDITION AND/OR CO
PA64	PLEASE SUBMIT A THERAPY PLAN OF CARE, INCLUDING A CURRENT, DATED EVALUATION.
PA65	A PLAN OF CARE SIGNED AND DATED BY THE PHYSICIAN IS REQUIRED.
PA66	THE SKILLS OF A THERAPIST ARE REQUIRED WHEN ONLY THE THERAPIST CAN SAFELY AND EFFECTIVELY DELIVER THE THERAPEUTIC PROCEDURES BECAUSE OF THEIR UNIQUE KNOWLEDGE, TRAINING, AND EXPERTISE. DESCRIBE THE REASON THAT SOMEONE OTHER THAN A THERAPIST CANNOT SAFELY
PA67	PLEASE SPECIFY IF THE CLIENTS WORK SITE DEMANDS GOOD BINAURAL HEARING.
PA68	DESCRIBE THE REASON, BASED ON THE CLIENTS COGNITIVE, PHYSICAL, COMMUNICATION, OR RESOURCE STATUS, THAT A HOME PROGRAM, EQUIPMENT, OR ENVIRONMENTAL ADAPTATIONS ALONE CANNOT MEET CLIENTS NEEDS.
PA69	PLEASE SPECIFY IF THE CLIENT HAS AN ACCOMPANYING DISABILITY THAT ADDS TO THE HEARING PROBLEM.
PA70	DISTINGUISH REQUESTED PROCEDURES AND GOALS FROM OTHER SERVICES THIS CLIENT RECEIVES. THEY MAY NOT BE DUPLICATIVE.

Denial Code	Long Description
PA71	PLEASE INDICATE THE NUMBER OF DAYS REQUESTED.
PA73	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA74	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA75	PLEASE DOCUMENT CARRYOVER OF THE THERAPY PROGRAM TO NURSING.
PA76	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA79	PROVIDE EVIDENCE OF SIGNIFICANT FUNCTIONAL PROGRESS IN LAST SIX MONTHS.
PA80	PA REQUESTS FOR PRIVATE DUTY NURSING CANNOT BE SUBMITTED WITH OTHER SERVICES. PLEASE SUBMIT SEPARATE PA REQUESTS.
PA81	THE PA AMENDMENT REQUEST MUST BE SUBMITTED BY THE BILLING PROVIDER INDICATED ON THE PA.
PA82	PA REQUESTS FOR PRIVATE DUTY NURSING MUST BE SUBMITTED BY A REGISTERED NURSE IN INDEPENDENT PRACTICE, HOME HEALTH AGENCY, OR PEDIATRIC COMMUNITY CARE PROVIDER.
PA84	THE GRANT DATE OF THIS REQUEST CANNOT BE PRIOR TO THE SIGNATURE DATE OF THE PRESCRIBING PHYSICIAN.
PA86	PROVIDE EVIDENCE OF SKILLS GAINED IN THERAPY CARRYING OVER TO OTHER SETTINGS WITHIN SIX MONTHS.
PA87	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE NUMBER OF SESSIONS REQUESTED.
PA88	THE REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL SCOPE OF PRACTICE.
PA89	PRIOR AUTHORIZATION IS NOT REQUIRED UNTIL LIMITATION OF SERVICE HAS BEEN REACHED.
PA91	PLEASE SUBMIT REQUIRED X-RAYS.
PA92	PLEASE PROVIDE AN EXPLANATION FOR THE MATERIAL SUBMITTED WITH THE REQUEST.
PA95	PLEASE DESCRIBE HOW THE PROVISION OF THIS SERVICE WOULD PREVENT INSTITUTIONALIZATION OF THE CLIENT.
PA96	COULD THE EXISTING DENTURE(S) BE RELINED OR REBASED? IF NOT, PLEASE EXPLAIN WHY NOT.
PA97	REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL STANDARDS OF PRACTICE.
PA98	PLEASE INDICATE IF THE CLIENT IS CURRENTLY BEING TUBE FED.
PB02	PLEASE PROVIDE THE REQUIRED DATED SIGNATURES ON THE ATTACHMENTS.
PB03	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING THE LOSS/DESTRUCTION/THEFT OF THE HEARING AID.
PB04	DESCRIBE THE CLIENTS ABILITY TO STAND OR AMBULATE SUFFICIENTLY TO ACCOMPLISH SELF-CARE ACTIVITIES.
PB07	PLEASE SUBMIT AN ORTHODONTIC STUDY MODEL OR DIAGNOSTIC CASTS.
PB09	PLEASE PROVIDE A PHOTOGRAPH OF THE INVOLVED AREA(S).
PB10	PLEASE PROVIDE AN ESTIMATION (IN GRAMS) OF THE TOTAL AMOUNT OF TISSUE TO BE RESECTED.
PB11	PLEASE SUBMIT THE PLAN OF CARE FOR CO-TREATMENT.
PB12	FURNISH A DETAILED DESCRIPTION FOR THE PROCEDURE CODE REQUESTED.
PB13	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB15	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB18	PLEASE COMPLETE THE ATTACHED OUT-OF-STATE PROVIDER DATA SHEET, F-11001, AND RESUBMIT.
PB20	A SIGNED AND DATED PRESCRIPTION IS REQUIRED WITHIN THREE MONTHS OF RECEIPT BY COLORADO MEDICAID FOR INITIAL REQUESTS AND WITHIN 12 MONTHS OF RECEIPT BY COLORADO MEDICAID FOR SUBSEQUENT REQUESTS.
PB21	PLEASE COMPLETE THE APPROPRIATE PRIOR AUTHORIZATION ATTACHMENT. CONTACT PROVIDER SERVICES OR THE PRIOR AUTHORIZATION UNIT FOR ASSISTANCE.
PB23	PHYSICAL THERAPY ASSISTANT NOTES AND ALL FORMS SUBMITTED MUST BE COSIGNED BY A REGISTERED PHYSICAL THERAPIST.
PB31	ARE YOU REQUESTING A COMPLETE APPLIANCE, OR REPLACEMENT PARTS?
PB32	THE PROCEDURE CODE INDICATED ON THE REQUEST DOES NOT MATCH THE DESCRIPTION OF SERVICE; PLEASE CORRECT AND RESUBMIT.
PB35	THE SERVICE REQUESTED DOES NOT REQUIRE PRIOR AUTHORIZATION.

Denial Code	Long Description
PB41	PLEASE FURNISH A CURRENT MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT, F-11090 (DATED WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID).
PB45	THE CERTIFICATION PERIOD ON THE PLAN OF CARE (POC) DOES NOT COVER THE REQUESTED GRANT/START DATE. PLEASE RESUBMIT YOUR REQUEST WITH A NEW POC.
PB49	A CERTIFIED OCCUPATIONAL THERAPY ASSISTANTS NOTES MUST BE COSIGNED BY AN OCCUPATIONAL THERAPIST REGISTERED.
PB51	ADDITIONAL INFORMATION IS REQUIRED ON PRIOR AUTHORIZATION TO ENABLE PRICING.
PB54	REQUESTED SERVICES DO NOT MATCH SERVICES ON THE PHYSICIANS ORDERS.
PB59	PLEASE PROVIDE AN INDIVIDUAL EDUCATIONAL PLAN (IEP), WHICH HAS BEEN SIGNED BY THE PROVIDER NO EARLIER THAN NINE MONTHS PRIOR TO RECEIPT AT COLORADO MEDICAID; OTHERWISE, DOCUMENT WHY NO IEP EXISTS.
PB65	PLEASE FURNISH THE ANTICIPATED TOTAL CHARGES FOR THIS REQUEST.
PB66	A PHOTOCOPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED; THE DATE MUST BE WITHIN SIX MONTHS OF RECEIPT BY COLORADO MEDICAID.
PB67	THE PRESCRIPTION DATE MUST INCLUDE MONTH, DAY, AND YEAR.
PB68	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID.
PB73	THE SERVICES IDENTIFIED ON THE PLAN OF CARE DO NOT APPEAR APPROPRIATE FOR THE PROCEDURE CODE(S) REQUESTED ON THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018.
PB74	THE CLIENT/PROVIDER DOES NOT HAVE RETROACTIVE ENROLLMENT.
PB75	THE REQUESTED START DATE IS MORE THAN 14 DAYS BEFORE OR 62 DAYS AFTER RECEIPT.
PB82	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
PB83	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A HOME HEALTH AIDE. PLEASE RESUBMIT AS A PERSONAL CARE WORKER OR PROVIDE ADDITIONAL DOCUMENTATION.
PB86	THE SERVICES REQUESTED ARE NOT BEING PROVIDED IN THE CLIENTS RESIDENCE. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL.
PB87	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A NURSE. PLEASE RESUBMIT AS A HOME HEALTH AIDE OR PROVIDE ADDITIONAL DOCUMENTATION.
PB92	PLEASE FURNISH THE CLIENTS COMPLETE ADDRESS.
PB94	IF THE CLIENT IS A RESIDENT OF A NURSING HOME, SUPPLY THE COMPLETE NAME AND ADDRESS OF THE NURSING HOME.
PB99	THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018, MUST BE SIGNED AND DATED.
PC01	PLEASE SUPPLY THE RENDERING PROVIDERS PROVIDER NUMBER.
PC03	THE DRUG ENFORCEMENT ADMINISTRATION NUMBER IS MISSING OR INVALID.
PC06	PLEASE DESCRIBE YOUR PROGRAM; INCLUDE ENTRY DATE, TERMINATION DATE, HOURS PER WEEK, AND NUMBER OF WEEKS OF PRIMARY INTENSIVE SERVICE REQUESTED.
PC07	PLEASE DESCRIBE YOUR "AFTERCARE/FOLLOW-UP" PLANS FOR THIS CLIENT.
PC08	PLEASE SUPPLY DOCUMENTATION OF PREVIOUS SUBSTANCE ABUSE SERVICES WITH DATE(S) AND OUTCOME.
PC09	PLEASE DESCRIBE IN DETAIL THE TREATMENT OBJECTIVES/GOALS FOR THIS CLIENT.
PC10	PLEASE DESCRIBE THE FAMILY SITUATION/DYNAMICS. EXPLAIN HOW THE FAMILY WILL BE INCORPORATED INTO THE CLIENTS PLAN OF CARE.
PC12	PLEASE EXPLAIN IF YOUR SERVICE ENCOURAGES THE CLIENT TO ATTEND SELF-HELP GROUPS.
PC13	PLEASE SUPPLY A SPECIFIC SCHEDULE OF ACTIVITIES, INCLUDING DAY, TIME OF DAY, LENGTH OF SESSION, AND SERVICE TO BE RENDERED DURING THAT TIME.
PC15	PLEASE FURNISH DIAGNOSTIC RATIONALE.
PC17	PLEASE DOCUMENT IF THE CLIENT EVER RECEIVED SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT.
PC19	PLEASE FURNISH MORE EXTENSIVE AND IN-DEPTH HISTORICAL AND PSYCHOSOCIAL DATA.
PC20	PLEASE SUPPLY THE DATE THE CLIENT BECAME TOTALLY ENDENTULOUS.
PC23	PLEASE SUBMIT A PHYSICIANS STATEMENT REGARDING THE MEDICAL NECESSITY OF DENTURES FOR THIS CLIENT. THE PHYSICIANS STATEMENT MUST DOCUMENT THE MEDICAL NEED FOR DENTURES.
PC24	THE SERVICE REQUESTED WAS PREVIOUSLY AUTHORIZED. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT INDICATING THIS FACT IS REQUIRED.

Denial Code	Long Description
PC25	PLEASE SUPPLY SUFFICIENT MITIGATING CIRCUMSTANCES TO WARRANT THE CONSTRUCTION OF NEW DENTURES(S).
PC26	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
PC28	PLEASE SUBMIT A PHYSICIANS STATEMENT INDICATING DENTURES ARE NECESSARY FOR THIS NURSING HOME CLIENT.
PC29	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING LOSS OR DESTRUCTION OF DENTURE(S). INCLUDE SIGNED STATEMENT FROM CLIENT OR FACILITY DIRECTOR REGARDING HOW, WHEN AND WHERE LOST.
PC30	PLEASE PROVIDE COMPLETE INTRAORAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PC31	PLEASE DESCRIBE ANY RELATED DEFORMITIES OF THE FEET.
PC34	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD WITH REQUESTED DME ITEM(S) AND DOCUMENT IF THE CLIENT CAN USE SAFELY AND INDEPENDENTLY.
PC35	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD AND DESCRIBE THE RESULTS AND EFFECTIVENESS OF THE SERVICE REQUESTED.
PC39	PLEASE INDICATE LITER FLOW PER MINUTE, HOURS OF USE PER 24 HOUR PERIOD, AND THE EXPECTED DURATION OF NEED.
PC40	THE ITEM DOES NOT REQUIRE PRIOR AUTHORIZATION UNTIL THE LIFE EXPECTANCY HAS BEEN REACHED.
PC41	PLEASE SUPPLY INFORMATION INDICATING THE NECESSITY OF POSITIONING THE CLIENT'S BODY IN MULTIPLE POSITIONS.
PC42	PLEASE INDICATE IF THE BED HEIGHT MUST BE CHANGED TO ALLOW FOR SAFE TRANSFER OR ADEQUATE BED CARE.
PC43	SUPPLY A PHYSICIANS STATEMENT INDICATING TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR UNIT HAS REDUCED PAIN, IMPROVED/INCREASED THE CLIENTS ACTIVITY LEVEL, AND/OR REDUCED CLIENTS USE OF PAIN MEDICATION.
PC44	A CURRENT AUTHORIZATION FOR THIS SERVICE IS ON FILE FOR ANOTHER PROVIDER. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT OF THAT FACT IS REQUIRED BY THE CLIENT OF FIRST PROVIDER.
PC59	DOCUMENT DECLINE OR PROGRESS IN SPECIFIC, MEASURABLE, OBJECTIVE TERMS.
PC60	DOCUMENT IF CLIENT HAS DEMONSTRATED A GOOD APPOINTMENT COMPLIANCE RECORD.
PC61	THE PHYSICIANS SIGNATURE DATE MUST NOT EXCEED 90 DAYS FROM THE DATE OF RECEIPT BY COLORADO MEDICAID.
PC62	REQUESTS FOR A CONTINUATION OF THERAPY SHOULD NOT BE SUBMITTED MORE THAN FOUR WEEKS PRIOR TO THE EXPIRATION DATE OF THE CURRENT AUTHORIZATION.
PC63	PLEASE FURNISH THE STYLE AND MANUFACTURER OF THE FRAME.
PC64	PLEASE FURNISH THE CLIENTS LENS FORMULA.
PC66	ALL REQUESTS FOR TINTS REQUIRE DOCUMENTATION OF THE VISUAL OR MEDICAL CONDITION RELATED TO PHOTOPHOBIA.
PC67	PLEASE DOCUMENT THE REASON AND JUSTIFICATION FOR REPLACEMENT BEYOND THE FIRST LENS/FRAME.
PC68	DOCUMENT IF ALL REMAINING MAXILLARY AND/OR MANDIBULAR TEETH ARE DECAY-FREE, PROPERLY RESTORED, AND PERIODONTICALLY SOUND.
PC72	SUPPLY MORE DETAIL REGARDING PROGRESS (ATTACHMENT OF GOALS, ETC.). CORRELATE PROGRESS TO PREVIOUS GOALS AND IDENTIFIED LIMITATIONS.
PC77	PLEASE SUBMIT A PLAN OF CARE DESCRIBING THE SERVICES THAT WOULD BE PROVIDED.
PC78	PLEASE DOCUMENT SPECIFIC, MEASURABLE GOALS.
PC82	THE PRIOR AUTHORIZATION (PA) SYSTEM CAN PROCESS ONLY 26 DETAILS PER PA REQUEST. PLEASE RESUBMIT YOUR REQUEST WITH NO MORE THAN 26 DETAILS.
PC83	PLEASE SUPPLY A PHYSICIANS PRESCRIPTION DATED WITHIN ONE MONTH OF REQUESTED SUBSTANCE ABUSE DAY TREATMENT.
PC84	PLEASE PROVIDE INFORMATION INDICATING THIS CLIENT IS APPROPRIATELY DETOXIFIED FROM ALCOHOL AND/OR OTHER DRUGS.
PC85	PLEASE PROVIDE INFORMATION TO INDICATE THE CLIENTS ABILITY TO ABSTAIN FROM ALCOHOL OR DRUGS WHILE IN THE SUBSTANCE ABUSE DAY TREATMENT PROGRAM.

Denial Code	Long Description
PC86	PLEASE INDICATE IF THIS CLIENT IS WILLING TO PARTICIPATE IN AFTERCARE OR CONTINUING CARE SERVICES.
PC87	PROVIDE MORE INFORMATION ON TREATMENT HISTORY; INCLUDE SERVICE PROVIDED, DATES, AND OUTCOME. PROVIDE DETAIL OF PREVIOUS TREATMENT.
PC88	PLEASE PROVIDE MORE RATIONALE FOR THE APPROPRIATENESS AND MEDICAL NECESSITY OF SUBSTANCE ABUSE DAY TREATMENT.
PC89	PROVIDE A TREATMENT PLAN THAT CONTAINS MEASURABLE GOALS AND OBJECTIVES CORRESPONDING TO THE IDENTIFIED DEFICIT.
PC91	PLEASE PROVIDE MORE INFORMATION ON FAMILY INVOLVEMENT TREATMENT.
PC92	PLEASE PROVIDE MORE HISTORY AND EXPLANATION ABOUT THE ISSUE OF ABSTINENCE FOR THIS CLIENT.
PC94	PLEASE PROVIDE THE ANTICIPATED BEGINNING DATE AND/OR THE ESTIMATED SUBSTANCE ABUSE DAY TREATMENT DISCHARGE DATE.
PC95	PLEASE SUPPLY JUSTIFICATION FOR BEGINNING CLIENT IN SERVICE PRIOR TO AUTHORIZATION BEING OBTAINED.
PC96	THE INITIAL THREE HOURS OF SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IN A CALENDAR YEAR DO NOT REQUIRE PRIOR AUTHORIZATION.
PC97	REIMBURSEMENT FOR INITIAL SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IS LIMITED TO THREE HOURS IN A CALENDAR YEAR AND DOES NOT REQUIRE PRIOR AUTHORIZATION.
PC98	THIS DRUG IS CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE BILL USING THE APPROPRIATE NATIONAL DRUG CODE (NDC) OR SUBMIT A COMPLETED DRUG ADDITION REQUEST FORM IF THE NDC IS NOT LISTED IN THE DRUG INDEX.
PC99	THIS DRUG IS NOT CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL, CURRENT ADMINISTRATIVE RULE, OR COLORADO DRUG INDEX FOR COVERAGE LIMITATIONS.
PD01	DOCUMENT THAT CLIENT HAS ACHIEVED GOOD ORAL HYGIENE, PERIODONTAL CASE TYPE 1 OR 2, AND IS MOTIVATED TO MAINTAIN SAME.
PD03	PLEASE PROVIDE AN ARTERIAL BLOOD GAS READING OR PULSE OXIMETRY RESULTS DONE ON ROOM AIR SIGNED AND DATED BY A MEDICAL DOCTOR. THIS SHOULD BE DONE WITHIN 60 DAYS OF REQUESTED SERVICE.
PD04	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 30 DAYS OF RECEIPT BY COLORADO MEDICAID.
PD07	SUBMIT A PHOTOCOPY OF A VALID PRESCRIPTION, ISSUED WITHIN THE PAST YEAR, OR COMPLETE SECTION B OF THE PRIOR AUTHORIZATION/DRUG ATTACHMENT (PA/DGA), F-11049.
PD10	BRAND MEDICALLY NECESSARY MUST BE IN THE PRESCRIBERS OWN HANDWRITING AND WRITTEN DIRECTLY ON THE PRESCRIPTION OR A SEPARATE ORDER ATTACHED TO THE ORIGINAL PRESCRIPTION.
PD12	COMPLETE DENTURES, PARTIAL DENTURES, DENTURE RELINES, AND FIXED PROSTHODONTIC SERVICES ARE NOT COVERED SERVICES FOR ADULTS FOR DATES OF SERVICE ON AND AFTER OCTOBER 1, 1995.
PD22	PLEASE COMPLETE ALL REQUIRED ELEMENTS ON THE PERSONAL CARE SCREENING TOOL (PCST), F-11133.
PD24	THIS PRIOR AUTHORIZATION REQUEST IS UNABLE TO BE PROCESSED. PLEASE RESUBMIT WITH ADDITIONAL REQUIRED FORMS, INCLUDING THE ENTIRE PERSONAL CARE SCREENING TOOL (PCST), F-11133; PERSONAL CARE ADDENDUM, F-11136; AND SUPPORTING DOCUMENTATION, AS DIRECTED.
PD25	THERE IS A PERSONAL CARE SCREENING TOOL (PCST), F-11133, COMPLETED BY ANOTHER AGENCY. CONTACT THE AGENCY TO TRANSFER SCREEN.
PD26	THERE IS A LIMITED TERM CARE FUNCTIONAL SCREEN (LTC-FS) COMPLETED BY ANOTHER AGENCY. THE PERSONAL CARE SCREENING TOOL (PCST), F-11133, INFORMATION IS IN CONFLICT WITH LTC-FS.
PD27	ONLY ONE LEVEL OF FUNCTION MAY BE SELECTED FOR ALL ELEMENTS EXCEPT TOILETING. COLORADO MEDICAID IS UNABLE TO PROCESS THE PRIOR AUTHORIZATION REQUEST.
PD28	NO UNITS MAY BE REQUESTED USING THIS PRIOR AUTHORIZATION PROCESS. PLEASE SUBMIT WITH THE APPROPRIATE ATTACHMENTS FOR REQUESTING SPECIFIC PERSONAL CARE WORKER UNITS.
PD29	CLIENT IS NOT ELIGIBLE FOR THE REQUESTED SERVICE(S) AS OF THE REQUESTED START DATE.
PD30	NO TRAVEL TIME MAY BE AUTHORIZED WHEN NO PERSONAL CARE WORKER SERVICE IS AUTHORIZED.
PD32	PROVIDER NOT CERTIFIED TO RENDER THE SERVICE(S) REQUESTED.

Denial Code	Long Description
PD34	BASED ON THE DOCUMENTATION SUBMITTED, THIS REQUEST CAN NOT BE PRIOR AUTHORIZED. REFER TO THE PA MESSAGES FROM THE CONSULTANT FOR COMPLETE EXPLANATION.
PD98	PLEASE DOCUMENT HOW AND WHEN EACH PREVIOUSLY AUTHORIZED PRO RE NATA VISIT WAS USED.

Hospice

Denial Code	Long Description
0201	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
0233	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0235	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0237	CLIENT IDENTIFICATION NUMBER DOES NOT MATCH CLIENTS FIRST NAME.
0238	THE CLIENT IDENTIFICATION NUMBER DOES NOT MATCH THE CLIENTS LAST NAME.
0242	SECONDARY DIAGNOSIS CODE IS INVALID.
0248	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0249	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0251	PROCEDURE CODE MODIFIER IN FIRST POSITION IS INVALID.
0252	THE PROCEDURE CODE MODIFIER IN SECOND POSITION IS INVALID FOR REQUESTED START DATE OR DATE OF RECEIPT.
0253	THE PROCEDURE CODE MODIFIER IN THIRD POSITION IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
0258	THE PRIMARY DIAGNOSIS CODE IS REQUIRED.
0272	THE PRIMARY DIAGNSOSIS CODE IS INVALID.
0400	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0853	HCPCS - ANNUAL UPDATE
0885	NEVER EVENTS MODIFIERS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
0886	NEVER EVENTS DIAGNOSIS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
1000	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
1002	RENDERING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1003	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1007	RENDERING PROVIDER ID IS NOT ON FILE.
1047	THE RENDERING PROVIDERS CERTIFICATION HAS BEEN CANCELLED.
1048	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1801	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
1804	A CERTIFIED SUBSTANCE ABUSE DAY TREATMENT PROVIDER MUST SUBMIT A SUBSTANCE ABUSE DAY TREATMENT PROCEDURE CODE.
1806	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
1808	THE BILLING PROVIDER DOES NOT HAVE THE REQUIRED CERTIFICATION ADDENDUM ON FILE.
1900	THE BILLING PROVIDERS TAXONOMY CODE IS INVALID.
1901	THE RENDERING PROVIDERS TAXONOMY CODE IS INVALID.
1927	A NATIONAL PROVIDER IDENTIFIER IS REQUIRED FOR THE BILLING PROVIDER.
1934	A NATIONAL PROVIDER INDENTIFIER IS REQUIRED FOR THE RENDERING PROVIDER.
1936	THE BILLING PROVIDER NUMBER IS INVALID.
1937	THE RENDERING PROVIDER NUMBER IS INVALID.
1960	INTERNAL PROCESSING IS REQUIRED.
1963	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.
1964	THE BILLING PROVIDER INDICATED IS NOT ALLOWABLE AS A BILLING PROVIDER.
1965	RENDERING PROVIDER NUMBER IS MISSING/INVALID FOR THIS PROCEDURE PROVIDER.

Denial Code	Long Description
1974	PRESCRIBING/REFERRING/ORDERING PROVIDER INDICATED IS NOT CERTIFIED AS A PRESCRIBING/REFERRING/ORDERING PROVIDER.
1975	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
1976	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
2001	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2003	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2017	THE CLIENT IS ENROLLED IN A MEDICAID OR OTHER MANAGED CARE PROGRAM.
2037	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2603	CLIENT LOCKED-IN TO A PROVIDER OR ENROLLED IN A HOSPICE. CONTACT CLIENTS HOSPICE FOR PAYMENT OF SERVICES OR RESUBMIT WITH DOCUMENTATION OF UNRELATED NATURE OF CARE.
3324	THE MODIFIER HAS BEEN DISCONTINUED BY THE CENTERS OF MEDICARE AND MEDICAID SERVICES OR THE AMERICAN MEDICAL ASSOCIATION FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
3337	THE PROCEDURE CODE HAS BEEN TERMINATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AMERICAN MEDICAL ASSOCIATION, OR AMERICAN DENTAL ASSOCIATION FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT. RESUBMIT WITH VALID A PROCEDURE CODE.
3339	THE PROCEDURE BILLED IS NOT PAYABLE ACCORDING TO DEFICIT REDUCTION ACT (DEFRA) GUIDELINES.
3351	THE PROCEDURE IS NOT COVERED FOR CLIENTS WITH A NURSING HOME AUTHORIZATION ON THE REQUESTED START DATE OR DATE OF RECEIPT.
3353	THE PROCEDURE IS NOT A COVERED SERVICE FOR HOME AND COMMUNITY-BASED WAIVER CLIENTS.
4021	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4027	THE DIAGNOSIS CODE IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
4031	THE PROCEDURE SUBMITTED IS NOT APPROPRIATE FOR CLIENTS GENDER.
4032	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4034	THE PROCEDURE CODE HAS AN AGE RESTRICTION.
4036	THE PLACE OF SERVICE CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4040	THE PRIMARY DIAGNOSIS CODE IS NOT ON FILE.
4041	THE SECONDARY DIAGNOSIS IS NOT ON FILE.
4046	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4127	INTERNAL PROCESSING IS REQUIRED.
4131	INTERNAL PROCESSING IS REQUIRED.
4141	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4149	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4150	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4236	ETIOLOGY DIAGNOSIS CODE(S) (E-CODES) ARE INVALID AS THE PRIMARY DIAGNOSIS.
4244	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4245	THE FOURTH POSITION MODIFIER IS INVALID FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT.
4256	THE PROCEDURE CODE AND MODIFIER COMBINATION IS NOT PAYABLE FOR THE CLIENTS BENEFIT PLAN.
4257	THE MODIFIERS SUBMITTED ARE EITHER INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT OR THE MODIFIERS ARE MISSING.
4311	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4315	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4316	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4371	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4372	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4711	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR CLIENTS AGE.
4714	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS AGE.
4731	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS DIAGNOSIS.
4742	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4743	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4744	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4745	DIAGNOSIS AND/OR PROCEDURE AND/OR PLACE OF SERVICE (POS) CODE IS NOT COVERED FOR EXPRESS ENROLLMENT CLIENTS.

Denial Code	Long Description
4746	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4801	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4802	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
4821	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
4871	PLEASE REFER TO PA MESSAGES FOR RETURN INFORMATION.
4963	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS GENDER.
4990	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
7500	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
7509	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
P001	THE BILLING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THE SERVICES.
P002	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P003	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P005	THE PRIOR AUTHORIZATION CAN NOT BE END DATED. THE PRIOR AUTHORIZATION STATUS IS NOT APPROVED OR APPROVED WITH REVISIONS.
P006	PLEASE FURNISH THE PROCEDURE CODE AND CORRESPONDING DESCRIPTION.
P008	THE BILLING PROVIDER NUMBER IS INVALID.
P009	THE BILLING PROVIDER NUMBER IS INVALID.
P010	THE REQUESTED END DATE IS INVALID.
P011	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P012	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P013	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P014	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P015	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P016	THE REQUESTED START DATE IS MISSING OR INVALID.
P019	THE REQUESTED START DATE IS MISSING OR INVALID.
P020	THE RENDERING PROVIDER NUMBER IS INVALID.
P021	THE RENDERING PROVIDER NUMBER IS INVALID.
P022	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P023	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P024	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P026	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P027	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P030	FIRST MODIFIER IS INVALID.
P031	FIRST MODIFIER IS INVALID.
P032	SECOND MODIFIER IS INVALID.
P033	SECOND MODIFIER IS INVALID.
P034	THIRD MODIFIER IS INVALID.
P035	THIRD MODIFIER IS INVALID.
P036	FOURTH MODIFIER IS INVALID.
P037	FOURTH MODIFIER IS INVALID.
P038	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P039	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P040	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P041	CLIENTS FIRST NAME IS MISSING.

Denial Code	Long Description
P042	CLIENTS LAST NAME IS MISSING.
P043	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P044	BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES REQUESTED.
P045	FIRST MODIFIER IS INVALID.
P046	SECOND MODIFIER IS INVALID.
P047	THIRD MODIFIER IS INVALID.
P048	FOURTH MODIFIER IS INVALID.
P052	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P053	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P054	RENDERING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES FOR THE BENEFIT PLAN.
P055	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P061	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P062	THE CLIENT ID AND/OR NAME INDICATED ON THE PA REQUEST IS INCORRECT. THE CLIENT ID AND/OR NAME HAS BEEN UPDATED. PLEASE VERIFY THE ID AND/OR NAME IS CORRECT.
P064	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
P067	THE FREQUENCY OF HOURS REQUESTED ARE NOT APPROPRIATE FOR THIS CLIENT AND HAVE BEEN MODIFIED ACCORDINGLY.
P079	BILLING PROVIDER IS ON PAYMENT SUSPENSION DUE TO CREDIBLE ALLEGATION OF FRAUD.
P120	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAS BEEN REDUCED.
P121	THE SERVICE/ PROCEDURE REQUESTED IS NOT SUPPORTED BY SUBMITTED DOCUMENTATION.
P126	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
P128	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.
P138	SERVICE(S) DO NOT MEET COLORADO MEDICAID GUIDELINES.
P167	REQUESTED DOCUMENTATION HAS NOT BEEN SUBMITTED.
P178	THE SERVICE REQUESTED IS NOT MEDICALLY NECESSARY.
P179	THE MEDICAL NECESSITY FOR THIS SERVICE IS NOT SUPPORTED BY THE SUBMITTED DOCUMENTATION.
P233	THE DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE ADDITIONAL CARE.
P257	THIS CLIENTS FUNCTIONAL ASSESSMENT SCORES PLACE THIS CLIENT OUTSIDE ELIGIBILITY FOR DAY TREATMENT.
P274	OUR RECORDS INDICATE THIS CLIENT IS INVOLVED IN EFFECTIVE AND APPROPRIATE SERVICE ELSEWHERE.
P292	INTENSIVE REHABILITATION HOURS ARE NO LONGER APPROPRIATE AS INDICATED BY HISTORY, DIAGNOSIS, AND/ OR FUNCTIONAL ASSESSMENT SCORES.
P328	THE SERVICES REQUESTED INCLUDE NON-COVERED SERVICES, AND HOURS ARE REDUCED ACCORDINGLY.
P339	THE CLIENTS PAST HISTORY INDICATES REDUCED TREATMENT HOURS ARE WARRANTED.
P342	THE REQUEST DOES NOT MEET GENERALLY ACCEPTED CONDITIONS REQUIRING FLUORIDE TREATMENTS.
P346	SERVICES EXCEED COLORADO MEDICAID LIMITATION AND DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE MEDICAL NECESSITY OF THE SERVICE.
P349	THE SERVICE REQUESTED WAS PERFORMED LESS THAN FIVE YEARS AGO.
P353	THE EXISTING APPLIANCE HAS NOT BEEN WORN FOR THREE YEARS.
P367	THE CLIENT HAS BEEN TOTALLY WITHOUT TEETH AND AN APPLIANCE FOR FIVE YEARS.
P392	THE CLIENT IS MISSING AN ANTERIOR TOOTH AND/OR HAS TWO OR MORE POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P405	THE SERVICE(S) REQUESTED COULD ADEQUATELY BE PERFORMED IN THE DENTAL OFFICE.
P406	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE OF GOOD PERIODONTAL HEALTH (AMERICAN ACADEMY OF PERIODONTOLOGY PERIODONTAL CLASSIFICATION OF TYPE I OR II).
P407	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE VISIBLE ON RADIOGRAPHS THAT AT LEAST 50 PERCENT OF THE CLINICAL CROWN IS INTACT.
P409	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING SIX OR MORE TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED, INCLUDING THIRD MOLARS.

Denial Code	Long Description
P410	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING ONE OR MORE ANTERIOR TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED.
P411	DOCUMENTATION DOES NOT SUPPORT THE NEED FOR PERIODONTIC SERVICES. POCKETS ARE LESS THAN 4MM AND/OR GREATER THAN 6MM FOR CLIENT AND/OR THE CLIENT IS UNDER THE AGE OF 13.
P412	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA.
P413	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA. THIS PA HAS BEEN GRANTED AS APPROVED NOT APPROVED WITH REVISIONS. THE DURATION REQUESTED MAY HAVE BEEN REDUCED TO REFLECT COVERAGE LIMITATIONS, PRESCRIBER ORDERS, CONFLICTI
P417	THE SERVICE(S) REQUESTED COULD BE ADEQUATELY PERFORMED WITH LOCAL ANESTHESIA.
P437	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO POOR ORAL HYGIENE.
P444	THIS LINE ITEM IS A DUPLICATE OF ANOTHER LINE ITEM ON THIS PRIOR AUTHORIZATION (PA) REQUEST. PLEASE CORRECT.
P446	THIS IS A DUPLICATE OF AN EXISTING PRIOR AUTHORIZATION (PA) REQUEST. YOU MAY CONTACT PROVIDER SERVICES IF YOU REQUIRE ASSISTANCE. DUPLICATE PA REQUEST
P448	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO DECAY HISTORY.
P449	QUESTIONABLE LONG TERM PROGNOSIS DUE TO GUM AND BONE DISEASE.
P456	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO APPARENT ROOT INFECTION.
P457	OUR RECORDS INDICATE THIS CLIENT HAS EXCEEDED ESTABLISHED PROGRAM LIMITATIONS. COLORADO MEDICAID WILL NOT AUTHORIZE NEW DENTURES.
P458	DOCUMENTATION PROVIDED INDICATES A LESS ELABORATE PROCEDURE SHOULD BE CONSIDERED.
P502	RENTAL ONLY ALLOWED; MEDICAL NEED FOR PURCHASE HAS NOT BEEN DOCUMENTED.
P503	PURCHASE ONLY ALLOWED; MEDICAL NEED FOR RENTAL HAS NOT BEEN DOCUMENTED.
P504	OCCUPATIONAL THERAPY GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P505	THE SERVICE REQUESTED IS INCLUDED IN THE NURSING HOME RATE STRUCTURE.
P511	THIS NATIONAL DRUG CODE IS ONLY BILLABLE AS PART OF A COMPOUND DRUG.
P515	THE PRESENCE OF A HANDICAPPING MALOCCLUSION OR HANDICAPPING DENTOFACIAL DEFORMITY IS NOT SUPPORTED BY THE DOCUMENTATION SUBMITTED.
P521	THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVERED BY COLORADO MEDICAID.
P522	GASTRO-INTESTINAL SURGERY FOR THE PURPOSE OF WEIGHT CONTROL IS COVERED ONLY AS A LIFE THREATENING PROCEDURE.
P523	THE TREATMENT REQUEST IS NOT CONSISTENT WITH THE CLIENT'S DIAGNOSIS.
P524	PSYCHOTHERAPY PROVIDED IN THE CLIENTS HOME IS NOT A COVERED BENEFIT OF COLORADO MEDICAID.
P525	THE INFORMATION PROVIDED IS NOT CONSISTENT WITH THE INTENSITY OF SERVICES REQUESTED.
P526	INTENSIVE MULTIPLE MODALITY TREATMENT IS NOT CONSISTENT WITH THE INFORMATION PROVIDED.
P527	MULTIPLE PROVIDERS OF TREATMENT ARE NOT INDICATED FOR THIS CLIENT.
P528	THE DURATION OF TREATMENT SESSIONS EXCEED CURRENT COLORADO MEDICAID GUIDELINES.
P534	DOCUMENTATION OF POOR PHYSICAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P535	OTHER PHYSICAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P536	THE PHYSICAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P537	USE OF PHYSICAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P538	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF A PHYSICAL THERAPIST.
P539	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS AND LIVING ARRANGEMENT.
P540	GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P541	THE PROCEDURE(S) REQUESTED ARE NOT MEDICAL IN NATURE.
P542	DOCUMENTATION OF POOR OCCUPATIONAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.

Denial Code	Long Description
P543	DOCUMENTATION OF POOR SPEECH THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P544	OTHER OCCUPATIONAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P546	THE OCCUPATIONAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P547	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF PHYSICAL THERAPY.
P548	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P549	ACTIVITIES TO PROMOTE DIVERSION OR GENERAL MOTIVATION ARE NONCOVERED COLORADO MEDICAID SERVICES.
P550	REVISIONS OF THE REQUEST IS NECESSITATED BY THE CLIENTS MINIMAL PROGRESS.
P551	RESTORATIVE NURSING INVOLVEMENT COULD BE INCREASED.
P552	CLIENTS DEMONSTRATED RESPONSE TO CURRENT THERAPY DOES NOT WARRANT THE INTENSE FREQUENCY REQUESTED.
P553	MAINTENANCE IS TWO TIMES PER WEEK OR LESS.
P554	THE SPEECH THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P555	USE OF OCCUPATIONAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P556	USE OF SPEECH THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P557	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF AN OCCUPATIONAL THERAPIST.
P558	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
P559	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P560	THE MATERIALS/ SERVICES REQUESTED ARE PRINCIPALLY COSMETIC IN NATURE.
P561	THE LENS FORMULA DOES NOT JUSTIFY REPLACEMENT.
P562	THE CHANGE IN THE LENS FORMULA DOES NOT WARRANT MULTIPLE REPLACEMENTS.
P563	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P564	LENSES ONLY ARE APPROVED; PLEASE DISPENSE A CONTRACTED FRAME. THE NON-CONTRACTED FRAME IS NOT MEDICALLY JUSTIFIED.
P565	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P566	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P567	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF OCCUPATIONAL THERAPY.
P568	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF SPEECH THERAPY.
P569	LEVEL, INTENSITY, OR EXTENT OF SERVICE(S) REQUESTED HAS BEEN MODIFIED CONSISTENT WITH MEDICAL NEED AS DEFINED IN THE PLAN OF CARE.
P570	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P571	THE SERVICE ASKED FOR IS NOT COVERED BY COLORADO MEDICAID AS THESE TASKS CAN BE DONE BY NURSES OR ACTIVITY STAFF.
P572	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P573	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.
P574	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P575	MEDICAL NEED FOR EQUIPMENT/ SUPPLY REQUESTED IS NOT SUPPORTED BY DOCUMENTATION SUBMITTED.
P576	OTHER SPEECH THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P577	DOCUMENTATION SUBMITTED IDENTIFIES THAT THE CLIENT HAS FEWER THAN TWO POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P582	LESS EXPENSIVE ALTERNATIVE SERVICES ARE AVAILABLE FOR THIS CLIENT.

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P634	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P711	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING PERIODONTAL SCALING AND ROOT PLANNING.
P712	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING GINGIVECTOMY.
P754	AN APPROVED SUBSTANCE ABUSE DAY TREATMENT PROGRAM CANNOT EXCEED A SIX WEEK PERIOD.
P761	THE CLIENT DOES NOT APPEAR TO BE ABLE OR WILLING TO ABSTAIN FROM ALCOHOL/DRUG USAGE WHILE IN TREATMENT. THEREFORE, SUBSTANCE ABUSE DAY TREATMENT SERVICES ARE NOT APPROVED.
P764	THIS CLIENT HAS COMPLETED INTENSIVE SUBSTANCE ABUSE TREATMENT WITHIN THE PAST 12 MONTHS. THE DOCUMENTATION PROVIDED IS NOT ADEQUATE TO JUSTIFY ADDITIONAL INTENSIVE TREATMENT AT THIS TIME.
P785	A LESS THAN SIX-WEEK HEALING PERIOD HAS BEEN SPECIFIED FOR THIS PRIOR AUTHORIZATION. THEREFORE IT IS NOT NECESSARY TO WAIT THE FULL SIX WEEKS AFTER EXTRACTIONS BEFORE TAKING DENTURE IMPRESSIONS.
P818	SIX-WEEK HEALING TIME IS REQUIRED BETWEEN EDENTULATION AND FINAL IMPRESSIONS. PAYMENT FOR DENTURES WILL BE DENIED OR RECOUPED IF HEALING PERIOD IS NOT OBSERVED.
P849	COLORADO MEDICAID HAS DETERMINED THERE WERE (ARE) SEVERAL HOME HEALTH AGENCIES WILLING TO PROVIDE MEDICALLY NECESSARY SKILLED NURSING SERVICES TO THIS CLIENT.
P864	THE DOCUMENTATION YOU HAVE SUBMITTED DOES NOT MEET THE REQUIREMENTS OF COLORADO MEDICAID.
P873	THE MEDICAL NECESSITY FOR THE HOURS REQUESTED IS NOT SUPPORTED BY THE INFORMATION SUBMITTED.
P874	THE DOCUMENTATION SUBMITTED INDICATES THE TASKS SPECIFIED CAN BE COMPLETED DURING THE VISITS APPROVED.
P878	THE DOCUMENTATION SUBMITTED DOES NOT INDICATE THAT MEDICALLY ORIENTED TASKS ARE MEDICALLY NECESSARY; THEREFORE PERSONAL CARE SERVICES HAVE BEEN APPROVED.
P880	THE QUANTITY OF SERVICES AUTHORIZED FOR THIS CLIENTS PERSONAL CARE HAS BEEN AMENDED BASED ON INFORMATION RECEIVED FROM ONE OR MORE OF THESE SOURCES: THE CLIENT, THEIR PHYSICIAN, AND/OR THE IN-HOME VISIT BY STAFF OF THE OIG (OFFICE OF INSPECTOR GENERAL).
P885	THE USE OF THIS DRUG FOR THE INTENDED PURPOSE IS NOT COVERED BY COLORADO MEDICAID, CONSISTENT WITH COLORADO ADMINISTRATIVE CODE AND FEDERAL LAW.
P924	THE MEDICAL RECORDS SUBMITTED WITH THE CURRENT REQUEST CONFLICT OR DISAGREE WITH OUR MEDICAL RECORDS ON THIS CLIENT.
P950	INDEPENDENT NURSES, PLEASE NOTE PAYABLE SERVICES MAY NOT EXCEED 12 HOURS/DAY OR 60 HOURS/WEEK.
P951	SERVICES CAN ONLY BE AUTHORIZED THROUGH ONE YEAR FROM THE PRESCRIPTION DATE.
P952	LEAD INSPECTION IS A COVERED COLORADO MEDICAID SERVICE WHEN THE CHILD HAS BEEN SHOWN TO HAVE LEAD POISONING (E.G., CHILD HAS A BLOOD LEAD LEVEL > 19 UG/DL OR TWO CONSECUTIVE BLOOD LEAD LEVELS OF 15-19 UG/DL DONE AT LEAST 90 DAYS APART). THE INSPECTION MUS
P953	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P954	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P956	THE REQUEST CAN ONLY BE BACKDATED A MAXIMUM OF 14 DAYS FROM FIRST DATE RECEIVED BY COLORADO MEDICAID.
P957	COMPLETE PERIODONTAL CHARTING AT TIME OF SERVICE, AND SUBMIT CHARTING, COPY OF OPERATIVE REPORT, TOGETHER WITH A COPY OF THE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF), F-11035, TO PA UNIT ATTENTION DENTAL CONTSULTANT.
P958	NOTE THAT CODE D4341 HAS BEEN CHANGED. REFER TO THE DECISION NOTICE FOR AUTHORIZED QUANTITY.
P960	YOUR PA HAS BEEN APPROVED FOR 90 DAYS. THE 90 DAY APPROVAL DOES NOT IMPLY THE PA REQUEST MEETS PRIOR AUTHORIZATION CRITERIA. AFTER ADDITIONAL INFORMATION IS AVAILABLE IN INTERCHANGE, COLORADO MEDICAID WILL CREATE AN AMENDMENT REQUEST TO EXTEND THE PA FOR

Denial Code	Long Description
P961	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P962	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
PA10	THE REQUESTED END DATE IS INVALID.
PA12	PLEASE FURNISH A WRITTEN DESCRIPTION OF THE CLIENTS DIAGNOSIS.
PA13	PROVIDE DIAGNOSES WITH DATES OF ONSET.
PA14	IDENTIFY PROBLEMS TO BE TREATED.
PA15	THE AUDIOLOGISTS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1), F-11020, AND PRIOR AUTHORIZATION REQUEST/HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2), F-11021.
PA16	THE PHYSICIANS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION/PHYSICIAN OTOLOGICAL REPORT (PA/POR), F-11019.
PA17	SUBMIT BRIEF HISTORY WITH REFERRAL INFORMATION, LIVING SITUATION, FUNCTIONAL STATUS, AND OTHER PERTINENT INFORMATION. WHAT CHANGE OF STATUS RESULTED IN REFERRAL AT THIS TIME?
PA18	PLEASE FURNISH THE CLIENTS HEIGHT AND WEIGHT.
PA19	PLEASE SUBMIT CLINICAL INFORMATION SUFFICIENT TO VERIFY THE NEED FOR THE REQUESTED SERVICE(S).
PA20	PLEASE RESUBMIT WITH COMPLETE PERIODONTAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PA21	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL EDUCATIONAL PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA22	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL PROGRAM PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA23	REFER TO THE DURABLE MEDICAL EQUIPMENT INDEX FOR APPROPRIATE CODE AND DESCRIPTION. DO NOT USE AN "UNLISTED" CODE.
PA24	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUALIZED FAMILY SERVICE PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA25	INFORMATION ON THE REQUEST FORM IS ILLEGIBLE, AND THE REQUEST CANNOT BE PROCESSED.
PA26	RE-EVALUATE YOUR GOALS. EMPHASIS SHOULD BE ON FUNCTIONAL SELF-CARE. GOALS MUST BE RELATED TO FUNCTIONAL OUTCOME.
PA27	PLEASE CLARIFY THE NUMBER OF HOURS PER WEEK REQUESTED.
PA28	PLEASE CLARIFY THE NUMBER OF HOURS PER DAY REQUESTED.
PA29	PLEASE CLARIFY THE NUMBER OF VISITS PER DAY REQUESTED.
PA30	ATTACH SUPPORTIVE DOCUMENTATION; HOME EXERCISE PROGRAM AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA31	THE DIAGNOSIS CODE INDICATED ON THE REQUEST DOES NOT CORRESPOND TO THE DIAGNOSIS CODE DESCRIPTION.
PA32	PLEASE SUBMIT ADDITIONAL INFORMATION SUFFICIENT TO VERIFY APPROPRIATENESS AND NEED FOR TRANSPLANT.
PA33	PLEASE SUBMIT THE INITIAL AND PROGRESSIVE OBJECTIVE FINDINGS.
PA34	ATTACH SUPPORTIVE DOCUMENTATION, FACILITY PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA35	PLEASE SUBMIT THE CLIENTS ORIGINAL COMPLAINTS AND EXAMINATION FINDINGS.
PA36	ATTACH SUPPORTIVE DOCUMENTATION, IN-HOME AUTISM PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA37	PLEASE SUBMIT YOUR TREATMENT PLAN FOR THIS CLIENT.
PA38	ATTACH SUPPORTIVE DOCUMENTATION AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA39	INITIAL EVALUATIONS MUST BE PERFORMED BY AN OCCUPATIONAL THERAPIST REGISTERED (OTR), PER AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA) STANDARDS.
PA41	IDENTIFY THE PLACE OF SERVICE AND ITS EFFECT ON SUPPORTING THE DESIRED TREATMENT OUTCOME.
PA42	PLEASE INDICATE THE HOURS OF USE OF OXYGEN PER 24-HOUR PERIOD.

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PA43	PROVIDE BASELINE DOCUMENTATION FOR THIS CLIENTS LIMITATIONS USING UNITS OF MEASUREMENT THAT ARE APPLIED CONSISTENTLY WHEN REPORTING STATUS.
PA44	IDENTIFY FUNCTIONAL LIMITATIONS AS THEY ARE RELATED TO IDENTIFIED CONDITIONS.
PA46	CORRELATE PLAN OF CARE TO REQUESTED PROCEDURE CODES.
PA47	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE FREQUENCY/DURATION REQUESTED.
PA48	PLEASE PROVIDE THE NAME AND CREDENTIALS OF THE RENDERING PROVIDER.
PA50	COLORADO MEDICAID RECORDS INDICATE THE CLIENT OWNS A WHEELCHAIR. DOCUMENT THE REASON AND NEED FOR REPLACEMENT AND COST TO REPAIR CURRENT WHEELCHAIR.
PA51	PLEASE DISTINGUISH PRIMARY AND SUPPORTIVE MODALITIES.
PA52	PLEASE SUBMIT A PROGRESS REPORT.
PA53	MULTIPLE FAMILY CLIENTS TREATMENT BY THE SAME PROVIDER REQUIRES FURTHER INFORMATION DOCUMENTING COORDINATION OF TREATMENT PLAN.
PA54	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE MINUTES REQUESTED.
PA55	MEDICAL NECESSITY OF TREATMENT REQUIRES ADDITIONAL DOCUMENTATION.
PA56	GIVEN AGE, DIAGNOSES, CURRENT LEVEL OF FUNCTION, PAST RESPONSE TO TREATMENT, AND LIVING SITUATION, EXPAND ON POTENTIAL FOR SIGNIFICANT FUNCTIONAL PROGRESS WITHIN THE NEXT SIX MONTHS. EMPHASIZE WHY PROGRESS IS EXPECTED WITH SERVICES AT THIS TIME.
PA57	SUBMIT THE INITIAL FINDINGS. INCLUDE A COMPREHENSIVE EVALUATION.
PA58	SUBMIT PROGRESSIVE, OBJECTIVE FINDINGS. INCLUDE A PERTINENT RE-EVALUATION.
PA59	PLEASE SUPPLY INFORMATION REGARDING THE CLIENTS MEDICATION REQUIREMENTS, IF ANY.
PA60	PLEASE SPECIFY IF THE CLIENT IS IN AN EDUCATIONAL SETTING.
PA61	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA62	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
PA63	THE SKILLS OF A THERAPIST ARE PURPOSEFUL AND SKILLED INTERVENTIONS REQUIRED TO CONTINUALLY DESIGN, IMPLEMENT, REASSESS, MODIFY/GRADE, AND/OR DISCONTINUE A PLAN OF CARE IN A TIMELY MANNER, BASED ON THE COMPLEXITY OF THE CLIENTS MEDICAL CONDITION AND/OR CO
PA64	PLEASE SUBMIT A THERAPY PLAN OF CARE, INCLUDING A CURRENT, DATED EVALUATION.
PA65	A PLAN OF CARE SIGNED AND DATED BY THE PHYSICIAN IS REQUIRED.
PA66	THE SKILLS OF A THERAPIST ARE REQUIRED WHEN ONLY THE THERAPIST CAN SAFELY AND EFFECTIVELY DELIVER THE THERAPEUTIC PROCEDURES BECAUSE OF THEIR UNIQUE KNOWLEDGE, TRAINING, AND EXPERTISE. DESCRIBE THE REASON THAT SOMEONE OTHER THAN A THERAPIST CANNOT SAFELY
PA67	PLEASE SPECIFY IF THE CLIENTS WORK SITE DEMANDS GOOD BINAURAL HEARING.
PA68	DESCRIBE THE REASON, BASED ON THE CLIENTS COGNITIVE, PHYSICAL, COMMUNICATION, OR RESOURCE STATUS, THAT A HOME PROGRAM, EQUIPMENT, OR ENVIRONMENTAL ADAPTATIONS ALONE CANNOT MEET CLIENTS NEEDS.
PA69	PLEASE SPECIFY IF THE CLIENT HAS AN ACCOMPANYING DISABILITY THAT ADDS TO THE HEARING PROBLEM.
PA70	DISTINGUISH REQUESTED PROCEDURES AND GOALS FROM OTHER SERVICES THIS CLIENT RECEIVES. THEY MAY NOT BE DUPLICATIVE.
PA71	PLEASE INDICATE THE NUMBER OF DAYS REQUESTED.
PA73	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA74	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA75	PLEASE DOCUMENT CARRYOVER OF THE THERAPY PROGRAM TO NURSING.
PA76	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA79	PROVIDE EVIDENCE OF SIGNIFICANT FUNCTIONAL PROGRESS IN LAST SIX MONTHS.
PA84	THE GRANT DATE OF THIS REQUEST CANNOT BE PRIOR TO THE SIGNATURE DATE OF THE PRESCRIBING PHYSICIAN.

Denial Code	Long Description
PA86	PROVIDE EVIDENCE OF SKILLS GAINED IN THERAPY CARRYING OVER TO OTHER SETTINGS WITHIN SIX MONTHS.
PA87	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE NUMBER OF SESSIONS REQUESTED.
PA88	THE REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL SCOPE OF PRACTICE.
PA89	PRIOR AUTHORIZATION IS NOT REQUIRED UNTIL LIMITATION OF SERVICE HAS BEEN REACHED.
PA91	PLEASE SUBMIT REQUIRED X-RAYS.
PA92	PLEASE PROVIDE AN EXPLANATION FOR THE MATERIAL SUBMITTED WITH THE REQUEST.
PA95	PLEASE DESCRIBE HOW THE PROVISION OF THIS SERVICE WOULD PREVENT INSTITUTIONALIZATION OF THE CLIENT.
PA96	COULD THE EXISTING DENTURE(S) BE RELINED OR REBASED? IF NOT, PLEASE EXPLAIN WHY NOT.
PA97	REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL STANDARDS OF PRACTICE.
PA98	PLEASE INDICATE IF THE CLIENT IS CURRENTLY BEING TUBE FED.
PB02	PLEASE PROVIDE THE REQUIRED DATED SIGNATURES ON THE ATTACHMENTS.
PB03	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING THE LOSS/DESTRUCTION/THEFT OF THE HEARING AID.
PB04	DESCRIBE THE CLIENTS ABILITY TO STAND OR AMBULATE SUFFICIENTLY TO ACCOMPLISH SELF-CARE ACTIVITIES.
PB07	PLEASE SUBMIT AN ORTHODONTIC STUDY MODEL OR DIAGNOSTIC CASTS.
PB09	PLEASE PROVIDE A PHOTOGRAPH OF THE INVOLVED AREA(S).
PB10	PLEASE PROVIDE AN ESTIMATION (IN GRAMS) OF THE TOTAL AMOUNT OF TISSUE TO BE RESECTED.
PB11	PLEASE SUBMIT THE PLAN OF CARE FOR CO-TREATMENT.
PB12	FURNISH A DETAILED DESCRIPTION FOR THE PROCEDURE CODE REQUESTED.
PB13	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB15	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB18	PLEASE COMPLETE THE ATTACHED OUT-OF-STATE PROVIDER DATA SHEET, F-11001, AND RESUBMIT.
PB20	A SIGNED AND DATED PRESCRIPTION IS REQUIRED WITHIN THREE MONTHS OF RECEIPT BY COLORADO MEDICAID FOR INITIAL REQUESTS AND WITHIN 12 MONTHS OF RECEIPT BY COLORADO MEDICAID FOR SUBSEQUENT REQUESTS.
PB21	PLEASE COMPLETE THE APPROPRIATE PRIOR AUTHORIZATION ATTACHMENT. CONTACT PROVIDER SERVICES OR THE PRIOR AUTHORIZATION UNIT FOR ASSISTANCE.
PB23	PHYSICAL THERAPY ASSISTANT NOTES AND ALL FORMS SUBMITTED MUST BE COSIGNED BY A REGISTERED PHYSICAL THERAPIST.
PB31	ARE YOU REQUESTING A COMPLETE APPLIANCE, OR REPLACEMENT PARTS?
PB32	THE PROCEDURE CODE INDICATED ON THE REQUEST DOES NOT MATCH THE DESCRIPTION OF SERVICE; PLEASE CORRECT AND RESUBMIT.
PB35	THE SERVICE REQUESTED DOES NOT REQUIRE PRIOR AUTHORIZATION.
PB41	PLEASE FURNISH A CURRENT MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT, F-11090 (DATED WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID).
PB45	THE CERTIFICATION PERIOD ON THE PLAN OF CARE (POC) DOES NOT COVER THE REQUESTED GRANT/START DATE. PLEASE RESUBMIT YOUR REQUEST WITH A NEW POC.
PB49	A CERTIFIED OCCUPATIONAL THERAPY ASSISTANTS NOTES MUST BE COSIGNED BY AN OCCUPATIONAL THERAPIST REGISTERED.
PB51	ADDITIONAL INFORMATION IS REQUIRED ON PRIOR AUTHORIZATION TO ENABLE PRICING.
PB54	REQUESTED SERVICES DO NOT MATCH SERVICES ON THE PHYSICIANS ORDERS.
PB59	PLEASE PROVIDE AN INDIVIDUAL EDUCATIONAL PLAN (IEP), WHICH HAS BEEN SIGNED BY THE PROVIDER NO EARLIER THAN NINE MONTHS PRIOR TO RECEIPT AT COLORADO MEDICAID; OTHERWISE, DOCUMENT WHY NO IEP EXISTS.
PB65	PLEASE FURNISH THE ANTICIPATED TOTAL CHARGES FOR THIS REQUEST.
PB66	A PHOTOCOPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED; THE DATE MUST BE WITHIN SIX MONTHS OF RECEIPT BY COLORADO MEDICAID.
PB67	THE PRESCRIPTION DATE MUST INCLUDE MONTH, DAY, AND YEAR.
PB68	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID.

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PB73	THE SERVICES IDENTIFIED ON THE PLAN OF CARE DO NOT APPEAR APPROPRIATE FOR THE PROCEDURE CODE(S) REQUESTED ON THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018.
PB74	THE CLIENT/PROVIDER DOES NOT HAVE RETROACTIVE ENROLLMENT.
PB75	THE REQUESTED START DATE IS MORE THAN 14 DAYS BEFORE OR 62 DAYS AFTER RECEIPT.
PB82	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
PB83	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A HOME HEALTH AIDE. PLEASE RESUBMIT AS A PERSONAL CARE WORKER OR PROVIDE ADDITIONAL DOCUMENTATION.
PB86	THE SERVICES REQUESTED ARE NOT BEING PROVIDED IN THE CLIENTS RESIDENCE. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL.
PB87	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A NURSE. PLEASE RESUBMIT AS A HOME HEALTH AIDE OR PROVIDE ADDITIONAL DOCUMENTATION.
PB92	PLEASE FURNISH THE CLIENTS COMPLETE ADDRESS.
PB94	IF THE CLIENT IS A RESIDENT OF A NURSING HOME, SUPPLY THE COMPLETE NAME AND ADDRESS OF THE NURSING HOME.
PB99	THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018, MUST BE SIGNED AND DATED.
PC01	PLEASE SUPPLY THE RENDERING PROVIDERS PROVIDER NUMBER.
PC03	THE DRUG ENFORCEMENT ADMINISTRATION NUMBER IS MISSING OR INVALID.
PC06	PLEASE DESCRIBE YOUR PROGRAM; INCLUDE ENTRY DATE, TERMINATION DATE, HOURS PER WEEK, AND NUMBER OF WEEKS OF PRIMARY INTENSIVE SERVICE REQUESTED.
PC07	PLEASE DESCRIBE YOUR "AFTERCARE/FOLLOW-UP" PLANS FOR THIS CLIENT.
PC08	PLEASE SUPPLY DOCUMENTATION OF PREVIOUS SUBSTANCE ABUSE SERVICES WITH DATE(S) AND OUTCOME.
PC09	PLEASE DESCRIBE IN DETAIL THE TREATMENT OBJECTIVES/GOALS FOR THIS CLIENT.
PC10	PLEASE DESCRIBE THE FAMILY SITUATION/DYNAMICS. EXPLAIN HOW THE FAMILY WILL BE INCORPORATED INTO THE CLIENTS PLAN OF CARE.
PC12	PLEASE EXPLAIN IF YOUR SERVICE ENCOURAGES THE CLIENT TO ATTEND SELF-HELP GROUPS.
PC13	PLEASE SUPPLY A SPECIFIC SCHEDULE OF ACTIVITIES, INCLUDING DAY, TIME OF DAY, LENGTH OF SESSION, AND SERVICE TO BE RENDERED DURING THAT TIME.
PC15	PLEASE FURNISH DIAGNOSTIC RATIONALE.
PC17	PLEASE DOCUMENT IF THE CLIENT EVER RECEIVED SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT.
PC19	PLEASE FURNISH MORE EXTENSIVE AND IN-DEPTH HISTORICAL AND PSYCHOSOCIAL DATA.
PC20	PLEASE SUPPLY THE DATE THE CLIENT BECAME TOTALLY ENDENTULOUS.
PC23	PLEASE SUBMIT A PHYSICIANS STATEMENT REGARDING THE MEDICAL NECESSITY OF DENTURES FOR THIS CLIENT. THE PHYSICIANS STATEMENT MUST DOCUMENT THE MEDICAL NEED FOR DENTURES.
PC24	THE SERVICE REQUESTED WAS PREVIOUSLY AUTHORIZED. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT INDICATING THIS FACT IS REQUIRED.
PC25	PLEASE SUPPLY SUFFICIENT MITIGATING CIRCUMSTANCES TO WARRANT THE CONSTRUCTION OF NEW DENTURES(S).
PC26	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
PC28	PLEASE SUBMIT A PHYSICIANS STATEMENT INDICATING DENTURES ARE NECESSARY FOR THIS NURSING HOME CLIENT.
PC29	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING LOSS OR DESTRUCTION OF DENTURE(S). INCLUDE SIGNED STATEMENT FROM CLIENT OR FACILITY DIRECTOR REGARDING HOW, WHEN AND WHERE LOST.
PC30	PLEASE PROVIDE COMPLETE INTRAORAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PC31	PLEASE DESCRIBE ANY RELATED DEFORMITIES OF THE FEET.
PC34	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD WITH REQUESTED DME ITEM(S) AND DOCUMENT IF THE CLIENT CAN USE SAFELY AND INDEPENDENTLY.
PC35	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD AND DESCRIBE THE RESULTS AND EFFECTIVENESS OF THE SERVICE REQUESTED.
PC39	PLEASE INDICATE LITER FLOW PER MINUTE, HOURS OF USE PER 24 HOUR PERIOD, AND THE EXPECTED DURATION OF NEED.
PC40	THE ITEM DOES NOT REQUIRE PRIOR AUTHORIZATION UNTIL THE LIFE EXPECTANCY HAS BEEN REACHED.

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PC41	PLEASE SUPPLY INFORMATION INDICATING THE NECESSITY OF POSITIONING THE CLIENT'S BODY IN MULTIPLE POSITIONS.
PC42	PLEASE INDICATE IF THE BED HEIGHT MUST BE CHANGED TO ALLOW FOR SAFE TRANSFER OR ADEQUATE BED CARE.
PC43	SUPPLY A PHYSICIANS STATEMENT INDICATING TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR UNIT HAS REDUCED PAIN, IMPROVED/INCREASED THE CLIENTS ACTIVITY LEVEL, AND/OR REDUCED CLIENTS USE OF PAIN MEDICATION.
PC44	A CURRENT AUTHORIZATION FOR THIS SERVICE IS ON FILE FOR ANOTHER PROVIDER. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT OF THAT FACT IS REQUIRED BY THE CLIENT OF FIRST PROVIDER.
PC59	DOCUMENT DECLINE OR PROGRESS IN SPECIFIC, MEASURABLE, OBJECTIVE TERMS.
PC60	DOCUMENT IF CLIENT HAS DEMONSTRATED A GOOD APPOINTMENT COMPLIANCE RECORD.
PC61	THE PHYSICIANS SIGNATURE DATE MUST NOT EXCEED 90 DAYS FROM THE DATE OF RECEIPT BY COLORADO MEDICAID.
PC62	REQUESTS FOR A CONTINUATION OF THERAPY SHOULD NOT BE SUBMITTED MORE THAN FOUR WEEKS PRIOR TO THE EXPIRATION DATE OF THE CURRENT AUTHORIZATION.
PC63	PLEASE FURNISH THE STYLE AND MANUFACTURER OF THE FRAME.
PC64	PLEASE FURNISH THE CLIENTS LENS FORMULA.
PC66	ALL REQUESTS FOR TINTS REQUIRE DOCUMENTATION OF THE VISUAL OR MEDICAL CONDITION RELATED TO PHOTOPHOBIA.
PC67	PLEASE DOCUMENT THE REASON AND JUSTIFICATION FOR REPLACEMENT BEYOND THE FIRST LENS/FRAME.
PC68	DOCUMENT IF ALL REMAINING MAXILLARY AND/OR MANDIBULAR TEETH ARE DECAY-FREE, PROPERLY RESTORED, AND PERIODONTICALLY SOUND.
PC72	SUPPLY MORE DETAIL REGARDING PROGRESS (ATTACHMENT OF GOALS, ETC.). CORRELATE PROGRESS TO PREVIOUS GOALS AND IDENTIFIED LIMITATIONS.
PC77	PLEASE SUBMIT A PLAN OF CARE DESCRIBING THE SERVICES THAT WOULD BE PROVIDED.
PC78	PLEASE DOCUMENT SPECIFIC, MEASURABLE GOALS.
PC82	THE PRIOR AUTHORIZATION (PA) SYSTEM CAN PROCESS ONLY 26 DETAILS PER PA REQUEST. PLEASE RESUBMIT YOUR REQUEST WITH NO MORE THAN 26 DETAILS.
PC83	PLEASE SUPPLY A PHYSICIANS PRESCRIPTION DATED WITHIN ONE MONTH OF REQUESTED SUBSTANCE ABUSE DAY TREATMENT.
PC84	PLEASE PROVIDE INFORMATION INDICATING THIS CLIENT IS APPROPRIATELY DETOXIFIED FROM ALCOHOL AND/OR OTHER DRUGS.
PC85	PLEASE PROVIDE INFORMATION TO INDICATE THE CLIENTS ABILITY TO ABSTAIN FROM ALCOHOL OR DRUGS WHILE IN THE SUBSTANCE ABUSE DAY TREATMENT PROGRAM.
PC86	PLEASE INDICATE IF THIS CLIENT IS WILLING TO PARTICIPATE IN AFTERCARE OR CONTINUING CARE SERVICES.
PC87	PROVIDE MORE INFORMATION ON TREATMENT HISTORY; INCLUDE SERVICE PROVIDED, DATES, AND OUTCOME. PROVIDE DETAIL OF PREVIOUS TREATMENT.
PC88	PLEASE PROVIDE MORE RATIONALE FOR THE APPROPRIATENESS AND MEDICAL NECESSITY OF SUBSTANCE ABUSE DAY TREATMENT.
PC89	PROVIDE A TREATMENT PLAN THAT CONTAINS MEASURABLE GOALS AND OBJECTIVES CORRESPONDING TO THE IDENTIFIED DEFICIT.
PC91	PLEASE PROVIDE MORE INFORMATION ON FAMILY INVOLVEMENT TREATMENT.
PC92	PLEASE PROVIDE MORE HISTORY AND EXPLANATION ABOUT THE ISSUE OF ABSTINENCE FOR THIS CLIENT.
PC94	PLEASE PROVIDE THE ANTICIPATED BEGINNING DATE AND/OR THE ESTIMATED SUBSTANCE ABUSE DAY TREATMENT DISCHARGE DATE.
PC95	PLEASE SUPPLY JUSTIFICATION FOR BEGINNING CLIENT IN SERVICE PRIOR TO AUTHORIZATION BEING OBTAINED.
PC96	THE INITIAL THREE HOURS OF SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IN A CALENDAR YEAR DO NOT REQUIRE PRIOR AUTHORIZATION.
PC97	REIMBURSEMENT FOR INITIAL SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IS LIMITED TO THREE HOURS IN A CALENDAR YEAR AND DOES NOT REQUIRE PRIOR AUTHORIZATION.

Denial Code	Long Description
PC98	THIS DRUG IS CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE BILL USING THE APPROPRIATE NATIONAL DRUG CODE (NDC) OR SUBMIT A COMPLETED DRUG ADDITION REQUEST FORM IF THE NDC IS NOT LISTED IN THE DRUG INDEX.
PC99	THIS DRUG IS NOT CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL, CURRENT ADMINISTRATIVE RULE, OR COLORADO DRUG INDEX FOR COVERAGE LIMITATIONS.
PD01	DOCUMENT THAT CLIENT HAS ACHIEVED GOOD ORAL HYGIENE, PERIODONTAL CASE TYPE 1 OR 2, AND IS MOTIVATED TO MAINTAIN SAME.
PD03	PLEASE PROVIDE AN ARTERIAL BLOOD GAS READING OR PULSE OXIMETRY RESULTS DONE ON ROOM AIR SIGNED AND DATED BY A MEDICAL DOCTOR. THIS SHOULD BE DONE WITHIN 60 DAYS OF REQUESTED SERVICE.
PD04	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 30 DAYS OF RECEIPT BY COLORADO MEDICAID.
PD07	SUBMIT A PHOTOCOPY OF A VALID PRESCRIPTION, ISSUED WITHIN THE PAST YEAR, OR COMPLETE SECTION B OF THE PRIOR AUTHORIZATION/DRUG ATTACHMENT (PA/DGA), F-11049.
PD10	BRAND MEDICALLY NECESSARY MUST BE IN THE PRESCRIBERS OWN HANDWRITING AND WRITTEN DIRECTLY ON THE PRESCRIPTION OR A SEPARATE ORDER ATTACHED TO THE ORIGINAL PRESCRIPTION.
PD12	COMPLETE DENTURES, PARTIAL DENTURES, DENTURE RELINES, AND FIXED PROSTHODONTIC SERVICES ARE NOT COVERED SERVICES FOR ADULTS FOR DATES OF SERVICE ON AND AFTER OCTOBER 1, 1995.
PD22	PLEASE COMPLETE ALL REQUIRED ELEMENTS ON THE PERSONAL CARE SCREENING TOOL (PCST), F-11133.
PD24	THIS PRIOR AUTHORIZATION REQUEST IS UNABLE TO BE PROCESSED. PLEASE RESUBMIT WITH ADDITIONAL REQUIRED FORMS, INCLUDING THE ENTIRE PERSONAL CARE SCREENING TOOL (PCST), F-11133; PERSONAL CARE ADDENDUM, F-11136; AND SUPPORTING DOCUMENTATION, AS DIRECTED.
PD25	THERE IS A PERSONAL CARE SCREENING TOOL (PCST), F-11133, COMPLETED BY ANOTHER AGENCY. CONTACT THE AGENCY TO TRANSFER SCREEN.
PD26	THERE IS A LIMITED TERM CARE FUNCTIONAL SCREEN (LTC-FS) COMPLETED BY ANOTHER AGENCY. THE PERSONAL CARE SCREENING TOOL (PCST), F-11133, INFORMATION IS IN CONFLICT WITH LTC-FS.
PD27	ONLY ONE LEVEL OF FUNCTION MAY BE SELECTED FOR ALL ELEMENTS EXCEPT TOILETING. COLORADO MEDICAID IS UNABLE TO PROCESS THE PRIOR AUTHORIZATION REQUEST.
PD28	NO UNITS MAY BE REQUESTED USING THIS PRIOR AUTHORIZATION PROCESS. PLEASE SUBMIT WITH THE APPROPRIATE ATTACHMENTS FOR REQUESTING SPECIFIC PERSONAL CARE WORKER UNITS.
PD29	CLIENT IS NOT ELIGIBLE FOR THE REQUESTED SERVICE(S) AS OF THE REQUESTED START DATE.
PD30	NO TRAVEL TIME MAY BE AUTHORIZED WHEN NO PERSONAL CARE WORKER SERVICE IS AUTHORIZED.
PD32	PROVIDER NOT CERTIFIED TO RENDER THE SERVICE(S) REQUESTED.
PD34	BASED ON THE DOCUMENTATION SUBMITTED, THIS REQUEST CAN NOT BE PRIOR AUTHORIZED. REFER TO THE PA MESSAGES FROM THE CONSULTANT FOR COMPLETE EXPLANATION.
PD98	PLEASE DOCUMENT HOW AND WHEN EACH PREVIOUSLY AUTHORIZED PRO RE NATA VISIT WAS USED.

Hot, Cold, Photo, Wound Therapy

Denial Code	Long Description
0201	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
0233	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0235	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0237	CLIENT IDENTIFICATION NUMBER DOES NOT MATCH CLIENTS FIRST NAME.
0238	THE CLIENT IDENTIFICATION NUMBER DOES NOT MATCH THE CLIENTS LAST NAME.
0242	SECONDARY DIAGNOSIS CODE IS INVALID.
0248	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0249	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.

Denial Code	Long Description
0251	PROCEDURE CODE MODIFIER IN FIRST POSITION IS INVALID.
0252	THE PROCEDURE CODE MODIFIER IN SECOND POSITION IS INVALID FOR REQUESTED START DATE OR DATE OF RECEIPT.
0253	THE PROCEDURE CODE MODIFIER IN THIRD POSITION IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
0258	THE PRIMARY DIAGNOSIS CODE IS REQUIRED.
0272	THE PRIMARY DIAGNSOSIS CODE IS INVALID.
0400	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0853	HCPCS - ANNUAL UPDATE
0885	NEVER EVENTS MODIFIERS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
0886	NEVER EVENTS DIAGNOSIS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
1000	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
1002	RENDERING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1003	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1007	RENDERING PROVIDER ID IS NOT ON FILE.
1047	THE RENDERING PROVIDERS CERTIFICATION HAS BEEN CANCELLED.
1048	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1801	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
1804	A CERTIFIED SUBSTANCE ABUSE DAY TREATMENT PROVIDER MUST SUBMIT A SUBSTANCE ABUSE DAY TREATMENT PROCEDURE CODE.
1806	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
1808	THE BILLING PROVIDER DOES NOT HAVE THE REQUIRED CERTIFICATION ADDENDUM ON FILE.
1900	THE BILLING PROVIDERS TAXONOMY CODE IS INVALID.
1901	THE RENDERING PROVIDERS TAXONOMY CODE IS INVALID.
1927	A NATIONAL PROVIDER IDENTIFIER IS REQUIRED FOR THE BILLING PROVIDER.
1934	A NATIONAL PROVIDER INDENTIFIER IS REQUIRED FOR THE RENDERING PROVIDER.
1936	THE BILLING PROVIDER NUMBER IS INVALID.
1937	THE RENDERING PROVIDER NUMBER IS INVALID.
1960	INTERNAL PROCESSING IS REQUIRED.
1963	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.
1964	THE BILLING PROVIDER INDICATED IS NOT ALLOWABLE AS A BILLING PROVIDER.
1965	RENDERING PROVIDER NUMBER IS MISSING/INVALID FOR THIS PROCEDURE PROVIDER.
1974	PRESCRIBING/REFERRING/ORDERING PROVIDER INDICATED IS NOT CERTIFIED AS A PRESCRIBING/REFERRING/ORDERING PROVIDER.
1975	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
1976	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
2001	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2003	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2017	THE CLIENT IS ENROLLED IN A MEDICAID OR OTHER MANAGED CARE PROGRAM.
2037	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2603	CLIENT LOCKED-IN TO A PROVIDER OR ENROLLED IN A HOSPICE. CONTACT CLIENTS HOSPICE FOR PAYMENT OF SERVICES OR RESUBMIT WITH DOCUMENTATION OF UNRELATED NATURE OF CARE.
3324	THE MODIFIER HAS BEEN DISCONTINUED BY THE CENTERS OF MEDICARE AND MEDICAID SERVICES OR THE AMERICAN MEDICAL ASSOCIATION FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
3337	THE PROCEDURE CODE HAS BEEN TERMINATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AMERICAN MEDICAL ASSOCIATION, OR AMERICAN DENTAL ASSOCIATION FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT. RESUBMIT WITH VALID A PROCEDURE CODE.
3339	THE PROCEDURE BILLED IS NOT PAYABLE ACCORDING TO DEFICIT REDUCTION ACT (DEFRA) GUIDELINES.
3351	THE PROCEDURE IS NOT COVERED FOR CLIENTS WITH A NURSING HOME AUTHORIZATION ON THE REQUESTED START DATE OR DATE OF RECEIPT.
3353	THE PROCEDURE IS NOT A COVERED SERVICE FOR HOME AND COMMUNITY-BASED WAIVER CLIENTS.
4021	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.

Denial Code	Long Description
4027	THE DIAGNOSIS CODE IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
4031	THE PROCEDURE SUBMITTED IS NOT APPROPRIATE FOR CLIENTS GENDER.
4032	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4034	THE PROCEDURE CODE HAS AN AGE RESTRICTION.
4036	THE PLACE OF SERVICE CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4040	THE PRIMARY DIAGNOSIS CODE IS NOT ON FILE.
4041	THE SECONDARY DIAGNOSIS IS NOT ON FILE.
4046	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4127	INTERNAL PROCESSING IS REQUIRED.
4131	INTERNAL PROCESSING IS REQUIRED.
4141	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4149	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4150	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4236	ETIOLOGY DIAGNOSIS CODE(S) (E-CODES) ARE INVALID AS THE PRIMARY DIAGNOSIS.
4244	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4245	THE FOURTH POSITION MODIFIER IS INVALID FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT.
4256	THE PROCEDURE CODE AND MODIFIER COMBINATION IS NOT PAYABLE FOR THE CLIENTS BENEFIT PLAN.
4257	THE MODIFIERS SUBMITTED ARE EITHER INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT OR THE MODIFIERS ARE MISSING.
4311	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4315	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4316	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4371	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4372	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4711	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR CLIENTS AGE.
4714	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS AGE.
4731	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS DIAGNOSIS.
4742	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4743	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4744	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4745	DIAGNOSIS AND/OR PROCEDURE AND/OR PLACE OF SERVICE (POS) CODE IS NOT COVERED FOR EXPRESS ENROLLMENT CLIENTS.
4746	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4801	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4802	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
4821	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
4871	PLEASE REFER TO PA MESSAGES FOR RETURN INFORMATION.
4963	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS GENDER.
4990	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
7500	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
7509	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
P001	THE BILLING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THE SERVICES.
P002	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P003	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P005	THE PRIOR AUTHORIZATION CAN NOT BE END DATED. THE PRIOR AUTHORIZATION STATUS IS NOT APPROVED OR APPROVED WITH REVISIONS.
P006	PLEASE FURNISH THE PROCEDURE CODE AND CORRESPONDING DESCRIPTION.
P008	THE BILLING PROVIDER NUMBER IS INVALID.

Denial Code	Long Description
P009	THE BILLING PROVIDER NUMBER IS INVALID.
P010	THE REQUESTED END DATE IS INVALID.
P011	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P012	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P013	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P014	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P015	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P016	THE REQUESTED START DATE IS MISSING OR INVALID.
P019	THE REQUESTED START DATE IS MISSING OR INVALID.
P020	THE RENDERING PROVIDER NUMBER IS INVALID.
P021	THE RENDERING PROVIDER NUMBER IS INVALID.
P022	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P023	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P024	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P026	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P027	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P030	FIRST MODIFIER IS INVALID.
P031	FIRST MODIFIER IS INVALID.
P032	SECOND MODIFIER IS INVALID.
P033	SECOND MODIFIER IS INVALID.
P034	THIRD MODIFIER IS INVALID.
P035	THIRD MODIFIER IS INVALID.
P036	FOURTH MODIFIER IS INVALID.
P037	FOURTH MODIFIER IS INVALID.
P038	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P039	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P040	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P041	CLIENTS FIRST NAME IS MISSING.
P042	CLIENTS LAST NAME IS MISSING.
P043	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P044	BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES REQUESTED.
P045	FIRST MODIFIER IS INVALID.
P046	SECOND MODIFIER IS INVALID.
P047	THIRD MODIFIER IS INVALID.
P048	FOURTH MODIFIER IS INVALID.
P052	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P053	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P054	RENDERING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES FOR THE BENEFIT PLAN.
P055	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P061	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P062	THE CLIENT ID AND/OR NAME INDICATED ON THE PA REQUEST IS INCORRECT. THE CLIENT ID AND/OR NAME HAS BEEN UPDATED. PLEASE VERIFY THE ID AND/OR NAME IS CORRECT.
P064	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
P067	THE FREQUENCY OF HOURS REQUESTED ARE NOT APPROPRIATE FOR THIS CLIENT AND HAVE BEEN MODIFIED ACCORDINGLY.

Denial Code	Long Description
P079	BILLING PROVIDER IS ON PAYMENT SUSPENSION DUE TO CREDIBLE ALLEGATION OF FRAUD.
P120	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAS BEEN REDUCED.
P121	THE SERVICE/ PROCEDURE REQUESTED IS NOT SUPPORTED BY SUBMITTED DOCUMENTATION.
P126	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
P128	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.
P138	SERVICE(S) DO NOT MEET COLORADO MEDICAID GUIDELINES.
P167	REQUESTED DOCUMENTATION HAS NOT BEEN SUBMITTED.
P178	THE SERVICE REQUESTED IS NOT MEDICALLY NECESSARY.
P179	THE MEDICAL NECESSITY FOR THIS SERVICE IS NOT SUPPORTED BY THE SUBMITTED DOCUMENTATION.
P233	THE DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE ADDITIONAL CARE.
P257	THIS CLIENTS FUNCTIONAL ASSESSMENT SCORES PLACE THIS CLIENT OUTSIDE ELIGIBILITY FOR DAY TREATMENT.
P274	OUR RECORDS INDICATE THIS CLIENT IS INVOLVED IN EFFECTIVE AND APPROPRIATE SERVICE ELSEWHERE.
P292	INTENSIVE REHABILITATION HOURS ARE NO LONGER APPROPRIATE AS INDICATED BY HISTORY, DIAGNOSIS, AND/ OR FUNCTIONAL ASSESSMENT SCORES.
P328	THE SERVICES REQUESTED INCLUDE NON-COVERED SERVICES, AND HOURS ARE REDUCED ACCORDINGLY.
P339	THE CLIENTS PAST HISTORY INDICATES REDUCED TREATMENT HOURS ARE WARRANTED.
P342	THE REQUEST DOES NOT MEET GENERALLY ACCEPTED CONDITIONS REQUIRING FLUORIDE TREATMENTS.
P346	SERVICES EXCEED COLORADO MEDICAID LIMITATION AND DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE MEDICAL NECESSITY OF THE SERVICE.
P349	THE SERVICE REQUESTED WAS PERFORMED LESS THAN FIVE YEARS AGO.
P353	THE EXISTING APPLIANCE HAS NOT BEEN WORN FOR THREE YEARS.
P367	THE CLIENT HAS BEEN TOTALLY WITHOUT TEETH AND AN APPLIANCE FOR FIVE YEARS.
P392	THE CLIENT IS MISSING AN ANTERIOR TOOTH AND/OR HAS TWO OR MORE POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P405	THE SERVICE(S) REQUESTED COULD ADEQUATELY BE PERFORMED IN THE DENTAL OFFICE.
P406	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE OF GOOD PERIODONTAL HEALTH (AMERICAN ACADEMY OF PERIODONTOLOGY PERIODONTAL CLASSIFICATION OF TYPE I OR II).
P407	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE VISIBLE ON RADIOGRAPHS THAT AT LEAST 50 PERCENT OF THE CLINICAL CROWN IS INTACT.
P409	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING SIX OR MORE TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED, INCLUDING THIRD MOLARS.
P410	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING ONE OR MORE ANTERIOR TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED.
P411	DOCUMENTATION DOES NOT SUPPORT THE NEED FOR PERIODONTIC SERVICES. POCKETS ARE LESS THAN 4MM AND/OR GREATER THAN 6MM FOR CLIENT AND/OR THE CLIENT IS UNDER THE AGE OF 13.
P412	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA.
P413	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA. THIS PA HAS BEEN GRANTED AS APPROVED NOT APPROVED WITH REVISIONS. THE DURATION REQUESTED MAY HAVE BEEN REDUCED TO REFLECT COVERAGE LIMITATIONS, PRESCRIBER ORDERS, CONFLICTI
P417	THE SERVICE(S) REQUESTED COULD BE ADEQUATELY PERFORMED WITH LOCAL ANESTHESIA.
P437	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO POOR ORAL HYGIENE.
P444	THIS LINE ITEM IS A DUPLICATE OF ANOTHER LINE ITEM ON THIS PRIOR AUTHORIZATION (PA) REQUEST. PLEASE CORRECT.
P446	THIS IS A DUPLICATE OF AN EXISTING PRIOR AUTHORIZATION (PA) REQUEST. YOU MAY CONTACT PROVIDER SERVICES IF YOU REQUIRE ASSISTANCE. DUPLICATE PA REQUEST
P448	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO DECAY HISTORY.
P449	QUESTIONABLE LONG TERM PROGNOSIS DUE TO GUM AND BONE DISEASE.
P456	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO APPARENT ROOT INFECTION.
P457	OUR RECORDS INDICATE THIS CLIENT HAS EXCEEDED ESTABLISHED PROGRAM LIMITATIONS. COLORADO MEDICAID WILL NOT AUTHORIZE NEW DENTURES.
P458	DOCUMENTATION PROVIDED INDICATES A LESS ELABORATE PROCEDURE SHOULD BE CONSIDERED.

Denial Code	Long Description
P502	RENTAL ONLY ALLOWED; MEDICAL NEED FOR PURCHASE HAS NOT BEEN DOCUMENTED.
P503	PURCHASE ONLY ALLOWED; MEDICAL NEED FOR RENTAL HAS NOT BEEN DOCUMENTED.
P504	OCCUPATIONAL THERAPY GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P505	THE SERVICE REQUESTED IS INCLUDED IN THE NURSING HOME RATE STRUCTURE.
P511	THIS NATIONAL DRUG CODE IS ONLY BILLABLE AS PART OF A COMPOUND DRUG.
P515	THE PRESENCE OF A HANDICAPPING MALOCCLUSION OR HANDICAPPING DENTOFACIAL DEFORMITY IS NOT SUPPORTED BY THE DOCUMENTATION SUBMITTED.
P521	THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVERED BY COLORADO MEDICAID.
P522	GASTRO-INTESTINAL SURGERY FOR THE PURPOSE OF WEIGHT CONTROL IS COVERED ONLY AS A LIFE THREATENING PROCEDURE.
P523	THE TREATMENT REQUEST IS NOT CONSISTENT WITH THE CLIENT'S DIAGNOSIS.
P524	PSYCHOTHERAPY PROVIDED IN THE CLIENTS HOME IS NOT A COVERED BENEFIT OF COLORADO MEDICAID.
P525	THE INFORMATION PROVIDED IS NOT CONSISTENT WITH THE INTENSITY OF SERVICES REQUESTED.
P526	INTENSIVE MULTIPLE MODALITY TREATMENT IS NOT CONSISTENT WITH THE INFORMATION PROVIDED.
P527	MULTIPLE PROVIDERS OF TREATMENT ARE NOT INDICATED FOR THIS CLIENT.
P528	THE DURATION OF TREATMENT SESSIONS EXCEED CURRENT COLORADO MEDICAID GUIDELINES.
P534	DOCUMENTATION OF POOR PHYSICAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P535	OTHER PHYSICAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P536	THE PHYSICAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P537	USE OF PHYSICAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P538	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF A PHYSICAL THERAPIST.
P539	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS AND LIVING ARRANGEMENT.
P540	GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P541	THE PROCEDURE(S) REQUESTED ARE NOT MEDICAL IN NATURE.
P542	DOCUMENTATION OF POOR OCCUPATIONAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P543	DOCUMENTATION OF POOR SPEECH THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P544	OTHER OCCUPATIONAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P546	THE OCCUPATIONAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P547	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF PHYSICAL THERAPY.
P548	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P549	ACTIVITIES TO PROMOTE DIVERSION OR GENERAL MOTIVATION ARE NONCOVERED COLORADO MEDICAID SERVICES.
P550	REVISIONS OF THE REQUEST IS NECESSITATED BY THE CLIENTS MINIMAL PROGRESS.
P551	RESTORATIVE NURSING INVOLVEMENT COULD BE INCREASED.
P552	CLIENTS DEMONSTRATED RESPONSE TO CURRENT THERAPY DOES NOT WARRANT THE INTENSE FREQUENCY REQUESTED.
P553	MAINTENANCE IS TWO TIMES PER WEEK OR LESS.
P554	THE SPEECH THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P555	USE OF OCCUPATIONAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P556	USE OF SPEECH THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.

Denial Code	Long Description
P557	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF AN OCCUPATIONAL THERAPIST.
P558	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
P559	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P560	THE MATERIALS/ SERVICES REQUESTED ARE PRINCIPALLY COSMETIC IN NATURE.
P561	THE LENS FORMULA DOES NOT JUSTIFY REPLACEMENT.
P562	THE CHANGE IN THE LENS FORMULA DOES NOT WARRANT MULTIPLE REPLACEMENTS.
P563	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P564	LENSES ONLY ARE APPROVED; PLEASE DISPENSE A CONTRACTED FRAME. THE NON-CONTRACTED FRAME IS NOT MEDICALLY JUSTIFIED.
P565	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P566	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P567	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF OCCUPATIONAL THERAPY.
P568	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF SPEECH THERAPY.
P569	LEVEL, INTENSITY, OR EXTENT OF SERVICE(S) REQUESTED HAS BEEN MODIFIED CONSISTENT WITH MEDICAL NEED AS DEFINED IN THE PLAN OF CARE.
P570	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P571	THE SERVICE ASKED FOR IS NOT COVERED BY COLORADO MEDICAID AS THESE TASKS CAN BE DONE BY NURSES OR ACTIVITY STAFF.
P572	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P573	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.
P574	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P575	MEDICAL NEED FOR EQUIPMENT/ SUPPLY REQUESTED IS NOT SUPPORTED BY DOCUMENTATION SUBMITTED.
P576	OTHER SPEECH THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P577	DOCUMENTATION SUBMITTED IDENTIFIES THAT THE CLIENT HAS FEWER THAN TWO POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P582	LESS EXPENSIVE ALTERNATIVE SERVICES ARE AVAILABLE FOR THIS CLIENT.
P634	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P711	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING PERIODONTAL SCALING AND ROOT PLANNING.
P712	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING GINGIVECTOMY.
P754	AN APPROVED SUBSTANCE ABUSE DAY TREATMENT PROGRAM CANNOT EXCEED A SIX WEEK PERIOD.
P761	THE CLIENT DOES NOT APPEAR TO BE ABLE OR WILLING TO ABSTAIN FROM ALCOHOL/DRUG USAGE WHILE IN TREATMENT. THEREFORE, SUBSTANCE ABUSE DAY TREATMENT SERVICES ARE NOT APPROVED.
P764	THIS CLIENT HAS COMPLETED INTENSIVE SUBSTANCE ABUSE TREATMENT WITHIN THE PAST 12 MONTHS. THE DOCUMENTATION PROVIDED IS NOT ADEQUATE TO JUSTIFY ADDITIONAL INTENSIVE TREATMENT AT THIS TIME.
P785	A LESS THAN SIX-WEEK HEALING PERIOD HAS BEEN SPECIFIED FOR THIS PRIOR AUTHORIZATION. THEREFORE IT IS NOT NECESSARY TO WAIT THE FULL SIX WEEKS AFTER EXTRACTIONS BEFORE TAKING DENTURE IMPRESSIONS.
P818	SIX-WEEK HEALING TIME IS REQUIRED BETWEEN EDENTULATION AND FINAL IMPRESSIONS. PAYMENT FOR DENTURES WILL BE DENIED OR RECOUPED IF HEALING PERIOD IS NOT OBSERVED.
P849	COLORADO MEDICAID HAS DETERMINED THERE WERE (ARE) SEVERAL HOME HEALTH AGENCIES WILLING TO PROVIDE MEDICALLY NECESSARY SKILLED NURSING SERVICES TO THIS CLIENT.
P864	THE DOCUMENTATION YOU HAVE SUBMITTED DOES NOT MEET THE REQUIREMENTS OF COLORADO MEDICAID.
P873	THE MEDICAL NECESSITY FOR THE HOURS REQUESTED IS NOT SUPPORTED BY THE INFORMATION SUBMITTED.

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P874	THE DOCUMENTATION SUBMITTED INDICATES THE TASKS SPECIFIED CAN BE COMPLETED DURING THE VISITS APPROVED.
P878	THE DOCUMENTATION SUBMITTED DOES NOT INDICATE THAT MEDICALLY ORIENTED TASKS ARE MEDICALLY NECESSARY; THEREFORE PERSONAL CARE SERVICES HAVE BEEN APPROVED.
P880	THE QUANTITY OF SERVICES AUTHORIZED FOR THIS CLIENTS PERSONAL CARE HAS BEEN AMENDED BASED ON INFORMATION RECEIVED FROM ONE OR MORE OF THESE SOURCES: THE CLIENT, THEIR PHYSICIAN, AND/OR THE IN-HOME VISIT BY STAFF OF THE OIG (OFFICE OF INSPECTOR GENERAL).
P885	THE USE OF THIS DRUG FOR THE INTENDED PURPOSE IS NOT COVERED BY COLORADO MEDICAID, CONSISTENT WITH COLORADO ADMINISTRATIVE CODE AND FEDERAL LAW.
P924	THE MEDICAL RECORDS SUBMITTED WITH THE CURRENT REQUEST CONFLICT OR DISAGREE WITH OUR MEDICAL RECORDS ON THIS CLIENT.
P950	INDEPENDENT NURSES, PLEASE NOTE PAYABLE SERVICES MAY NOT EXCEED 12 HOURS/DAY OR 60 HOURS/WEEK.
P951	SERVICES CAN ONLY BE AUTHORIZED THROUGH ONE YEAR FROM THE PRESCRIPTION DATE.
P952	LEAD INSPECTION IS A COVERED COLORADO MEDICAID SERVICE WHEN THE CHILD HAS BEEN SHOWN TO HAVE LEAD POISONING (E.G., CHILD HAS A BLOOD LEAD LEVEL > 19 UG/DL OR TWO CONSECUTIVE BLOOD LEAD LEVELS OF 15-19 UG/DL DONE AT LEAST 90 DAYS APART). THE INSPECTION MUS
P953	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P954	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P956	THE REQUEST CAN ONLY BE BACKDATED A MAXIMUM OF 14 DAYS FROM FIRST DATE RECEIVED BY COLORADO MEDICAID.
P957	COMPLETE PERIODONTAL CHARTING AT TIME OF SERVICE, AND SUBMIT CHARTING, COPY OF OPERATIVE REPORT, TOGETHER WITH A COPY OF THE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF), F-11035, TO PA UNIT ATTENTION DENTAL CONTSULTANT.
P958	NOTE THAT CODE D4341 HAS BEEN CHANGED. REFER TO THE DECISION NOTICE FOR AUTHORIZED QUANTITY.
P960	YOUR PA HAS BEEN APPROVED FOR 90 DAYS. THE 90 DAY APPROVAL DOES NOT IMPLY THE PA REQUEST MEETS PRIOR AUTHORIZATION CRITERIA. AFTER ADDITIONAL INFORMATION IS AVAILABLE IN INTERCHANGE, COLORADO MEDICAID WILL CREATE AN AMENDMENT REQUEST TO EXTEND THE PA FOR
P961	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P962	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
PA10	THE REQUESTED END DATE IS INVALID.
PA12	PLEASE FURNISH A WRITTEN DESCRIPTION OF THE CLIENTS DIAGNOSIS.
PA13	PROVIDE DIAGNOSES WITH DATES OF ONSET.
PA14	IDENTIFY PROBLEMS TO BE TREATED.
PA15	THE AUDIOLOGISTS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1), F-11020, AND PRIOR AUTHORIZATION REQUEST/HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2), F-11021.
PA16	THE PHYSICIANS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION/PHYSICIAN OTOLOGICAL REPORT (PA/POR), F-11019.
PA17	SUBMIT BRIEF HISTORY WITH REFERRAL INFORMATION, LIVING SITUATION, FUNCTIONAL STATUS, AND OTHER PERTINENT INFORMATION. WHAT CHANGE OF STATUS RESULTED IN REFERRAL AT THIS TIME?
PA18	PLEASE FURNISH THE CLIENTS HEIGHT AND WEIGHT.
PA19	PLEASE SUBMIT CLINICAL INFORMATION SUFFICIENT TO VERIFY THE NEED FOR THE REQUESTED SERVICE(S).
PA20	PLEASE RESUBMIT WITH COMPLETE PERIODONTAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PA21	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL EDUCATIONAL PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.

Denial Code	Long Description
PA22	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL PROGRAM PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA23	REFER TO THE DURABLE MEDICAL EQUIPMENT INDEX FOR APPROPRIATE CODE AND DESCRIPTION. DO NOT USE AN "UNLISTED" CODE.
PA24	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUALIZED FAMILY SERVICE PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA25	INFORMATION ON THE REQUEST FORM IS ILLEGIBLE, AND THE REQUEST CANNOT BE PROCESSED.
PA26	RE-EVALUATE YOUR GOALS. EMPHASIS SHOULD BE ON FUNCTIONAL SELF-CARE. GOALS MUST BE RELATED TO FUNCTIONAL OUTCOME.
PA27	PLEASE CLARIFY THE NUMBER OF HOURS PER WEEK REQUESTED.
PA28	PLEASE CLARIFY THE NUMBER OF HOURS PER DAY REQUESTED.
PA29	PLEASE CLARIFY THE NUMBER OF VISITS PER DAY REQUESTED.
PA30	ATTACH SUPPORTIVE DOCUMENTATION; HOME EXERCISE PROGRAM AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA31	THE DIAGNOSIS CODE INDICATED ON THE REQUEST DOES NOT CORRESPOND TO THE DIAGNOSIS CODE DESCRIPTION.
PA32	PLEASE SUBMIT ADDITIONAL INFORMATION SUFFICIENT TO VERIFY APPROPRIATENESS AND NEED FOR TRANSPLANT.
PA33	PLEASE SUBMIT THE INITIAL AND PROGRESSIVE OBJECTIVE FINDINGS.
PA34	ATTACH SUPPORTIVE DOCUMENTATION, FACILITY PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA35	PLEASE SUBMIT THE CLIENTS ORIGINAL COMPLAINTS AND EXAMINATION FINDINGS.
PA36	ATTACH SUPPORTIVE DOCUMENTATION, IN-HOME AUTISM PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA37	PLEASE SUBMIT YOUR TREATMENT PLAN FOR THIS CLIENT.
PA38	ATTACH SUPPORTIVE DOCUMENTATION AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA39	INITIAL EVALUATIONS MUST BE PERFORMED BY AN OCCUPATIONAL THERAPIST REGISTERED (OTR), PER AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA) STANDARDS.
PA41	IDENTIFY THE PLACE OF SERVICE AND ITS EFFECT ON SUPPORTING THE DESIRED TREATMENT OUTCOME.
PA42	PLEASE INDICATE THE HOURS OF USE OF OXYGEN PER 24-HOUR PERIOD.
PA43	PROVIDE BASELINE DOCUMENTATION FOR THIS CLIENTS LIMITATIONS USING UNITS OF MEASUREMENT THAT ARE APPLIED CONSISTENTLY WHEN REPORTING STATUS.
PA44	IDENTIFY FUNCTIONAL LIMITATIONS AS THEY ARE RELATED TO IDENTIFIED CONDITIONS.
PA46	CORRELATE PLAN OF CARE TO REQUESTED PROCEDURE CODES.
PA47	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE FREQUENCY/DURATION REQUESTED.
PA48	PLEASE PROVIDE THE NAME AND CREDENTIALS OF THE RENDERING PROVIDER.
PA50	COLORADO MEDICAID RECORDS INDICATE THE CLIENT OWNS A WHEELCHAIR. DOCUMENT THE REASON AND NEED FOR REPLACEMENT AND COST TO REPAIR CURRENT WHEELCHAIR.
PA51	PLEASE DISTINGUISH PRIMARY AND SUPPORTIVE MODALITIES.
PA52	PLEASE SUBMIT A PROGRESS REPORT.
PA53	MULTIPLE FAMILY CLIENTS TREATMENT BY THE SAME PROVIDER REQUIRES FURTHER INFORMATION DOCUMENTING COORDINATION OF TREATMENT PLAN.
PA54	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE MINUTES REQUESTED.
PA55	MEDICAL NECESSITY OF TREATMENT REQUIRES ADDITIONAL DOCUMENTATION.
PA56	GIVEN AGE, DIAGNOSES, CURRENT LEVEL OF FUNCTION, PAST RESPONSE TO TREATMENT, AND LIVING SITUATION, EXPAND ON POTENTIAL FOR SIGNIFICANT FUNCTIONAL PROGRESS WITHIN THE NEXT SIX MONTHS. EMPHASIZE WHY PROGRESS IS EXPECTED WITH SERVICES AT THIS TIME.
PA57	SUBMIT THE INITIAL FINDINGS. INCLUDE A COMPREHENSIVE EVALUATION.
PA58	SUBMIT PROGRESSIVE, OBJECTIVE FINDINGS. INCLUDE A PERTINENT RE-EVALUATION.
PA59	PLEASE SUPPLY INFORMATION REGARDING THE CLIENTS MEDICATION REQUIREMENTS, IF ANY.
PA60	PLEASE SPECIFY IF THE CLIENT IS IN AN EDUCATIONAL SETTING.

Denial Code	Long Description
PA61	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA62	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
PA63	THE SKILLS OF A THERAPIST ARE PURPOSEFUL AND SKILLED INTERVENTIONS REQUIRED TO CONTINUALLY DESIGN, IMPLEMENT, REASSESS, MODIFY/GRADE, AND/OR DISCONTINUE A PLAN OF CARE IN A TIMELY MANNER, BASED ON THE COMPLEXITY OF THE CLIENTS MEDICAL CONDITION AND/OR CO
PA64	PLEASE SUBMIT A THERAPY PLAN OF CARE, INCLUDING A CURRENT, DATED EVALUATION.
PA65	A PLAN OF CARE SIGNED AND DATED BY THE PHYSICIAN IS REQUIRED.
PA66	THE SKILLS OF A THERAPIST ARE REQUIRED WHEN ONLY THE THERAPIST CAN SAFELY AND EFFECTIVELY DELIVER THE THERAPEUTIC PROCEDURES BECAUSE OF THEIR UNIQUE KNOWLEDGE, TRAINING, AND EXPERTISE. DESCRIBE THE REASON THAT SOMEONE OTHER THAN A THERAPIST CANNOT SAFELY
PA67	PLEASE SPECIFY IF THE CLIENTS WORK SITE DEMANDS GOOD BINAURAL HEARING.
PA68	DESCRIBE THE REASON, BASED ON THE CLIENTS COGNITIVE, PHYSICAL, COMMUNICATION, OR RESOURCE STATUS, THAT A HOME PROGRAM, EQUIPMENT, OR ENVIRONMENTAL ADAPTATIONS ALONE CANNOT MEET CLIENTS NEEDS.
PA69	PLEASE SPECIFY IF THE CLIENT HAS AN ACCOMPANYING DISABILITY THAT ADDS TO THE HEARING PROBLEM.
PA70	DISTINGUISH REQUESTED PROCEDURES AND GOALS FROM OTHER SERVICES THIS CLIENT RECEIVES. THEY MAY NOT BE DUPLICATIVE.
PA71	PLEASE INDICATE THE NUMBER OF DAYS REQUESTED.
PA73	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA74	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA75	PLEASE DOCUMENT CARRYOVER OF THE THERAPY PROGRAM TO NURSING.
PA76	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA79	PROVIDE EVIDENCE OF SIGNIFICANT FUNCTIONAL PROGRESS IN LAST SIX MONTHS.
PA84	THE GRANT DATE OF THIS REQUEST CANNOT BE PRIOR TO THE SIGNATURE DATE OF THE PRESCRIBING PHYSICIAN.
PA86	PROVIDE EVIDENCE OF SKILLS GAINED IN THERAPY CARRYING OVER TO OTHER SETTINGS WITHIN SIX MONTHS.
PA87	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE NUMBER OF SESSIONS REQUESTED.
PA88	THE REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL SCOPE OF PRACTICE.
PA89	PRIOR AUTHORIZATION IS NOT REQUIRED UNTIL LIMITATION OF SERVICE HAS BEEN REACHED.
PA91	PLEASE SUBMIT REQUIRED X-RAYS.
PA92	PLEASE PROVIDE AN EXPLANATION FOR THE MATERIAL SUBMITTED WITH THE REQUEST.
PA95	PLEASE DESCRIBE HOW THE PROVISION OF THIS SERVICE WOULD PREVENT INSTITUTIONALIZATION OF THE CLIENT.
PA96	COULD THE EXISTING DENTURE(S) BE RELINED OR REBASED? IF NOT, PLEASE EXPLAIN WHY NOT.
PA97	REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL STANDARDS OF PRACTICE.
PA98	PLEASE INDICATE IF THE CLIENT IS CURRENTLY BEING TUBE FED.
PB02	PLEASE PROVIDE THE REQUIRED DATED SIGNATURES ON THE ATTACHMENTS.
PB03	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING THE LOSS/DESTRUCTION/THEFT OF THE HEARING AID.
PB04	DESCRIBE THE CLIENTS ABILITY TO STAND OR AMBULATE SUFFICIENTLY TO ACCOMPLISH SELF-CARE ACTIVITIES.
PB07	PLEASE SUBMIT AN ORTHODONTIC STUDY MODEL OR DIAGNOSTIC CASTS.
PB09	PLEASE PROVIDE A PHOTOGRAPH OF THE INVOLVED AREA(S).
PB10	PLEASE PROVIDE AN ESTIMATION (IN GRAMS) OF THE TOTAL AMOUNT OF TISSUE TO BE RESECTED.
PB11	PLEASE SUBMIT THE PLAN OF CARE FOR CO-TREATMENT.
PB12	FURNISH A DETAILED DESCRIPTION FOR THE PROCEDURE CODE REQUESTED.
PB13	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.

Denial Code	Long Description
PB15	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB18	PLEASE COMPLETE THE ATTACHED OUT-OF-STATE PROVIDER DATA SHEET, F-11001, AND RESUBMIT.
PB20	A SIGNED AND DATED PRESCRIPTION IS REQUIRED WITHIN THREE MONTHS OF RECEIPT BY COLORADO MEDICAID FOR INITIAL REQUESTS AND WITHIN 12 MONTHS OF RECEIPT BY COLORADO MEDICAID FOR SUBSEQUENT REQUESTS.
PB21	PLEASE COMPLETE THE APPROPRIATE PRIOR AUTHORIZATION ATTACHMENT. CONTACT PROVIDER SERVICES OR THE PRIOR AUTHORIZATION UNIT FOR ASSISTANCE.
PB23	PHYSICAL THERAPY ASSISTANT NOTES AND ALL FORMS SUBMITTED MUST BE COSIGNED BY A REGISTERED PHYSICAL THERAPIST.
PB31	ARE YOU REQUESTING A COMPLETE APPLIANCE, OR REPLACEMENT PARTS?
PB32	THE PROCEDURE CODE INDICATED ON THE REQUEST DOES NOT MATCH THE DESCRIPTION OF SERVICE; PLEASE CORRECT AND RESUBMIT.
PB35	THE SERVICE REQUESTED DOES NOT REQUIRE PRIOR AUTHORIZATION.
PB41	PLEASE FURNISH A CURRENT MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT, F-11090 (DATED WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID).
PB45	THE CERTIFICATION PERIOD ON THE PLAN OF CARE (POC) DOES NOT COVER THE REQUESTED GRANT/START DATE. PLEASE RESUBMIT YOUR REQUEST WITH A NEW POC.
PB49	A CERTIFIED OCCUPATIONAL THERAPY ASSISTANTS NOTES MUST BE COSIGNED BY AN OCCUPATIONAL THERAPIST REGISTERED.
PB51	ADDITIONAL INFORMATION IS REQUIRED ON PRIOR AUTHORIZATION TO ENABLE PRICING.
PB54	REQUESTED SERVICES DO NOT MATCH SERVICES ON THE PHYSICIANS ORDERS.
PB59	PLEASE PROVIDE AN INDIVIDUAL EDUCATIONAL PLAN (IEP), WHICH HAS BEEN SIGNED BY THE PROVIDER NO EARLIER THAN NINE MONTHS PRIOR TO RECEIPT AT COLORADO MEDICAID; OTHERWISE, DOCUMENT WHY NO IEP EXISTS.
PB65	PLEASE FURNISH THE ANTICIPATED TOTAL CHARGES FOR THIS REQUEST.
PB66	A PHOTOCOPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED; THE DATE MUST BE WITHIN SIX MONTHS OF RECEIPT BY COLORADO MEDICAID.
PB67	THE PRESCRIPTION DATE MUST INCLUDE MONTH, DAY, AND YEAR.
PB68	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID.
PB73	THE SERVICES IDENTIFIED ON THE PLAN OF CARE DO NOT APPEAR APPROPRIATE FOR THE PROCEDURE CODE(S) REQUESTED ON THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018.
PB74	THE CLIENT/PROVIDER DOES NOT HAVE RETROACTIVE ENROLLMENT.
PB75	THE REQUESTED START DATE IS MORE THAN 14 DAYS BEFORE OR 62 DAYS AFTER RECEIPT.
PB82	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
PB83	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A HOME HEALTH AIDE. PLEASE RESUBMIT AS A PERSONAL CARE WORKER OR PROVIDE ADDITIONAL DOCUMENTATION.
PB86	THE SERVICES REQUESTED ARE NOT BEING PROVIDED IN THE CLIENTS RESIDENCE. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL.
PB87	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A NURSE. PLEASE RESUBMIT AS A HOME HEALTH AIDE OR PROVIDE ADDITIONAL DOCUMENTATION.
PB92	PLEASE FURNISH THE CLIENTS COMPLETE ADDRESS.
PB94	IF THE CLIENT IS A RESIDENT OF A NURSING HOME, SUPPLY THE COMPLETE NAME AND ADDRESS OF THE NURSING HOME.
PB99	THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018, MUST BE SIGNED AND DATED.
PC01	PLEASE SUPPLY THE RENDERING PROVIDERS PROVIDER NUMBER.
PC03	THE DRUG ENFORCEMENT ADMINISTRATION NUMBER IS MISSING OR INVALID.
PC06	PLEASE DESCRIBE YOUR PROGRAM; INCLUDE ENTRY DATE, TERMINATION DATE, HOURS PER WEEK, AND NUMBER OF WEEKS OF PRIMARY INTENSIVE SERVICE REQUESTED.
PC07	PLEASE DESCRIBE YOUR "AFTERCARE/FOLLOW-UP" PLANS FOR THIS CLIENT.
PC08	PLEASE SUPPLY DOCUMENTATION OF PREVIOUS SUBSTANCE ABUSE SERVICES WITH DATE(S) AND OUTCOME.
PC09	PLEASE DESCRIBE IN DETAIL THE TREATMENT OBJECTIVES/GOALS FOR THIS CLIENT.

Denial Code	Long Description
PC10	PLEASE DESCRIBE THE FAMILY SITUATION/DYNAMICS. EXPLAIN HOW THE FAMILY WILL BE INCORPORATED INTO THE CLIENTS PLAN OF CARE.
PC12	PLEASE EXPLAIN IF YOUR SERVICE ENCOURAGES THE CLIENT TO ATTEND SELF-HELP GROUPS.
PC13	PLEASE SUPPLY A SPECIFIC SCHEDULE OF ACTIVITIES, INCLUDING DAY, TIME OF DAY, LENGTH OF SESSION, AND SERVICE TO BE RENDERED DURING THAT TIME.
PC15	PLEASE FURNISH DIAGNOSTIC RATIONALE.
PC17	PLEASE DOCUMENT IF THE CLIENT EVER RECEIVED SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT.
PC19	PLEASE FURNISH MORE EXTENSIVE AND IN-DEPTH HISTORICAL AND PSYCHOSOCIAL DATA.
PC20	PLEASE SUPPLY THE DATE THE CLIENT BECAME TOTALLY ENDENTULOUS.
PC23	PLEASE SUBMIT A PHYSICIANS STATEMENT REGARDING THE MEDICAL NECESSITY OF DENTURES FOR THIS CLIENT. THE PHYSICIANS STATEMENT MUST DOCUMENT THE MEDICAL NEED FOR DENTURES.
PC24	THE SERVICE REQUESTED WAS PREVIOUSLY AUTHORIZED. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT INDICATING THIS FACT IS REQUIRED.
PC25	PLEASE SUPPLY SUFFICIENT MITIGATING CIRCUMSTANCES TO WARRANT THE CONSTRUCTION OF NEW DENTURES(S).
PC26	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
PC28	PLEASE SUBMIT A PHYSICIANS STATEMENT INDICATING DENTURES ARE NECESSARY FOR THIS NURSING HOME CLIENT.
PC29	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING LOSS OR DESTRUCTION OF DENTURE(S). INCLUDE SIGNED STATEMENT FROM CLIENT OR FACILITY DIRECTOR REGARDING HOW, WHEN AND WHERE LOST.
PC30	PLEASE PROVIDE COMPLETE INTRAORAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PC31	PLEASE DESCRIBE ANY RELATED DEFORMITIES OF THE FEET.
PC34	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD WITH REQUESTED DME ITEM(S) AND DOCUMENT IF THE CLIENT CAN USE SAFELY AND INDEPENDENTLY.
PC35	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD AND DESCRIBE THE RESULTS AND EFFECTIVENESS OF THE SERVICE REQUESTED.
PC39	PLEASE INDICATE LITER FLOW PER MINUTE, HOURS OF USE PER 24 HOUR PERIOD, AND THE EXPECTED DURATION OF NEED.
PC40	THE ITEM DOES NOT REQUIRE PRIOR AUTHORIZATION UNTIL THE LIFE EXPECTANCY HAS BEEN REACHED.
PC41	PLEASE SUPPLY INFORMATION INDICATING THE NECESSITY OF POSITIONING THE CLIENT'S BODY IN MULTIPLE POSITIONS.
PC42	PLEASE INDICATE IF THE BED HEIGHT MUST BE CHANGED TO ALLOW FOR SAFE TRANSFER OR ADEQUATE BED CARE.
PC43	SUPPLY A PHYSICIANS STATEMENT INDICATING TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR UNIT HAS REDUCED PAIN, IMPROVED/INCREASED THE CLIENTS ACTIVITY LEVEL, AND/OR REDUCED CLIENTS USE OF PAIN MEDICATION.
PC44	A CURRENT AUTHORIZATION FOR THIS SERVICE IS ON FILE FOR ANOTHER PROVIDER. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT OF THAT FACT IS REQUIRED BY THE CLIENT OF FIRST PROVIDER.
PC59	DOCUMENT DECLINE OR PROGRESS IN SPECIFIC, MEASURABLE, OBJECTIVE TERMS.
PC60	DOCUMENT IF CLIENT HAS DEMONSTRATED A GOOD APPOINTMENT COMPLIANCE RECORD.
PC61	THE PHYSICIANS SIGNATURE DATE MUST NOT EXCEED 90 DAYS FROM THE DATE OF RECEIPT BY COLORADO MEDICAID.
PC62	REQUESTS FOR A CONTINUATION OF THERAPY SHOULD NOT BE SUBMITTED MORE THAN FOUR WEEKS PRIOR TO THE EXPIRATION DATE OF THE CURRENT AUTHORIZATION.
PC63	PLEASE FURNISH THE STYLE AND MANUFACTURER OF THE FRAME.
PC64	PLEASE FURNISH THE CLIENTS LENS FORMULA.
PC66	ALL REQUESTS FOR TINTS REQUIRE DOCUMENTATION OF THE VISUAL OR MEDICAL CONDITION RELATED TO PHOTOPHOBIA.
PC67	PLEASE DOCUMENT THE REASON AND JUSTIFICATION FOR REPLACEMENT BEYOND THE FIRST LENS/FRAME.
PC68	DOCUMENT IF ALL REMAINING MAXILLARY AND/OR MANDIBULAR TEETH ARE DECAY-FREE, PROPERLY RESTORED, AND PERIODONTICALLY SOUND.

Denial Code	Long Description
PC72	SUPPLY MORE DETAIL REGARDING PROGRESS (ATTACHMENT OF GOALS, ETC.). CORRELATE PROGRESS TO PREVIOUS GOALS AND IDENTIFIED LIMITATIONS.
PC77	PLEASE SUBMIT A PLAN OF CARE DESCRIBING THE SERVICES THAT WOULD BE PROVIDED.
PC78	PLEASE DOCUMENT SPECIFIC, MEASURABLE GOALS.
PC82	THE PRIOR AUTHORIZATION (PA) SYSTEM CAN PROCESS ONLY 26 DETAILS PER PA REQUEST. PLEASE RESUBMIT YOUR REQUEST WITH NO MORE THAN 26 DETAILS.
PC83	PLEASE SUPPLY A PHYSICIANS PRESCRIPTION DATED WITHIN ONE MONTH OF REQUESTED SUBSTANCE ABUSE DAY TREATMENT.
PC84	PLEASE PROVIDE INFORMATION INDICATING THIS CLIENT IS APPROPRIATELY DETOXIFIED FROM ALCOHOL AND/OR OTHER DRUGS.
PC85	PLEASE PROVIDE INFORMATION TO INDICATE THE CLIENTS ABILITY TO ABSTAIN FROM ALCOHOL OR DRUGS WHILE IN THE SUBSTANCE ABUSE DAY TREATMENT PROGRAM.
PC86	PLEASE INDICATE IF THIS CLIENT IS WILLING TO PARTICIPATE IN AFTERCARE OR CONTINUING CARE SERVICES.
PC87	PROVIDE MORE INFORMATION ON TREATMENT HISTORY; INCLUDE SERVICE PROVIDED, DATES, AND OUTCOME. PROVIDE DETAIL OF PREVIOUS TREATMENT.
PC88	PLEASE PROVIDE MORE RATIONALE FOR THE APPROPRIATENESS AND MEDICAL NECESSITY OF SUBSTANCE ABUSE DAY TREATMENT.
PC89	PROVIDE A TREATMENT PLAN THAT CONTAINS MEASURABLE GOALS AND OBJECTIVES CORRESPONDING TO THE IDENTIFIED DEFICIT.
PC91	PLEASE PROVIDE MORE INFORMATION ON FAMILY INVOLVEMENT TREATMENT.
PC92	PLEASE PROVIDE MORE HISTORY AND EXPLANATION ABOUT THE ISSUE OF ABSTINENCE FOR THIS CLIENT.
PC94	PLEASE PROVIDE THE ANTICIPATED BEGINNING DATE AND/OR THE ESTIMATED SUBSTANCE ABUSE DAY TREATMENT DISCHARGE DATE.
PC95	PLEASE SUPPLY JUSTIFICATION FOR BEGINNING CLIENT IN SERVICE PRIOR TO AUTHORIZATION BEING OBTAINED.
PC96	THE INITIAL THREE HOURS OF SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IN A CALENDAR YEAR DO NOT REQUIRE PRIOR AUTHORIZATION.
PC97	REIMBURSEMENT FOR INITIAL SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IS LIMITED TO THREE HOURS IN A CALENDAR YEAR AND DOES NOT REQUIRE PRIOR AUTHORIZATION.
PC98	THIS DRUG IS CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE BILL USING THE APPROPRIATE NATIONAL DRUG CODE (NDC) OR SUBMIT A COMPLETED DRUG ADDITION REQUEST FORM IF THE NDC IS NOT LISTED IN THE DRUG INDEX.
PC99	THIS DRUG IS NOT CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL, CURRENT ADMINISTRATIVE RULE, OR COLORADO DRUG INDEX FOR COVERAGE LIMITATIONS.
PD01	DOCUMENT THAT CLIENT HAS ACHIEVED GOOD ORAL HYGIENE, PERIODONTAL CASE TYPE 1 OR 2, AND IS MOTIVATED TO MAINTAIN SAME.
PD03	PLEASE PROVIDE AN ARTERIAL BLOOD GAS READING OR PULSE OXIMETRY RESULTS DONE ON ROOM AIR SIGNED AND DATED BY A MEDICAL DOCTOR. THIS SHOULD BE DONE WITHIN 60 DAYS OF REQUESTED SERVICE.
PD04	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 30 DAYS OF RECEIPT BY COLORADO MEDICAID.
PD07	SUBMIT A PHOTOCOPY OF A VALID PRESCRIPTION, ISSUED WITHIN THE PAST YEAR, OR COMPLETE SECTION B OF THE PRIOR AUTHORIZATION/DRUG ATTACHMENT (PA/DGA), F-11049.
PD10	BRAND MEDICALLY NECESSARY MUST BE IN THE PRESCRIBERS OWN HANDWRITING AND WRITTEN DIRECTLY ON THE PRESCRIPTION OR A SEPARATE ORDER ATTACHED TO THE ORIGINAL PRESCRIPTION.
PD12	COMPLETE DENTURES, PARTIAL DENTURES, DENTURE RELINES, AND FIXED PROSTHODONTIC SERVICES ARE NOT COVERED SERVICES FOR ADULTS FOR DATES OF SERVICE ON AND AFTER OCTOBER 1, 1995.
PD22	PLEASE COMPLETE ALL REQUIRED ELEMENTS ON THE PERSONAL CARE SCREENING TOOL (PCST), F-11133.
PD24	THIS PRIOR AUTHORIZATION REQUEST IS UNABLE TO BE PROCESSED. PLEASE RESUBMIT WITH ADDITIONAL REQUIRED FORMS, INCLUDING THE ENTIRE PERSONAL CARE SCREENING TOOL (PCST), F-11133; PERSONAL CARE ADDENDUM, F-11136; AND SUPPORTING DOCUMENTATION, AS DIRECTED.

Denial Code	Long Description
PD25	THERE IS A PERSONAL CARE SCREENING TOOL (PCST), F-11133, COMPLETED BY ANOTHER AGENCY. CONTACT THE AGENCY TO TRANSFER SCREEN.
PD26	THERE IS A LIMITED TERM CARE FUNCTIONAL SCREEN (LTC-FS) COMPLETED BY ANOTHER AGENCY. THE PERSONAL CARE SCREENING TOOL (PCST), F-11133, INFORMATION IS IN CONFLICT WITH LTC-FS.
PD27	ONLY ONE LEVEL OF FUNCTION MAY BE SELECTED FOR ALL ELEMENTS EXCEPT TOILETING. COLORADO MEDICAID IS UNABLE TO PROCESS THE PRIOR AUTHORIZATION REQUEST.
PD28	NO UNITS MAY BE REQUESTED USING THIS PRIOR AUTHORIZATION PROCESS. PLEASE SUBMIT WITH THE APPROPRIATE ATTACHMENTS FOR REQUESTING SPECIFIC PERSONAL CARE WORKER UNITS.
PD29	CLIENT IS NOT ELIGIBLE FOR THE REQUESTED SERVICE(S) AS OF THE REQUESTED START DATE.
PD30	NO TRAVEL TIME MAY BE AUTHORIZED WHEN NO PERSONAL CARE WORKER SERVICE IS AUTHORIZED.
PD32	PROVIDER NOT CERTIFIED TO RENDER THE SERVICE(S) REQUESTED.
PD34	BASED ON THE DOCUMENTATION SUBMITTED, THIS REQUEST CAN NOT BE PRIOR AUTHORIZED. REFER TO THE PA MESSAGES FROM THE CONSULTANT FOR COMPLETE EXPLANATION.
PD98	PLEASE DOCUMENT HOW AND WHEN EACH PREVIOUSLY AUTHORIZED PRO RE NATA VISIT WAS USED.

Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)

Denial Code	Long Description
0201	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
0233	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0235	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0237	CLIENT IDENTIFICATION NUMBER DOES NOT MATCH CLIENTS FIRST NAME.
0238	THE CLIENT IDENTIFICATION NUMBER DOES NOT MATCH THE CLIENTS LAST NAME.
0242	SECONDARY DIAGNOSIS CODE IS INVALID.
0248	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0249	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0251	PROCEDURE CODE MODIFIER IN FIRST POSITION IS INVALID.
0252	THE PROCEDURE CODE MODIFIER IN SECOND POSITION IS INVALID FOR REQUESTED START DATE OR DATE OF RECEIPT.
0253	THE PROCEDURE CODE MODIFIER IN THIRD POSITION IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
0258	THE PRIMARY DIAGNOSIS CODE IS REQUIRED.
0272	THE PRIMARY DIAGNSOSIS CODE IS INVALID.
0400	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0853	HCPCS - ANNUAL UPDATE
0885	NEVER EVENTS MODIFIERS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
0886	NEVER EVENTS DIAGNOSIS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
1000	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
1002	RENDERING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1003	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1007	RENDERING PROVIDER ID IS NOT ON FILE.
1047	THE RENDERING PROVIDERS CERTIFICATION HAS BEEN CANCELLED.
1048	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1801	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
1804	A CERTIFIED SUBSTANCE ABUSE DAY TREATMENT PROVIDER MUST SUBMIT A SUBSTANCE ABUSE DAY TREATMENT PROCEDURE CODE.
1806	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
1808	THE BILLING PROVIDER DOES NOT HAVE THE REQUIRED CERTIFICATION ADDENDUM ON FILE.

Denial Code	Long Description
1900	THE BILLING PROVIDERS TAXONOMY CODE IS INVALID.
1901	THE RENDERING PROVIDERS TAXONOMY CODE IS INVALID.
1927	A NATIONAL PROVIDER IDENTIFIER IS REQUIRED FOR THE BILLING PROVIDER.
1934	A NATIONAL PROVIDER INDENTIFIER IS REQUIRED FOR THE RENDERING PROVIDER.
1936	THE BILLING PROVIDER NUMBER IS INVALID.
1937	THE RENDERING PROVIDER NUMBER IS INVALID.
1960	INTERNAL PROCESSING IS REQUIRED.
1963	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.
1964	THE BILLING PROVIDER INDICATED IS NOT ALLOWABLE AS A BILLING PROVIDER.
1965	RENDERING PROVIDER NUMBER IS MISSING/INVALID FOR THIS PROCEDURE PROVIDER.
1974	PRESCRIBING/REFERRING/ORDERING PROVIDER INDICATED IS NOT CERTIFIED AS A PRESCRIBING/REFERRING/ORDERING PROVIDER.
1975	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
1976	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
2001	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2003	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2017	THE CLIENT IS ENROLLED IN A MEDICAID OR OTHER MANAGED CARE PROGRAM.
2037	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2603	CLIENT LOCKED-IN TO A PROVIDER OR ENROLLED IN A HOSPICE. CONTACT CLIENTS HOSPICE FOR PAYMENT OF SERVICES OR RESUBMIT WITH DOCUMENTATION OF UNRELATED NATURE OF CARE.
3324	THE MODIFIER HAS BEEN DISCONTINUED BY THE CENTERS OF MEDICARE AND MEDICAID SERVICES OR THE AMERICAN MEDICAL ASSOCIATION FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
3337	THE PROCEDURE CODE HAS BEEN TERMINATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AMERICAN MEDICAL ASSOCIATION, OR AMERICAN DENTAL ASSOCIATION FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT. RESUBMIT WITH VALID A PROCEDURE CODE.
3339	THE PROCEDURE BILLED IS NOT PAYABLE ACCORDING TO DEFICIT REDUCTION ACT (DEFRA) GUIDELINES.
3351	THE PROCEDURE IS NOT COVERED FOR CLIENTS WITH A NURSING HOME AUTHORIZATION ON THE REQUESTED START DATE OR DATE OF RECEIPT.
3353	THE PROCEDURE IS NOT A COVERED SERVICE FOR HOME AND COMMUNITY-BASED WAIVER CLIENTS.
4021	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4027	THE DIAGNOSIS CODE IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
4031	THE PROCEDURE SUBMITTED IS NOT APPROPRIATE FOR CLIENTS GENDER.
4032	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4034	THE PROCEDURE CODE HAS AN AGE RESTRICTION.
4036	THE PLACE OF SERVICE CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4040	THE PRIMARY DIAGNOSIS CODE IS NOT ON FILE.
4041	THE SECONDARY DIAGNOSIS IS NOT ON FILE.
4046	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4127	INTERNAL PROCESSING IS REQUIRED.
4131	INTERNAL PROCESSING IS REQUIRED.
4141	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4149	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4150	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4236	ETIOLOGY DIAGNOSIS CODE(S) (E-CODES) ARE INVALID AS THE PRIMARY DIAGNOSIS.
4244	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4245	THE FOURTH POSITION MODIFIER IS INVALID FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT.
4256	THE PROCEDURE CODE AND MODIFIER COMBINATION IS NOT PAYABLE FOR THE CLIENTS BENEFIT PLAN.
4257	THE MODIFIERS SUBMITTED ARE EITHER INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT OR THE MODIFIERS ARE MISSING.
4311	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4315	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4316	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.

Denial Code	Long Description
4371	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4372	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4711	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR CLIENTS AGE.
4714	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS AGE.
4731	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS DIAGNOSIS.
4742	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4743	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4744	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4745	DIAGNOSIS AND/OR PROCEDURE AND/OR PLACE OF SERVICE (POS) CODE IS NOT COVERED FOR EXPRESS ENROLLMENT CLIENTS.
4746	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4801	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4802	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
4821	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
4871	PLEASE REFER TO PA MESSAGES FOR RETURN INFORMATION.
4963	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS GENDER.
4990	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
7500	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
7509	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
P001	THE BILLING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THE SERVICES.
P002	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P003	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P005	THE PRIOR AUTHORIZATION CAN NOT BE END DATED. THE PRIOR AUTHORIZATION STATUS IS NOT APPROVED OR APPROVED WITH REVISIONS.
P006	PLEASE FURNISH THE PROCEDURE CODE AND CORRESPONDING DESCRIPTION.
P008	THE BILLING PROVIDER NUMBER IS INVALID.
P009	THE BILLING PROVIDER NUMBER IS INVALID.
P010	THE REQUESTED END DATE IS INVALID.
P011	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P012	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P013	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P014	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P015	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P016	THE REQUESTED START DATE IS MISSING OR INVALID.
P019	THE REQUESTED START DATE IS MISSING OR INVALID.
P020	THE RENDERING PROVIDER NUMBER IS INVALID.
P021	THE RENDERING PROVIDER NUMBER IS INVALID.
P022	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P023	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P024	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P026	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P027	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P030	FIRST MODIFIER IS INVALID.
P031	FIRST MODIFIER IS INVALID.
P032	SECOND MODIFIER IS INVALID.
P033	SECOND MODIFIER IS INVALID.

Denial Code	Long Description
P034	THIRD MODIFIER IS INVALID.
P035	THIRD MODIFIER IS INVALID.
P036	FOURTH MODIFIER IS INVALID.
P037	FOURTH MODIFIER IS INVALID.
P038	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P039	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P040	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P041	CLIENTS FIRST NAME IS MISSING.
P042	CLIENTS LAST NAME IS MISSING.
P043	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P044	BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES REQUESTED.
P045	FIRST MODIFIER IS INVALID.
P046	SECOND MODIFIER IS INVALID.
P047	THIRD MODIFIER IS INVALID.
P048	FOURTH MODIFIER IS INVALID.
P052	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P053	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P054	RENDERING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES FOR THE BENEFIT PLAN.
P055	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P061	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P062	THE CLIENT ID AND/OR NAME INDICATED ON THE PA REQUEST IS INCORRECT. THE CLIENT ID AND/OR NAME HAS BEEN UPDATED. PLEASE VERIFY THE ID AND/OR NAME IS CORRECT.
P064	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
P067	THE FREQUENCY OF HOURS REQUESTED ARE NOT APPROPRIATE FOR THIS CLIENT AND HAVE BEEN MODIFIED ACCORDINGLY.
P079	BILLING PROVIDER IS ON PAYMENT SUSPENSION DUE TO CREDIBLE ALLEGATION OF FRAUD.
P120	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAS BEEN REDUCED.
P121	THE SERVICE/ PROCEDURE REQUESTED IS NOT SUPPORTED BY SUBMITTED DOCUMENTATION.
P126	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
P128	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.
P138	SERVICE(S) DO NOT MEET COLORADO MEDICAID GUIDELINES.
P167	REQUESTED DOCUMENTATION HAS NOT BEEN SUBMITTED.
P178	THE SERVICE REQUESTED IS NOT MEDICALLY NECESSARY.
P179	THE MEDICAL NECESSITY FOR THIS SERVICE IS NOT SUPPORTED BY THE SUBMITTED DOCUMENTATION.
P233	THE DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE ADDITIONAL CARE.
P257	THIS CLIENTS FUNCTIONAL ASSESSMENT SCORES PLACE THIS CLIENT OUTSIDE ELIGIBILITY FOR DAY TREATMENT.
P274	OUR RECORDS INDICATE THIS CLIENT IS INVOLVED IN EFFECTIVE AND APPROPRIATE SERVICE ELSEWHERE.
P292	INTENSIVE REHABILITATION HOURS ARE NO LONGER APPROPRIATE AS INDICATED BY HISTORY, DIAGNOSIS, AND/ OR FUNCTIONAL ASSESSMENT SCORES.
P328	THE SERVICES REQUESTED INCLUDE NON-COVERED SERVICES, AND HOURS ARE REDUCED ACCORDINGLY.
P339	THE CLIENTS PAST HISTORY INDICATES REDUCED TREATMENT HOURS ARE WARRANTED.
P342	THE REQUEST DOES NOT MEET GENERALLY ACCEPTED CONDITIONS REQUIRING FLUORIDE TREATMENTS.
P346	SERVICES EXCEED COLORADO MEDICAID LIMITATION AND DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE MEDICAL NECESSITY OF THE SERVICE.
P349	THE SERVICE REQUESTED WAS PERFORMED LESS THAN FIVE YEARS AGO.
P353	THE EXISTING APPLIANCE HAS NOT BEEN WORN FOR THREE YEARS.

Denial Code	Long Description
P367	THE CLIENT HAS BEEN TOTALLY WITHOUT TEETH AND AN APPLIANCE FOR FIVE YEARS.
P392	THE CLIENT IS MISSING AN ANTERIOR TOOTH AND/OR HAS TWO OR MORE POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P405	THE SERVICE(S) REQUESTED COULD ADEQUATELY BE PERFORMED IN THE DENTAL OFFICE.
P406	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE OF GOOD PERIODONTAL HEALTH (AMERICAN ACADEMY OF PERIODONTOLOGY PERIODONTAL CLASSIFICATION OF TYPE I OR II).
P407	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE VISIBLE ON RADIOGRAPHS THAT AT LEAST 50 PERCENT OF THE CLINICAL CROWN IS INTACT.
P409	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING SIX OR MORE TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED, INCLUDING THIRD MOLARS.
P410	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING ONE OR MORE ANTERIOR TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED.
P411	DOCUMENTATION DOES NOT SUPPORT THE NEED FOR PERIODONTIC SERVICES. POCKETS ARE LESS THAN 4MM AND/OR GREATER THAN 6MM FOR CLIENT AND/OR THE CLIENT IS UNDER THE AGE OF 13.
P412	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA.
P413	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA. THIS PA HAS BEEN GRANTED AS APPROVED NOT APPROVED WITH REVISIONS. THE DURATION REQUESTED MAY HAVE BEEN REDUCED TO REFLECT COVERAGE LIMITATIONS, PRESCRIBER ORDERS, CONFLICTI
P417	THE SERVICE(S) REQUESTED COULD BE ADEQUATELY PERFORMED WITH LOCAL ANESTHESIA.
P437	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO POOR ORAL HYGIENE.
P444	THIS LINE ITEM IS A DUPLICATE OF ANOTHER LINE ITEM ON THIS PRIOR AUTHORIZATION (PA) REQUEST. PLEASE CORRECT.
P446	THIS IS A DUPLICATE OF AN EXISTING PRIOR AUTHORIZATION (PA) REQUEST. YOU MAY CONTACT PROVIDER SERVICES IF YOU REQUIRE ASSISTANCE. DUPLICATE PA REQUEST
P448	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO DECAY HISTORY.
P449	QUESTIONABLE LONG TERM PROGNOSIS DUE TO GUM AND BONE DISEASE.
P456	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO APPARENT ROOT INFECTION.
P457	OUR RECORDS INDICATE THIS CLIENT HAS EXCEEDED ESTABLISHED PROGRAM LIMITATIONS. COLORADO MEDICAID WILL NOT AUTHORIZE NEW DENTURES.
P458	DOCUMENTATION PROVIDED INDICATES A LESS ELABORATE PROCEDURE SHOULD BE CONSIDERED.
P502	RENTAL ONLY ALLOWED; MEDICAL NEED FOR PURCHASE HAS NOT BEEN DOCUMENTED.
P503	PURCHASE ONLY ALLOWED; MEDICAL NEED FOR RENTAL HAS NOT BEEN DOCUMENTED.
P504	OCCUPATIONAL THERAPY GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P505	THE SERVICE REQUESTED IS INCLUDED IN THE NURSING HOME RATE STRUCTURE.
P511	THIS NATIONAL DRUG CODE IS ONLY BILLABLE AS PART OF A COMPOUND DRUG.
P515	THE PRESENCE OF A HANDICAPPING MALOCCLUSION OR HANDICAPPING DENTOFACIAL DEFORMITY IS NOT SUPPORTED BY THE DOCUMENTATION SUBMITTED.
P521	THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVERED BY COLORADO MEDICAID.
P522	GASTRO-INTESTINAL SURGERY FOR THE PURPOSE OF WEIGHT CONTROL IS COVERED ONLY AS A LIFE THREATENING PROCEDURE.
P523	THE TREATMENT REQUEST IS NOT CONSISTENT WITH THE CLIENT'S DIAGNOSIS.
P524	PSYCHOTHERAPY PROVIDED IN THE CLIENTS HOME IS NOT A COVERED BENEFIT OF COLORADO MEDICAID.
P525	THE INFORMATION PROVIDED IS NOT CONSISTENT WITH THE INTENSITY OF SERVICES REQUESTED.
P526	INTENSIVE MULTIPLE MODALITY TREATMENT IS NOT CONSISTENT WITH THE INFORMATION PROVIDED.
P527	MULTIPLE PROVIDERS OF TREATMENT ARE NOT INDICATED FOR THIS CLIENT.
P528	THE DURATION OF TREATMENT SESSIONS EXCEED CURRENT COLORADO MEDICAID GUIDELINES.
P534	DOCUMENTATION OF POOR PHYSICAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P535	OTHER PHYSICAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P536	THE PHYSICAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.

Denial Code	Long Description
P537	USE OF PHYSICAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P538	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF A PHYSICAL THERAPIST.
P539	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS AND LIVING ARRANGEMENT.
P540	GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P541	THE PROCEDURE(S) REQUESTED ARE NOT MEDICAL IN NATURE.
P542	DOCUMENTATION OF POOR OCCUPATIONAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P543	DOCUMENTATION OF POOR SPEECH THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P544	OTHER OCCUPATIONAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P546	THE OCCUPATIONAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P547	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF PHYSICAL THERAPY.
P548	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P549	ACTIVITIES TO PROMOTE DIVERSION OR GENERAL MOTIVATION ARE NONCOVERED COLORADO MEDICAID SERVICES.
P550	REVISIONS OF THE REQUEST IS NECESSITATED BY THE CLIENTS MINIMAL PROGRESS.
P551	RESTORATIVE NURSING INVOLVEMENT COULD BE INCREASED.
P552	CLIENTS DEMONSTRATED RESPONSE TO CURRENT THERAPY DOES NOT WARRANT THE INTENSE FREQUENCY REQUESTED.
P553	MAINTENANCE IS TWO TIMES PER WEEK OR LESS.
P554	THE SPEECH THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P555	USE OF OCCUPATIONAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P556	USE OF SPEECH THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P557	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF AN OCCUPATIONAL THERAPIST.
P558	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
P559	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P560	THE MATERIALS/ SERVICES REQUESTED ARE PRINCIPALLY COSMETIC IN NATURE.
P561	THE LENS FORMULA DOES NOT JUSTIFY REPLACEMENT.
P562	THE CHANGE IN THE LENS FORMULA DOES NOT WARRANT MULTIPLE REPLACEMENTS.
P563	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P564	LENSES ONLY ARE APPROVED; PLEASE DISPENSE A CONTRACTED FRAME. THE NON-CONTRACTED FRAME IS NOT MEDICALLY JUSTIFIED.
P565	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P566	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P567	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF OCCUPATIONAL THERAPY.
P568	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF SPEECH THERAPY.
P569	LEVEL, INTENSITY, OR EXTENT OF SERVICE(S) REQUESTED HAS BEEN MODIFIED CONSISTENT WITH MEDICAL NEED AS DEFINED IN THE PLAN OF CARE.
P570	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P571	THE SERVICE ASKED FOR IS NOT COVERED BY COLORADO MEDICAID AS THESE TASKS CAN BE DONE BY NURSES OR ACTIVITY STAFF.
P572	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.

Denial Code	Long Description
P573	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.
P574	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P575	MEDICAL NEED FOR EQUIPMENT/ SUPPLY REQUESTED IS NOT SUPPORTED BY DOCUMENTATION SUBMITTED.
P576	OTHER SPEECH THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P577	DOCUMENTATION SUBMITTED IDENTIFIES THAT THE CLIENT HAS FEWER THAN TWO POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P582	LESS EXPENSIVE ALTERNATIVE SERVICES ARE AVAILABLE FOR THIS CLIENT.
P634	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P711	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING PERIODONTAL SCALING AND ROOT PLANNING.
P712	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING GINGIVECTOMY.
P754	AN APPROVED SUBSTANCE ABUSE DAY TREATMENT PROGRAM CANNOT EXCEED A SIX WEEK PERIOD.
P761	THE CLIENT DOES NOT APPEAR TO BE ABLE OR WILLING TO ABSTAIN FROM ALCOHOL/DRUG USAGE WHILE IN TREATMENT. THEREFORE, SUBSTANCE ABUSE DAY TREATMENT SERVICES ARE NOT APPROVED.
P764	THIS CLIENT HAS COMPLETED INTENSIVE SUBSTANCE ABUSE TREATMENT WITHIN THE PAST 12 MONTHS. THE DOCUMENTATION PROVIDED IS NOT ADEQUATE TO JUSTIFY ADDITIONAL INTENSIVE TREATMENT AT THIS TIME.
P785	A LESS THAN SIX-WEEK HEALING PERIOD HAS BEEN SPECIFIED FOR THIS PRIOR AUTHORIZATION. THEREFORE IT IS NOT NECESSARY TO WAIT THE FULL SIX WEEKS AFTER EXTRACTIONS BEFORE TAKING DENTURE IMPRESSIONS.
P818	SIX-WEEK HEALING TIME IS REQUIRED BETWEEN EDENTULATION AND FINAL IMPRESSIONS. PAYMENT FOR DENTURES WILL BE DENIED OR RECOUPED IF HEALING PERIOD IS NOT OBSERVED.
P849	COLORADO MEDICAID HAS DETERMINED THERE WERE (ARE) SEVERAL HOME HEALTH AGENCIES WILLING TO PROVIDE MEDICALLY NECESSARY SKILLED NURSING SERVICES TO THIS CLIENT.
P864	THE DOCUMENTATION YOU HAVE SUBMITTED DOES NOT MEET THE REQUIREMENTS OF COLORADO MEDICAID.
P873	THE MEDICAL NECESSITY FOR THE HOURS REQUESTED IS NOT SUPPORTED BY THE INFORMATION SUBMITTED.
P874	THE DOCUMENTATION SUBMITTED INDICATES THE TASKS SPECIFIED CAN BE COMPLETED DURING THE VISITS APPROVED.
P878	THE DOCUMENTATION SUBMITTED DOES NOT INDICATE THAT MEDICALLY ORIENTED TASKS ARE MEDICALLY NECESSARY; THEREFORE PERSONAL CARE SERVICES HAVE BEEN APPROVED.
P880	THE QUANTITY OF SERVICES AUTHORIZED FOR THIS CLIENTS PERSONAL CARE HAS BEEN AMENDED BASED ON INFORMATION RECEIVED FROM ONE OR MORE OF THESE SOURCES: THE CLIENT, THEIR PHYSICIAN, AND/OR THE IN-HOME VISIT BY STAFF OF THE OIG (OFFICE OF INSPECTOR GENERAL).
P885	THE USE OF THIS DRUG FOR THE INTENDED PURPOSE IS NOT COVERED BY COLORADO MEDICAID, CONSISTENT WITH COLORADO ADMINISTRATIVE CODE AND FEDERAL LAW.
P924	THE MEDICAL RECORDS SUBMITTED WITH THE CURRENT REQUEST CONFLICT OR DISAGREE WITH OUR MEDICAL RECORDS ON THIS CLIENT.
P950	INDEPENDENT NURSES, PLEASE NOTE PAYABLE SERVICES MAY NOT EXCEED 12 HOURS/DAY OR 60 HOURS/WEEK.
P951	SERVICES CAN ONLY BE AUTHORIZED THROUGH ONE YEAR FROM THE PRESCRIPTION DATE.
P952	LEAD INSPECTION IS A COVERED COLORADO MEDICAID SERVICE WHEN THE CHILD HAS BEEN SHOWN TO HAVE LEAD POISONING (E.G., CHILD HAS A BLOOD LEAD LEVEL > 19 UG/DL OR TWO CONSECUTIVE BLOOD LEAD LEVELS OF 15-19 UG/DL DONE AT LEAST 90 DAYS APART). THE INSPECTION MUS
P953	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P954	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P956	THE REQUEST CAN ONLY BE BACKDATED A MAXIMUM OF 14 DAYS FROM FIRST DATE RECEIVED BY COLORADO MEDICAID.

Denial Code	Long Description
P957	COMPLETE PERIODONTAL CHARTING AT TIME OF SERVICE, AND SUBMIT CHARTING, COPY OF OPERATIVE REPORT, TOGETHER WITH A COPY OF THE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF), F-11035, TO PA UNIT ATTENTION DENTAL CONTSULTANT.
P958	NOTE THAT CODE D4341 HAS BEEN CHANGED. REFER TO THE DECISION NOTICE FOR AUTHORIZED QUANTITY.
P960	YOUR PA HAS BEEN APPROVED FOR 90 DAYS. THE 90 DAY APPROVAL DOES NOT IMPLY THE PA REQUEST MEETS PRIOR AUTHORIZATION CRITERIA. AFTER ADDITIONAL INFORMATION IS AVAILABLE IN INTERCHANGE, COLORADO MEDICAID WILL CREATE AN AMENDMENT REQUEST TO EXTEND THE PA FOR
P961	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P962	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
PA10	THE REQUESTED END DATE IS INVALID.
PA12	PLEASE FURNISH A WRITTEN DESCRIPTION OF THE CLIENTS DIAGNOSIS.
PA13	PROVIDE DIAGNOSES WITH DATES OF ONSET.
PA14	IDENTIFY PROBLEMS TO BE TREATED.
PA15	THE AUDIOLOGISTS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1), F-11020, AND PRIOR AUTHORIZATION REQUEST/HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2), F-11021.
PA16	THE PHYSICIANS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION/PHYSICIAN OTOLOGICAL REPORT (PA/POR), F-11019.
PA17	SUBMIT BRIEF HISTORY WITH REFERRAL INFORMATION, LIVING SITUATION, FUNCTIONAL STATUS, AND OTHER PERTINENT INFORMATION. WHAT CHANGE OF STATUS RESULTED IN REFERRAL AT THIS TIME?
PA18	PLEASE FURNISH THE CLIENTS HEIGHT AND WEIGHT.
PA19	PLEASE SUBMIT CLINICAL INFORMATION SUFFICIENT TO VERIFY THE NEED FOR THE REQUESTED SERVICE(S).
PA20	PLEASE RESUBMIT WITH COMPLETE PERIODONTAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PA21	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL EDUCATIONAL PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA22	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL PROGRAM PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA23	REFER TO THE DURABLE MEDICAL EQUIPMENT INDEX FOR APPROPRIATE CODE AND DESCRIPTION. DO NOT USE AN "UNLISTED" CODE.
PA24	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUALIZED FAMILY SERVICE PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA25	INFORMATION ON THE REQUEST FORM IS ILLEGIBLE, AND THE REQUEST CANNOT BE PROCESSED.
PA26	RE-EVALUATE YOUR GOALS. EMPHASIS SHOULD BE ON FUNCTIONAL SELF-CARE. GOALS MUST BE RELATED TO FUNCTIONAL OUTCOME.
PA27	PLEASE CLARIFY THE NUMBER OF HOURS PER WEEK REQUESTED.
PA28	PLEASE CLARIFY THE NUMBER OF HOURS PER DAY REQUESTED.
PA29	PLEASE CLARIFY THE NUMBER OF VISITS PER DAY REQUESTED.
PA30	ATTACH SUPPORTIVE DOCUMENTATION; HOME EXERCISE PROGRAM AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA31	THE DIAGNOSIS CODE INDICATED ON THE REQUEST DOES NOT CORRESPOND TO THE DIAGNOSIS CODE DESCRIPTION.
PA32	PLEASE SUBMIT ADDITIONAL INFORMATION SUFFICIENT TO VERIFY APPROPRIATENESS AND NEED FOR TRANSPLANT.
PA33	PLEASE SUBMIT THE INITIAL AND PROGRESSIVE OBJECTIVE FINDINGS.
PA34	ATTACH SUPPORTIVE DOCUMENTATION, FACILITY PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA35	PLEASE SUBMIT THE CLIENTS ORIGINAL COMPLAINTS AND EXAMINATION FINDINGS.

Denial Code	Long Description
PA36	ATTACH SUPPORTIVE DOCUMENTATION, IN-HOME AUTISM PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA37	PLEASE SUBMIT YOUR TREATMENT PLAN FOR THIS CLIENT.
PA38	ATTACH SUPPORTIVE DOCUMENTATION AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA39	INITIAL EVALUATIONS MUST BE PERFORMED BY AN OCCUPATIONAL THERAPIST REGISTERED (OTR), PER AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA) STANDARDS.
PA41	IDENTIFY THE PLACE OF SERVICE AND ITS EFFECT ON SUPPORTING THE DESIRED TREATMENT OUTCOME.
PA42	PLEASE INDICATE THE HOURS OF USE OF OXYGEN PER 24-HOUR PERIOD.
PA43	PROVIDE BASELINE DOCUMENTATION FOR THIS CLIENTS LIMITATIONS USING UNITS OF MEASUREMENT THAT ARE APPLIED CONSISTENTLY WHEN REPORTING STATUS.
PA44	IDENTIFY FUNCTIONAL LIMITATIONS AS THEY ARE RELATED TO IDENTIFIED CONDITIONS.
PA46	CORRELATE PLAN OF CARE TO REQUESTED PROCEDURE CODES.
PA47	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE FREQUENCY/DURATION REQUESTED.
PA48	PLEASE PROVIDE THE NAME AND CREDENTIALS OF THE RENDERING PROVIDER.
PA50	COLORADO MEDICAID RECORDS INDICATE THE CLIENT OWNS A WHEELCHAIR. DOCUMENT THE REASON AND NEED FOR REPLACEMENT AND COST TO REPAIR CURRENT WHEELCHAIR.
PA51	PLEASE DISTINGUISH PRIMARY AND SUPPORTIVE MODALITIES.
PA52	PLEASE SUBMIT A PROGRESS REPORT.
PA53	MULTIPLE FAMILY CLIENTS TREATMENT BY THE SAME PROVIDER REQUIRES FURTHER INFORMATION DOCUMENTING COORDINATION OF TREATMENT PLAN.
PA54	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE MINUTES REQUESTED.
PA55	MEDICAL NECESSITY OF TREATMENT REQUIRES ADDITIONAL DOCUMENTATION.
PA56	GIVEN AGE, DIAGNOSES, CURRENT LEVEL OF FUNCTION, PAST RESPONSE TO TREATMENT, AND LIVING SITUATION, EXPAND ON POTENTIAL FOR SIGNIFICANT FUNCTIONAL PROGRESS WITHIN THE NEXT SIX MONTHS. EMPHASIZE WHY PROGRESS IS EXPECTED WITH SERVICES AT THIS TIME.
PA57	SUBMIT THE INITIAL FINDINGS. INCLUDE A COMPREHENSIVE EVALUATION.
PA58	SUBMIT PROGRESSIVE, OBJECTIVE FINDINGS. INCLUDE A PERTINENT RE-EVALUATION.
PA59	PLEASE SUPPLY INFORMATION REGARDING THE CLIENTS MEDICATION REQUIREMENTS, IF ANY.
PA60	PLEASE SPECIFY IF THE CLIENT IS IN AN EDUCATIONAL SETTING.
PA61	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA62	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
PA63	THE SKILLS OF A THERAPIST ARE PURPOSEFUL AND SKILLED INTERVENTIONS REQUIRED TO CONTINUALLY DESIGN, IMPLEMENT, REASSESS, MODIFY/GRADE, AND/OR DISCONTINUE A PLAN OF CARE IN A TIMELY MANNER, BASED ON THE COMPLEXITY OF THE CLIENTS MEDICAL CONDITION AND/OR CO
PA64	PLEASE SUBMIT A THERAPY PLAN OF CARE, INCLUDING A CURRENT, DATED EVALUATION.
PA65	A PLAN OF CARE SIGNED AND DATED BY THE PHYSICIAN IS REQUIRED.
PA66	THE SKILLS OF A THERAPIST ARE REQUIRED WHEN ONLY THE THERAPIST CAN SAFELY AND EFFECTIVELY DELIVER THE THERAPEUTIC PROCEDURES BECAUSE OF THEIR UNIQUE KNOWLEDGE, TRAINING, AND EXPERTISE. DESCRIBE THE REASON THAT SOMEONE OTHER THAN A THERAPIST CANNOT SAFELY
PA67	PLEASE SPECIFY IF THE CLIENTS WORK SITE DEMANDS GOOD BINAURAL HEARING.
PA68	DESCRIBE THE REASON, BASED ON THE CLIENTS COGNITIVE, PHYSICAL, COMMUNICATION, OR RESOURCE STATUS, THAT A HOME PROGRAM, EQUIPMENT, OR ENVIRONMENTAL ADAPTATIONS ALONE CANNOT MEET CLIENTS NEEDS.
PA69	PLEASE SPECIFY IF THE CLIENT HAS AN ACCOMPANYING DISABILITY THAT ADDS TO THE HEARING PROBLEM.
PA70	DISTINGUISH REQUESTED PROCEDURES AND GOALS FROM OTHER SERVICES THIS CLIENT RECEIVES. THEY MAY NOT BE DUPLICATIVE.
PA71	PLEASE INDICATE THE NUMBER OF DAYS REQUESTED.
PA73	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).

Denial Code	Long Description
PA74	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA75	PLEASE DOCUMENT CARRYOVER OF THE THERAPY PROGRAM TO NURSING.
PA76	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA79	PROVIDE EVIDENCE OF SIGNIFICANT FUNCTIONAL PROGRESS IN LAST SIX MONTHS.
PA84	THE GRANT DATE OF THIS REQUEST CANNOT BE PRIOR TO THE SIGNATURE DATE OF THE PRESCRIBING PHYSICIAN.
PA86	PROVIDE EVIDENCE OF SKILLS GAINED IN THERAPY CARRYING OVER TO OTHER SETTINGS WITHIN SIX MONTHS.
PA87	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE NUMBER OF SESSIONS REQUESTED.
PA88	THE REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL SCOPE OF PRACTICE.
PA89	PRIOR AUTHORIZATION IS NOT REQUIRED UNTIL LIMITATION OF SERVICE HAS BEEN REACHED.
PA91	PLEASE SUBMIT REQUIRED X-RAYS.
PA92	PLEASE PROVIDE AN EXPLANATION FOR THE MATERIAL SUBMITTED WITH THE REQUEST.
PA95	PLEASE DESCRIBE HOW THE PROVISION OF THIS SERVICE WOULD PREVENT INSTITUTIONALIZATION OF THE CLIENT.
PA96	COULD THE EXISTING DENTURE(S) BE RELINED OR REBASED? IF NOT, PLEASE EXPLAIN WHY NOT.
PA97	REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL STANDARDS OF PRACTICE.
PA98	PLEASE INDICATE IF THE CLIENT IS CURRENTLY BEING TUBE FED.
PB02	PLEASE PROVIDE THE REQUIRED DATED SIGNATURES ON THE ATTACHMENTS.
PB03	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING THE LOSS/DESTRUCTION/THEFT OF THE HEARING AID.
PB04	DESCRIBE THE CLIENTS ABILITY TO STAND OR AMBULATE SUFFICIENTLY TO ACCOMPLISH SELF-CARE ACTIVITIES.
PB07	PLEASE SUBMIT AN ORTHODONTIC STUDY MODEL OR DIAGNOSTIC CASTS.
PB09	PLEASE PROVIDE A PHOTOGRAPH OF THE INVOLVED AREA(S).
PB10	PLEASE PROVIDE AN ESTIMATION (IN GRAMS) OF THE TOTAL AMOUNT OF TISSUE TO BE RESECTED.
PB11	PLEASE SUBMIT THE PLAN OF CARE FOR CO-TREATMENT.
PB12	FURNISH A DETAILED DESCRIPTION FOR THE PROCEDURE CODE REQUESTED.
PB13	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB15	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB18	PLEASE COMPLETE THE ATTACHED OUT-OF-STATE PROVIDER DATA SHEET, F-11001, AND RESUBMIT.
PB20	A SIGNED AND DATED PRESCRIPTION IS REQUIRED WITHIN THREE MONTHS OF RECEIPT BY COLORADO MEDICAID FOR INITIAL REQUESTS AND WITHIN 12 MONTHS OF RECEIPT BY COLORADO MEDICAID FOR SUBSEQUENT REQUESTS.
PB21	PLEASE COMPLETE THE APPROPRIATE PRIOR AUTHORIZATION ATTACHMENT. CONTACT PROVIDER SERVICES OR THE PRIOR AUTHORIZATION UNIT FOR ASSISTANCE.
PB23	PHYSICAL THERAPY ASSISTANT NOTES AND ALL FORMS SUBMITTED MUST BE COSIGNED BY A REGISTERED PHYSICAL THERAPIST.
PB31	ARE YOU REQUESTING A COMPLETE APPLIANCE, OR REPLACEMENT PARTS?
PB32	THE PROCEDURE CODE INDICATED ON THE REQUEST DOES NOT MATCH THE DESCRIPTION OF SERVICE; PLEASE CORRECT AND RESUBMIT.
PB35	THE SERVICE REQUESTED DOES NOT REQUIRE PRIOR AUTHORIZATION.
PB41	PLEASE FURNISH A CURRENT MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT, F-11090 (DATED WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID).
PB45	THE CERTIFICATION PERIOD ON THE PLAN OF CARE (POC) DOES NOT COVER THE REQUESTED GRANT/START DATE. PLEASE RESUBMIT YOUR REQUEST WITH A NEW POC.
PB49	A CERTIFIED OCCUPATIONAL THERAPY ASSISTANTS NOTES MUST BE COSIGNED BY AN OCCUPATIONAL THERAPIST REGISTERED.
PB51	ADDITIONAL INFORMATION IS REQUIRED ON PRIOR AUTHORIZATION TO ENABLE PRICING.
PB54	REQUESTED SERVICES DO NOT MATCH SERVICES ON THE PHYSICIANS ORDERS.

Denial Code	Long Description
PB59	PLEASE PROVIDE AN INDIVIDUAL EDUCATIONAL PLAN (IEP), WHICH HAS BEEN SIGNED BY THE PROVIDER NO EARLIER THAN NINE MONTHS PRIOR TO RECEIPT AT COLORADO MEDICAID; OTHERWISE, DOCUMENT WHY NO IEP EXISTS.
PB65	PLEASE FURNISH THE ANTICIPATED TOTAL CHARGES FOR THIS REQUEST.
PB66	A PHOTOCOPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED; THE DATE MUST BE WITHIN SIX MONTHS OF RECEIPT BY COLORADO MEDICAID.
PB67	THE PRESCRIPTION DATE MUST INCLUDE MONTH, DAY, AND YEAR.
PB68	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID.
PB73	THE SERVICES IDENTIFIED ON THE PLAN OF CARE DO NOT APPEAR APPROPRIATE FOR THE PROCEDURE CODE(S) REQUESTED ON THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018.
PB74	THE CLIENT/PROVIDER DOES NOT HAVE RETROACTIVE ENROLLMENT.
PB75	THE REQUESTED START DATE IS MORE THAN 14 DAYS BEFORE OR 62 DAYS AFTER RECEIPT.
PB82	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
PB83	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A HOME HEALTH AIDE. PLEASE RESUBMIT AS A PERSONAL CARE WORKER OR PROVIDE ADDITIONAL DOCUMENTATION.
PB86	THE SERVICES REQUESTED ARE NOT BEING PROVIDED IN THE CLIENTS RESIDENCE. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL.
PB87	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A NURSE. PLEASE RESUBMIT AS A HOME HEALTH AIDE OR PROVIDE ADDITIONAL DOCUMENTATION.
PB92	PLEASE FURNISH THE CLIENTS COMPLETE ADDRESS.
PB94	IF THE CLIENT IS A RESIDENT OF A NURSING HOME, SUPPLY THE COMPLETE NAME AND ADDRESS OF THE NURSING HOME.
PB99	THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018, MUST BE SIGNED AND DATED.
PC01	PLEASE SUPPLY THE RENDERING PROVIDERS PROVIDER NUMBER.
PC03	THE DRUG ENFORCEMENT ADMINISTRATION NUMBER IS MISSING OR INVALID.
PC06	PLEASE DESCRIBE YOUR PROGRAM; INCLUDE ENTRY DATE, TERMINATION DATE, HOURS PER WEEK, AND NUMBER OF WEEKS OF PRIMARY INTENSIVE SERVICE REQUESTED.
PC07	PLEASE DESCRIBE YOUR "AFTERCARE/FOLLOW-UP" PLANS FOR THIS CLIENT.
PC08	PLEASE SUPPLY DOCUMENTATION OF PREVIOUS SUBSTANCE ABUSE SERVICES WITH DATE(S) AND OUTCOME.
PC09	PLEASE DESCRIBE IN DETAIL THE TREATMENT OBJECTIVES/GOALS FOR THIS CLIENT.
PC10	PLEASE DESCRIBE THE FAMILY SITUATION/DYNAMICS. EXPLAIN HOW THE FAMILY WILL BE INCORPORATED INTO THE CLIENTS PLAN OF CARE.
PC12	PLEASE EXPLAIN IF YOUR SERVICE ENCOURAGES THE CLIENT TO ATTEND SELF-HELP GROUPS.
PC13	PLEASE SUPPLY A SPECIFIC SCHEDULE OF ACTIVITIES, INCLUDING DAY, TIME OF DAY, LENGTH OF SESSION, AND SERVICE TO BE RENDERED DURING THAT TIME.
PC15	PLEASE FURNISH DIAGNOSTIC RATIONALE.
PC17	PLEASE DOCUMENT IF THE CLIENT EVER RECEIVED SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT.
PC19	PLEASE FURNISH MORE EXTENSIVE AND IN-DEPTH HISTORICAL AND PSYCHOSOCIAL DATA.
PC20	PLEASE SUPPLY THE DATE THE CLIENT BECAME TOTALLY ENDENTULOUS.
PC23	PLEASE SUBMIT A PHYSICIANS STATEMENT REGARDING THE MEDICAL NECESSITY OF DENTURES FOR THIS CLIENT. THE PHYSICIANS STATEMENT MUST DOCUMENT THE MEDICAL NEED FOR DENTURES.
PC24	THE SERVICE REQUESTED WAS PREVIOUSLY AUTHORIZED. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT INDICATING THIS FACT IS REQUIRED.
PC25	PLEASE SUPPLY SUFFICIENT MITIGATING CIRCUMSTANCES TO WARRANT THE CONSTRUCTION OF NEW DENTURES(S).
PC26	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
PC28	PLEASE SUBMIT A PHYSICIANS STATEMENT INDICATING DENTURES ARE NECESSARY FOR THIS NURSING HOME CLIENT.
PC29	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING LOSS OR DESTRUCTION OF DENTURE(S). INCLUDE SIGNED STATEMENT FROM CLIENT OR FACILITY DIRECTOR REGARDING HOW, WHEN AND WHERE LOST.

Denial Code	Long Description
PC30	PLEASE PROVIDE COMPLETE INTRAORAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PC31	PLEASE DESCRIBE ANY RELATED DEFORMITIES OF THE FEET.
PC34	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD WITH REQUESTED DME ITEM(S) AND DOCUMENT IF THE CLIENT CAN USE SAFELY AND INDEPENDENTLY.
PC35	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD AND DESCRIBE THE RESULTS AND EFFECTIVENESS OF THE SERVICE REQUESTED.
PC39	PLEASE INDICATE LITER FLOW PER MINUTE, HOURS OF USE PER 24 HOUR PERIOD, AND THE EXPECTED DURATION OF NEED.
PC40	THE ITEM DOES NOT REQUIRE PRIOR AUTHORIZATION UNTIL THE LIFE EXPECTANCY HAS BEEN REACHED.
PC41	PLEASE SUPPLY INFORMATION INDICATING THE NECESSITY OF POSITIONING THE CLIENT'S BODY IN MULTIPLE POSITIONS.
PC42	PLEASE INDICATE IF THE BED HEIGHT MUST BE CHANGED TO ALLOW FOR SAFE TRANSFER OR ADEQUATE BED CARE.
PC43	SUPPLY A PHYSICIANS STATEMENT INDICATING TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR UNIT HAS REDUCED PAIN, IMPROVED/INCREASED THE CLIENTS ACTIVITY LEVEL, AND/OR REDUCED CLIENTS USE OF PAIN MEDICATION.
PC44	A CURRENT AUTHORIZATION FOR THIS SERVICE IS ON FILE FOR ANOTHER PROVIDER. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT OF THAT FACT IS REQUIRED BY THE CLIENT OF FIRST PROVIDER.
PC59	DOCUMENT DECLINE OR PROGRESS IN SPECIFIC, MEASURABLE, OBJECTIVE TERMS.
PC60	DOCUMENT IF CLIENT HAS DEMONSTRATED A GOOD APPOINTMENT COMPLIANCE RECORD.
PC61	THE PHYSICIANS SIGNATURE DATE MUST NOT EXCEED 90 DAYS FROM THE DATE OF RECEIPT BY COLORADO MEDICAID.
PC62	REQUESTS FOR A CONTINUATION OF THERAPY SHOULD NOT BE SUBMITTED MORE THAN FOUR WEEKS PRIOR TO THE EXPIRATION DATE OF THE CURRENT AUTHORIZATION.
PC63	PLEASE FURNISH THE STYLE AND MANUFACTURER OF THE FRAME.
PC64	PLEASE FURNISH THE CLIENTS LENS FORMULA.
PC66	ALL REQUESTS FOR TINTS REQUIRE DOCUMENTATION OF THE VISUAL OR MEDICAL CONDITION RELATED TO PHOTOPHOBIA.
PC67	PLEASE DOCUMENT THE REASON AND JUSTIFICATION FOR REPLACEMENT BEYOND THE FIRST LENS/FRAME.
PC68	DOCUMENT IF ALL REMAINING MAXILLARY AND/OR MANDIBULAR TEETH ARE DECAY-FREE, PROPERLY RESTORED, AND PERIODONTICALLY SOUND.
PC72	SUPPLY MORE DETAIL REGARDING PROGRESS (ATTACHMENT OF GOALS, ETC.). CORRELATE PROGRESS TO PREVIOUS GOALS AND IDENTIFIED LIMITATIONS.
PC77	PLEASE SUBMIT A PLAN OF CARE DESCRIBING THE SERVICES THAT WOULD BE PROVIDED.
PC78	PLEASE DOCUMENT SPECIFIC, MEASURABLE GOALS.
PC82	THE PRIOR AUTHORIZATION (PA) SYSTEM CAN PROCESS ONLY 26 DETAILS PER PA REQUEST. PLEASE RESUBMIT YOUR REQUEST WITH NO MORE THAN 26 DETAILS.
PC83	PLEASE SUPPLY A PHYSICIANS PRESCRIPTION DATED WITHIN ONE MONTH OF REQUESTED SUBSTANCE ABUSE DAY TREATMENT.
PC84	PLEASE PROVIDE INFORMATION INDICATING THIS CLIENT IS APPROPRIATELY DETOXIFIED FROM ALCOHOL AND/OR OTHER DRUGS.
PC85	PLEASE PROVIDE INFORMATION TO INDICATE THE CLIENTS ABILITY TO ABSTAIN FROM ALCOHOL OR DRUGS WHILE IN THE SUBSTANCE ABUSE DAY TREATMENT PROGRAM.
PC86	PLEASE INDICATE IF THIS CLIENT IS WILLING TO PARTICIPATE IN AFTERCARE OR CONTINUING CARE SERVICES.
PC87	PROVIDE MORE INFORMATION ON TREATMENT HISTORY; INCLUDE SERVICE PROVIDED, DATES, AND OUTCOME. PROVIDE DETAIL OF PREVIOUS TREATMENT.
PC88	PLEASE PROVIDE MORE RATIONALE FOR THE APPROPRIATENESS AND MEDICAL NECESSITY OF SUBSTANCE ABUSE DAY TREATMENT.
PC89	PROVIDE A TREATMENT PLAN THAT CONTAINS MEASURABLE GOALS AND OBJECTIVES CORRESPONDING TO THE IDENTIFIED DEFICIT.
PC91	PLEASE PROVIDE MORE INFORMATION ON FAMILY INVOLVEMENT TREATMENT.

Denial Code	Long Description
PC92	PLEASE PROVIDE MORE HISTORY AND EXPLANATION ABOUT THE ISSUE OF ABSTINENCE FOR THIS CLIENT.
PC94	PLEASE PROVIDE THE ANTICIPATED BEGINNING DATE AND/OR THE ESTIMATED SUBSTANCE ABUSE DAY TREATMENT DISCHARGE DATE.
PC95	PLEASE SUPPLY JUSTIFICATION FOR BEGINNING CLIENT IN SERVICE PRIOR TO AUTHORIZATION BEING OBTAINED.
PC96	THE INITIAL THREE HOURS OF SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IN A CALENDAR YEAR DO NOT REQUIRE PRIOR AUTHORIZATION.
PC97	REIMBURSEMENT FOR INITIAL SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IS LIMITED TO THREE HOURS IN A CALENDAR YEAR AND DOES NOT REQUIRE PRIOR AUTHORIZATION.
PC98	THIS DRUG IS CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE BILL USING THE APPROPRIATE NATIONAL DRUG CODE (NDC) OR SUBMIT A COMPLETED DRUG ADDITION REQUEST FORM IF THE NDC IS NOT LISTED IN THE DRUG INDEX.
PC99	THIS DRUG IS NOT CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL, CURRENT ADMINISTRATIVE RULE, OR COLORADO DRUG INDEX FOR COVERAGE LIMITATIONS.
PD01	DOCUMENT THAT CLIENT HAS ACHIEVED GOOD ORAL HYGIENE, PERIODONTAL CASE TYPE 1 OR 2, AND IS MOTIVATED TO MAINTAIN SAME.
PD03	PLEASE PROVIDE AN ARTERIAL BLOOD GAS READING OR PULSE OXIMETRY RESULTS DONE ON ROOM AIR SIGNED AND DATED BY A MEDICAL DOCTOR. THIS SHOULD BE DONE WITHIN 60 DAYS OF REQUESTED SERVICE.
PD04	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 30 DAYS OF RECEIPT BY COLORADO MEDICAID.
PD07	SUBMIT A PHOTOCOPY OF A VALID PRESCRIPTION, ISSUED WITHIN THE PAST YEAR, OR COMPLETE SECTION B OF THE PRIOR AUTHORIZATION/DRUG ATTACHMENT (PA/DGA), F-11049.
PD10	BRAND MEDICALLY NECESSARY MUST BE IN THE PRESCRIBERS OWN HANDWRITING AND WRITTEN DIRECTLY ON THE PRESCRIPTION OR A SEPARATE ORDER ATTACHED TO THE ORIGINAL PRESCRIPTION.
PD12	COMPLETE DENTURES, PARTIAL DENTURES, DENTURE RELINES, AND FIXED PROSTHODONTIC SERVICES ARE NOT COVERED SERVICES FOR ADULTS FOR DATES OF SERVICE ON AND AFTER OCTOBER 1, 1995.
PD22	PLEASE COMPLETE ALL REQUIRED ELEMENTS ON THE PERSONAL CARE SCREENING TOOL (PCST), F-11133.
PD24	THIS PRIOR AUTHORIZATION REQUEST IS UNABLE TO BE PROCESSED. PLEASE RESUBMIT WITH ADDITIONAL REQUIRED FORMS, INCLUDING THE ENTIRE PERSONAL CARE SCREENING TOOL (PCST), F-11133; PERSONAL CARE ADDENDUM, F-11136; AND SUPPORTING DOCUMENTATION, AS DIRECTED.
PD25	THERE IS A PERSONAL CARE SCREENING TOOL (PCST), F-11133, COMPLETED BY ANOTHER AGENCY. CONTACT THE AGENCY TO TRANSFER SCREEN.
PD26	THERE IS A LIMITED TERM CARE FUNCTIONAL SCREEN (LTC-FS) COMPLETED BY ANOTHER AGENCY. THE PERSONAL CARE SCREENING TOOL (PCST), F-11133, INFORMATION IS IN CONFLICT WITH LTC-FS.
PD27	ONLY ONE LEVEL OF FUNCTION MAY BE SELECTED FOR ALL ELEMENTS EXCEPT TOILETING. COLORADO MEDICAID IS UNABLE TO PROCESS THE PRIOR AUTHORIZATION REQUEST.
PD28	NO UNITS MAY BE REQUESTED USING THIS PRIOR AUTHORIZATION PROCESS. PLEASE SUBMIT WITH THE APPROPRIATE ATTACHMENTS FOR REQUESTING SPECIFIC PERSONAL CARE WORKER UNITS.
PD29	CLIENT IS NOT ELIGIBLE FOR THE REQUESTED SERVICE(S) AS OF THE REQUESTED START DATE.
PD30	NO TRAVEL TIME MAY BE AUTHORIZED WHEN NO PERSONAL CARE WORKER SERVICE IS AUTHORIZED.
PD32	PROVIDER NOT CERTIFIED TO RENDER THE SERVICE(S) REQUESTED.
PD34	BASED ON THE DOCUMENTATION SUBMITTED, THIS REQUEST CAN NOT BE PRIOR AUTHORIZED. REFER TO THE PA MESSAGES FROM THE CONSULTANT FOR COMPLETE EXPLANATION.
PD98	PLEASE DOCUMENT HOW AND WHEN EACH PREVIOUSLY AUTHORIZED PRO RE NATA VISIT WAS USED.

Inpatient Diagnosis Related Group (DRG)

Denial Code	Long Description
0201	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.

Denial Code	Long Description
0233	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0235	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0237	CLIENT IDENTIFICATION NUMBER DOES NOT MATCH CLIENTS FIRST NAME.
0238	THE CLIENT IDENTIFICATION NUMBER DOES NOT MATCH THE CLIENTS LAST NAME.
0242	SECONDARY DIAGNOSIS CODE IS INVALID.
0248	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0249	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0251	PROCEDURE CODE MODIFIER IN FIRST POSITION IS INVALID.
0252	THE PROCEDURE CODE MODIFIER IN SECOND POSITION IS INVALID FOR REQUESTED START DATE OR DATE OF RECEIPT.
0253	THE PROCEDURE CODE MODIFIER IN THIRD POSITION IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
0258	THE PRIMARY DIAGNOSIS CODE IS REQUIRED.
0272	THE PRIMARY DIAGNSOSIS CODE IS INVALID.
0400	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0853	HCPCS - ANNUAL UPDATE
0885	NEVER EVENTS MODIFIERS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
0886	NEVER EVENTS DIAGNOSIS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
1000	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
1002	RENDERING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1003	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1007	RENDERING PROVIDER ID IS NOT ON FILE.
1047	THE RENDERING PROVIDERS CERTIFICATION HAS BEEN CANCELLED.
1048	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1801	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
1804	A CERTIFIED SUBSTANCE ABUSE DAY TREATMENT PROVIDER MUST SUBMIT A SUBSTANCE ABUSE DAY TREATMENT PROCEDURE CODE.
1806	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
1808	THE BILLING PROVIDER DOES NOT HAVE THE REQUIRED CERTIFICATION ADDENDUM ON FILE.
1900	THE BILLING PROVIDERS TAXONOMY CODE IS INVALID.
1901	THE RENDERING PROVIDERS TAXONOMY CODE IS INVALID.
1927	A NATIONAL PROVIDER IDENTIFIER IS REQUIRED FOR THE BILLING PROVIDER.
1934	A NATIONAL PROVIDER INDENTIFIER IS REQUIRED FOR THE RENDERING PROVIDER.
1936	THE BILLING PROVIDER NUMBER IS INVALID.
1937	THE RENDERING PROVIDER NUMBER IS INVALID.
1960	INTERNAL PROCESSING IS REQUIRED.
1963	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.
1964	THE BILLING PROVIDER INDICATED IS NOT ALLOWABLE AS A BILLING PROVIDER.
1965	RENDERING PROVIDER NUMBER IS MISSING/INVALID FOR THIS PROCEDURE PROVIDER.
1974	PRESCRIBING/REFERRING/ORDERING PROVIDER INDICATED IS NOT CERTIFIED AS A PRESCRIBING/REFERRING/ORDERING PROVIDER.
1975	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
1976	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
2001	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2003	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2017	THE CLIENT IS ENROLLED IN A MEDICAID OR OTHER MANAGED CARE PROGRAM.
2037	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2603	CLIENT LOCKED-IN TO A PROVIDER OR ENROLLED IN A HOSPICE. CONTACT CLIENTS HOSPICE FOR PAYMENT OF SERVICES OR RESUBMIT WITH DOCUMENTATION OF UNRELATED NATURE OF CARE.

Denial Code	Long Description
3324	THE MODIFIER HAS BEEN DISCONTINUED BY THE CENTERS OF MEDICARE AND MEDICAID SERVICES OR THE AMERICAN MEDICAL ASSOCIATION FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
3337	THE PROCEDURE CODE HAS BEEN TERMINATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AMERICAN MEDICAL ASSOCIATION, OR AMERICAN DENTAL ASSOCIATION FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT. RESUBMIT WITH VALID A PROCEDURE CODE.
3339	THE PROCEDURE BILLED IS NOT PAYABLE ACCORDING TO DEFICIT REDUCTION ACT (DEFRA) GUIDELINES.
3351	THE PROCEDURE IS NOT COVERED FOR CLIENTS WITH A NURSING HOME AUTHORIZATION ON THE REQUESTED START DATE OR DATE OF RECEIPT.
3353	THE PROCEDURE IS NOT A COVERED SERVICE FOR HOME AND COMMUNITY-BASED WAIVER CLIENTS.
4021	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4027	THE DIAGNOSIS CODE IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
4031	THE PROCEDURE SUBMITTED IS NOT APPROPRIATE FOR CLIENTS GENDER.
4032	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4034	THE PROCEDURE CODE HAS AN AGE RESTRICTION.
4036	THE PLACE OF SERVICE CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4040	THE PRIMARY DIAGNOSIS CODE IS NOT ON FILE.
4041	THE SECONDARY DIAGNOSIS IS NOT ON FILE.
4046	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4127	INTERNAL PROCESSING IS REQUIRED.
4131	INTERNAL PROCESSING IS REQUIRED.
4141	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4149	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4150	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4236	ETIOLOGY DIAGNOSIS CODE(S) (E-CODES) ARE INVALID AS THE PRIMARY DIAGNOSIS.
4244	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4245	THE FOURTH POSITION MODIFIER IS INVALID FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT.
4256	THE PROCEDURE CODE AND MODIFIER COMBINATION IS NOT PAYABLE FOR THE CLIENTS BENEFIT PLAN.
4257	THE MODIFIERS SUBMITTED ARE EITHER INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT OR THE MODIFIERS ARE MISSING.
4311	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4315	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4316	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4371	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4372	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4711	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR CLIENTS AGE.
4714	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS AGE.
4731	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS DIAGNOSIS.
4742	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4743	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4744	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4745	DIAGNOSIS AND/OR PROCEDURE AND/OR PLACE OF SERVICE (POS) CODE IS NOT COVERED FOR EXPRESS ENROLLMENT CLIENTS.
4746	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4801	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4802	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
4821	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
4871	PLEASE REFER TO PA MESSAGES FOR RETURN INFORMATION.
4963	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS GENDER.
4990	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
7500	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.

Denial Code	Long Description
7509	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
P001	THE BILLING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THE SERVICES.
P002	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P003	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P005	THE PRIOR AUTHORIZATION CAN NOT BE END DATED. THE PRIOR AUTHORIZATION STATUS IS NOT APPROVED OR APPROVED WITH REVISIONS.
P006	PLEASE FURNISH THE PROCEDURE CODE AND CORRESPONDING DESCRIPTION.
P008	THE BILLING PROVIDER NUMBER IS INVALID.
P009	THE BILLING PROVIDER NUMBER IS INVALID.
P010	THE REQUESTED END DATE IS INVALID.
P011	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P012	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P013	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P014	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P015	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P016	THE REQUESTED START DATE IS MISSING OR INVALID.
P019	THE REQUESTED START DATE IS MISSING OR INVALID.
P020	THE RENDERING PROVIDER NUMBER IS INVALID.
P021	THE RENDERING PROVIDER NUMBER IS INVALID.
P022	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P023	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P024	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P026	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P027	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P030	FIRST MODIFIER IS INVALID.
P031	FIRST MODIFIER IS INVALID.
P032	SECOND MODIFIER IS INVALID.
P033	SECOND MODIFIER IS INVALID.
P034	THIRD MODIFIER IS INVALID.
P035	THIRD MODIFIER IS INVALID.
P036	FOURTH MODIFIER IS INVALID.
P037	FOURTH MODIFIER IS INVALID.
P038	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P039	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P040	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P041	CLIENTS FIRST NAME IS MISSING.
P042	CLIENTS LAST NAME IS MISSING.
P043	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P044	BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES REQUESTED.
P045	FIRST MODIFIER IS INVALID.
P046	SECOND MODIFIER IS INVALID.
P047	THIRD MODIFIER IS INVALID.
P048	FOURTH MODIFIER IS INVALID.
P052	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P053	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.

Denial Code	Long Description
P054	RENDERING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES FOR THE BENEFIT PLAN.
P055	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P061	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P062	THE CLIENT ID AND/OR NAME INDICATED ON THE PA REQUEST IS INCORRECT. THE CLIENT ID AND/OR NAME HAS BEEN UPDATED. PLEASE VERIFY THE ID AND/OR NAME IS CORRECT.
P064	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
P067	THE FREQUENCY OF HOURS REQUESTED ARE NOT APPROPRIATE FOR THIS CLIENT AND HAVE BEEN MODIFIED ACCORDINGLY.
P079	BILLING PROVIDER IS ON PAYMENT SUSPENSION DUE TO CREDIBLE ALLEGATION OF FRAUD.
P120	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAS BEEN REDUCED.
P121	THE SERVICE/ PROCEDURE REQUESTED IS NOT SUPPORTED BY SUBMITTED DOCUMENTATION.
P126	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
P128	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.
P138	SERVICE(S) DO NOT MEET COLORADO MEDICAID GUIDELINES.
P167	REQUESTED DOCUMENTATION HAS NOT BEEN SUBMITTED.
P178	THE SERVICE REQUESTED IS NOT MEDICALLY NECESSARY.
P179	THE MEDICAL NECESSITY FOR THIS SERVICE IS NOT SUPPORTED BY THE SUBMITTED DOCUMENTATION.
P233	THE DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE ADDITIONAL CARE.
P257	THIS CLIENTS FUNCTIONAL ASSESSMENT SCORES PLACE THIS CLIENT OUTSIDE ELIGIBILITY FOR DAY TREATMENT.
P274	OUR RECORDS INDICATE THIS CLIENT IS INVOLVED IN EFFECTIVE AND APPROPRIATE SERVICE ELSEWHERE.
P292	INTENSIVE REHABILITATION HOURS ARE NO LONGER APPROPRIATE AS INDICATED BY HISTORY, DIAGNOSIS, AND/ OR FUNCTIONAL ASSESSMENT SCORES.
P328	THE SERVICES REQUESTED INCLUDE NON-COVERED SERVICES, AND HOURS ARE REDUCED ACCORDINGLY.
P339	THE CLIENTS PAST HISTORY INDICATES REDUCED TREATMENT HOURS ARE WARRANTED.
P342	THE REQUEST DOES NOT MEET GENERALLY ACCEPTED CONDITIONS REQUIRING FLUORIDE TREATMENTS.
P346	SERVICES EXCEED COLORADO MEDICAID LIMITATION AND DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE MEDICAL NECESSITY OF THE SERVICE.
P349	THE SERVICE REQUESTED WAS PERFORMED LESS THAN FIVE YEARS AGO.
P353	THE EXISTING APPLIANCE HAS NOT BEEN WORN FOR THREE YEARS.
P367	THE CLIENT HAS BEEN TOTALLY WITHOUT TEETH AND AN APPLIANCE FOR FIVE YEARS.
P392	THE CLIENT IS MISSING AN ANTERIOR TOOTH AND/OR HAS TWO OR MORE POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P405	THE SERVICE(S) REQUESTED COULD ADEQUATELY BE PERFORMED IN THE DENTAL OFFICE.
P406	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE OF GOOD PERIODONTAL HEALTH (AMERICAN ACADEMY OF PERIODONTOLOGY PERIODONTAL CLASSIFICATION OF TYPE I OR II).
P407	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE VISIBLE ON RADIOGRAPHS THAT AT LEAST 50 PERCENT OF THE CLINICAL CROWN IS INTACT.
P409	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING SIX OR MORE TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED, INCLUDING THIRD MOLARS.
P410	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING ONE OR MORE ANTERIOR TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED.
P411	DOCUMENTATION DOES NOT SUPPORT THE NEED FOR PERIODONTIC SERVICES. POCKETS ARE LESS THAN 4MM AND/OR GREATER THAN 6MM FOR CLIENT AND/OR THE CLIENT IS UNDER THE AGE OF 13.
P412	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA.
P413	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA. THIS PA HAS BEEN GRANTED AS APPROVED NOT APPROVED WITH REVISIONS. THE DURATION REQUESTED MAY HAVE BEEN REDUCED TO REFLECT COVERAGE LIMITATIONS, PRESCRIBER ORDERS, CONFLICTI
P417	THE SERVICE(S) REQUESTED COULD BE ADEQUATELY PERFORMED WITH LOCAL ANESTHESIA.
P437	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO POOR ORAL HYGIENE.

Denial Code	Long Description
P444	THIS LINE ITEM IS A DUPLICATE OF ANOTHER LINE ITEM ON THIS PRIOR AUTHORIZATION (PA) REQUEST. PLEASE CORRECT.
P446	THIS IS A DUPLICATE OF AN EXISTING PRIOR AUTHORIZATION (PA) REQUEST. YOU MAY CONTACT PROVIDER SERVICES IF YOU REQUIRE ASSISTANCE. DUPLICATE PA REQUEST
P448	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO DECAY HISTORY.
P449	QUESTIONABLE LONG TERM PROGNOSIS DUE TO GUM AND BONE DISEASE.
P456	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO APPARENT ROOT INFECTION.
P457	OUR RECORDS INDICATE THIS CLIENT HAS EXCEEDED ESTABLISHED PROGRAM LIMITATIONS. COLORADO MEDICAID WILL NOT AUTHORIZE NEW DENTURES.
P458	DOCUMENTATION PROVIDED INDICATES A LESS ELABORATE PROCEDURE SHOULD BE CONSIDERED.
P502	RENTAL ONLY ALLOWED; MEDICAL NEED FOR PURCHASE HAS NOT BEEN DOCUMENTED.
P503	PURCHASE ONLY ALLOWED; MEDICAL NEED FOR RENTAL HAS NOT BEEN DOCUMENTED.
P504	OCCUPATIONAL THERAPY GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P505	THE SERVICE REQUESTED IS INCLUDED IN THE NURSING HOME RATE STRUCTURE.
P511	THIS NATIONAL DRUG CODE IS ONLY BILLABLE AS PART OF A COMPOUND DRUG.
P515	THE PRESENCE OF A HANDICAPPING MALOCCLUSION OR HANDICAPPING DENTOFACIAL DEFORMITY IS NOT SUPPORTED BY THE DOCUMENTATION SUBMITTED.
P521	THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVERED BY COLORADO MEDICAID.
P522	GASTRO-INTESTINAL SURGERY FOR THE PURPOSE OF WEIGHT CONTROL IS COVERED ONLY AS A LIFE THREATENING PROCEDURE.
P523	THE TREATMENT REQUEST IS NOT CONSISTENT WITH THE CLIENT'S DIAGNOSIS.
P524	PSYCHOTHERAPY PROVIDED IN THE CLIENTS HOME IS NOT A COVERED BENEFIT OF COLORADO MEDICAID.
P525	THE INFORMATION PROVIDED IS NOT CONSISTENT WITH THE INTENSITY OF SERVICES REQUESTED.
P526	INTENSIVE MULTIPLE MODALITY TREATMENT IS NOT CONSISTENT WITH THE INFORMATION PROVIDED.
P527	MULTIPLE PROVIDERS OF TREATMENT ARE NOT INDICATED FOR THIS CLIENT.
P528	THE DURATION OF TREATMENT SESSIONS EXCEED CURRENT COLORADO MEDICAID GUIDELINES.
P534	DOCUMENTATION OF POOR PHYSICAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P535	OTHER PHYSICAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P536	THE PHYSICAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P537	USE OF PHYSICAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P538	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF A PHYSICAL THERAPIST.
P539	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS AND LIVING ARRANGEMENT.
P540	GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P541	THE PROCEDURE(S) REQUESTED ARE NOT MEDICAL IN NATURE.
P542	DOCUMENTATION OF POOR OCCUPATIONAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P543	DOCUMENTATION OF POOR SPEECH THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P544	OTHER OCCUPATIONAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P546	THE OCCUPATIONAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P547	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF PHYSICAL THERAPY.
P548	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.

Denial Code	Long Description
P549	ACTIVITIES TO PROMOTE DIVERSION OR GENERAL MOTIVATION ARE NONCOVERED COLORADO MEDICAID SERVICES.
P550	REVISIONS OF THE REQUEST IS NECESSITATED BY THE CLIENTS MINIMAL PROGRESS.
P551	RESTORATIVE NURSING INVOLVEMENT COULD BE INCREASED.
P552	CLIENTS DEMONSTRATED RESPONSE TO CURRENT THERAPY DOES NOT WARRANT THE INTENSE FREQUENCY REQUESTED.
P553	MAINTENANCE IS TWO TIMES PER WEEK OR LESS.
P554	THE SPEECH THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P555	USE OF OCCUPATIONAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P556	USE OF SPEECH THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P557	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF AN OCCUPATIONAL THERAPIST.
P558	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
P559	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P560	THE MATERIALS/ SERVICES REQUESTED ARE PRINCIPALLY COSMETIC IN NATURE.
P561	THE LENS FORMULA DOES NOT JUSTIFY REPLACEMENT.
P562	THE CHANGE IN THE LENS FORMULA DOES NOT WARRANT MULTIPLE REPLACEMENTS.
P563	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P564	LENSES ONLY ARE APPROVED; PLEASE DISPENSE A CONTRACTED FRAME. THE NON-CONTRACTED FRAME IS NOT MEDICALLY JUSTIFIED.
P565	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P566	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P567	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF OCCUPATIONAL THERAPY.
P568	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF SPEECH THERAPY.
P569	LEVEL, INTENSITY, OR EXTENT OF SERVICE(S) REQUESTED HAS BEEN MODIFIED CONSISTENT WITH MEDICAL NEED AS DEFINED IN THE PLAN OF CARE.
P570	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P571	THE SERVICE ASKED FOR IS NOT COVERED BY COLORADO MEDICAID AS THESE TASKS CAN BE DONE BY NURSES OR ACTIVITY STAFF.
P572	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P573	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.
P574	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P575	MEDICAL NEED FOR EQUIPMENT/ SUPPLY REQUESTED IS NOT SUPPORTED BY DOCUMENTATION SUBMITTED.
P576	OTHER SPEECH THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P577	DOCUMENTATION SUBMITTED IDENTIFIES THAT THE CLIENT HAS FEWER THAN TWO POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P582	LESS EXPENSIVE ALTERNATIVE SERVICES ARE AVAILABLE FOR THIS CLIENT.
P634	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P711	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING PERIODONTAL SCALING AND ROOT PLANNING.
P712	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING GINGIVECTOMY.
P754	AN APPROVED SUBSTANCE ABUSE DAY TREATMENT PROGRAM CANNOT EXCEED A SIX WEEK PERIOD.
P761	THE CLIENT DOES NOT APPEAR TO BE ABLE OR WILLING TO ABSTAIN FROM ALCOHOL/DRUG USAGE WHILE IN TREATMENT. THEREFORE, SUBSTANCE ABUSE DAY TREATMENT SERVICES ARE NOT APPROVED.
P764	THIS CLIENT HAS COMPLETED INTENSIVE SUBSTANCE ABUSE TREATMENT WITHIN THE PAST 12 MONTHS. THE DOCUMENTATION PROVIDED IS NOT ADEQUATE TO JUSTIFY ADDITIONAL INTENSIVE TREATMENT AT THIS TIME.

Denial Code	Long Description
P785	A LESS THAN SIX-WEEK HEALING PERIOD HAS BEEN SPECIFIED FOR THIS PRIOR AUTHORIZATION. THEREFORE IT IS NOT NECESSARY TO WAIT THE FULL SIX WEEKS AFTER EXTRACTIONS BEFORE TAKING DENTURE IMPRESSIONS.
P818	SIX-WEEK HEALING TIME IS REQUIRED BETWEEN EDENTULATION AND FINAL IMPRESSIONS. PAYMENT FOR DENTURES WILL BE DENIED OR RECOUPED IF HEALING PERIOD IS NOT OBSERVED.
P849	COLORADO MEDICAID HAS DETERMINED THERE WERE (ARE) SEVERAL HOME HEALTH AGENCIES WILLING TO PROVIDE MEDICALLY NECESSARY SKILLED NURSING SERVICES TO THIS CLIENT.
P864	THE DOCUMENTATION YOU HAVE SUBMITTED DOES NOT MEET THE REQUIREMENTS OF COLORADO MEDICAID.
P873	THE MEDICAL NECESSITY FOR THE HOURS REQUESTED IS NOT SUPPORTED BY THE INFORMATION SUBMITTED.
P874	THE DOCUMENTATION SUBMITTED INDICATES THE TASKS SPECIFIED CAN BE COMPLETED DURING THE VISITS APPROVED.
P878	THE DOCUMENTATION SUBMITTED DOES NOT INDICATE THAT MEDICALLY ORIENTED TASKS ARE MEDICALLY NECESSARY; THEREFORE PERSONAL CARE SERVICES HAVE BEEN APPROVED.
P880	THE QUANTITY OF SERVICES AUTHORIZED FOR THIS CLIENTS PERSONAL CARE HAS BEEN AMENDED BASED ON INFORMATION RECEIVED FROM ONE OR MORE OF THESE SOURCES: THE CLIENT, THEIR PHYSICIAN, AND/OR THE IN-HOME VISIT BY STAFF OF THE OIG (OFFICE OF INSPECTOR GENERAL).
P885	THE USE OF THIS DRUG FOR THE INTENDED PURPOSE IS NOT COVERED BY COLORADO MEDICAID, CONSISTENT WITH COLORADO ADMINISTRATIVE CODE AND FEDERAL LAW.
P924	THE MEDICAL RECORDS SUBMITTED WITH THE CURRENT REQUEST CONFLICT OR DISAGREE WITH OUR MEDICAL RECORDS ON THIS CLIENT.
P950	INDEPENDENT NURSES, PLEASE NOTE PAYABLE SERVICES MAY NOT EXCEED 12 HOURS/DAY OR 60 HOURS/WEEK.
P951	SERVICES CAN ONLY BE AUTHORIZED THROUGH ONE YEAR FROM THE PRESCRIPTION DATE.
P952	LEAD INSPECTION IS A COVERED COLORADO MEDICAID SERVICE WHEN THE CHILD HAS BEEN SHOWN TO HAVE LEAD POISONING (E.G., CHILD HAS A BLOOD LEAD LEVEL > 19 UG/DL OR TWO CONSECUTIVE BLOOD LEAD LEVELS OF 15-19 UG/DL DONE AT LEAST 90 DAYS APART). THE INSPECTION MUS
P953	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P954	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P956	THE REQUEST CAN ONLY BE BACKDATED A MAXIMUM OF 14 DAYS FROM FIRST DATE RECEIVED BY COLORADO MEDICAID.
P957	COMPLETE PERIODONTAL CHARTING AT TIME OF SERVICE, AND SUBMIT CHARTING, COPY OF OPERATIVE REPORT, TOGETHER WITH A COPY OF THE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF), F-11035, TO PA UNIT ATTENTION DENTAL CONTSULTANT.
P958	NOTE THAT CODE D4341 HAS BEEN CHANGED. REFER TO THE DECISION NOTICE FOR AUTHORIZED QUANTITY.
P960	YOUR PA HAS BEEN APPROVED FOR 90 DAYS. THE 90 DAY APPROVAL DOES NOT IMPLY THE PA REQUEST MEETS PRIOR AUTHORIZATION CRITERIA. AFTER ADDITIONAL INFORMATION IS AVAILABLE IN INTERCHANGE, COLORADO MEDICAID WILL CREATE AN AMENDMENT REQUEST TO EXTEND THE PA FOR
P961	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P962	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
PA10	THE REQUESTED END DATE IS INVALID.
PA12	PLEASE FURNISH A WRITTEN DESCRIPTION OF THE CLIENTS DIAGNOSIS.
PA13	PROVIDE DIAGNOSES WITH DATES OF ONSET.
PA14	IDENTIFY PROBLEMS TO BE TREATED.
PA15	THE AUDIOLOGISTS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1), F-11020, AND PRIOR AUTHORIZATION REQUEST/HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2), F-11021.

Denial Code	Long Description
PA16	THE PHYSICIANS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION/PHYSICIAN OTOLOGICAL REPORT (PA/POR), F-11019.
PA17	SUBMIT BRIEF HISTORY WITH REFERRAL INFORMATION, LIVING SITUATION, FUNCTIONAL STATUS, AND OTHER PERTINENT INFORMATION. WHAT CHANGE OF STATUS RESULTED IN REFERRAL AT THIS TIME?
PA18	PLEASE FURNISH THE CLIENTS HEIGHT AND WEIGHT.
PA19	PLEASE SUBMIT CLINICAL INFORMATION SUFFICIENT TO VERIFY THE NEED FOR THE REQUESTED SERVICE(S).
PA20	PLEASE RESUBMIT WITH COMPLETE PERIODONTAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PA21	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL EDUCATIONAL PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA22	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL PROGRAM PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA23	REFER TO THE DURABLE MEDICAL EQUIPMENT INDEX FOR APPROPRIATE CODE AND DESCRIPTION. DO NOT USE AN "UNLISTED" CODE.
PA24	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUALIZED FAMILY SERVICE PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA25	INFORMATION ON THE REQUEST FORM IS ILLEGIBLE, AND THE REQUEST CANNOT BE PROCESSED.
PA26	RE-EVALUATE YOUR GOALS. EMPHASIS SHOULD BE ON FUNCTIONAL SELF-CARE. GOALS MUST BE RELATED TO FUNCTIONAL OUTCOME.
PA27	PLEASE CLARIFY THE NUMBER OF HOURS PER WEEK REQUESTED.
PA28	PLEASE CLARIFY THE NUMBER OF HOURS PER DAY REQUESTED.
PA29	PLEASE CLARIFY THE NUMBER OF VISITS PER DAY REQUESTED.
PA30	ATTACH SUPPORTIVE DOCUMENTATION; HOME EXERCISE PROGRAM AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA31	THE DIAGNOSIS CODE INDICATED ON THE REQUEST DOES NOT CORRESPOND TO THE DIAGNOSIS CODE DESCRIPTION.
PA32	PLEASE SUBMIT ADDITIONAL INFORMATION SUFFICIENT TO VERIFY APPROPRIATENESS AND NEED FOR TRANSPLANT.
PA33	PLEASE SUBMIT THE INITIAL AND PROGRESSIVE OBJECTIVE FINDINGS.
PA34	ATTACH SUPPORTIVE DOCUMENTATION, FACILITY PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA35	PLEASE SUBMIT THE CLIENTS ORIGINAL COMPLAINTS AND EXAMINATION FINDINGS.
PA36	ATTACH SUPPORTIVE DOCUMENTATION, IN-HOME AUTISM PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA37	PLEASE SUBMIT YOUR TREATMENT PLAN FOR THIS CLIENT.
PA38	ATTACH SUPPORTIVE DOCUMENTATION AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA39	INITIAL EVALUATIONS MUST BE PERFORMED BY AN OCCUPATIONAL THERAPIST REGISTERED (OTR), PER AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA) STANDARDS.
PA41	IDENTIFY THE PLACE OF SERVICE AND ITS EFFECT ON SUPPORTING THE DESIRED TREATMENT OUTCOME.
PA42	PLEASE INDICATE THE HOURS OF USE OF OXYGEN PER 24-HOUR PERIOD.
PA43	PROVIDE BASELINE DOCUMENTATION FOR THIS CLIENTS LIMITATIONS USING UNITS OF MEASUREMENT THAT ARE APPLIED CONSISTENTLY WHEN REPORTING STATUS.
PA44	IDENTIFY FUNCTIONAL LIMITATIONS AS THEY ARE RELATED TO IDENTIFIED CONDITIONS.
PA46	CORRELATE PLAN OF CARE TO REQUESTED PROCEDURE CODES.
PA47	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE FREQUENCY/DURATION REQUESTED.
PA48	PLEASE PROVIDE THE NAME AND CREDENTIALS OF THE RENDERING PROVIDER.
PA50	COLORADO MEDICAID RECORDS INDICATE THE CLIENT OWNS A WHEELCHAIR. DOCUMENT THE REASON AND NEED FOR REPLACEMENT AND COST TO REPAIR CURRENT WHEELCHAIR.
PA51	PLEASE DISTINGUISH PRIMARY AND SUPPORTIVE MODALITIES.
PA52	PLEASE SUBMIT A PROGRESS REPORT.

Denial Code	Long Description
PA53	MULTIPLE FAMILY CLIENTS TREATMENT BY THE SAME PROVIDER REQUIRES FURTHER INFORMATION DOCUMENTING COORDINATION OF TREATMENT PLAN.
PA54	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE MINUTES REQUESTED.
PA55	MEDICAL NECESSITY OF TREATMENT REQUIRES ADDITIONAL DOCUMENTATION.
PA56	GIVEN AGE, DIAGNOSES, CURRENT LEVEL OF FUNCTION, PAST RESPONSE TO TREATMENT, AND LIVING SITUATION, EXPAND ON POTENTIAL FOR SIGNIFICANT FUNCTIONAL PROGRESS WITHIN THE NEXT SIX MONTHS. EMPHASIZE WHY PROGRESS IS EXPECTED WITH SERVICES AT THIS TIME.
PA57	SUBMIT THE INITIAL FINDINGS. INCLUDE A COMPREHENSIVE EVALUATION.
PA58	SUBMIT PROGRESSIVE, OBJECTIVE FINDINGS. INCLUDE A PERTINENT RE-EVALUATION.
PA59	PLEASE SUPPLY INFORMATION REGARDING THE CLIENTS MEDICATION REQUIREMENTS, IF ANY.
PA60	PLEASE SPECIFY IF THE CLIENT IS IN AN EDUCATIONAL SETTING.
PA61	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA62	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
PA63	THE SKILLS OF A THERAPIST ARE PURPOSEFUL AND SKILLED INTERVENTIONS REQUIRED TO CONTINUALLY DESIGN, IMPLEMENT, REASSESS, MODIFY/GRADE, AND/OR DISCONTINUE A PLAN OF CARE IN A TIMELY MANNER, BASED ON THE COMPLEXITY OF THE CLIENTS MEDICAL CONDITION AND/OR CO
PA64	PLEASE SUBMIT A THERAPY PLAN OF CARE, INCLUDING A CURRENT, DATED EVALUATION.
PA65	A PLAN OF CARE SIGNED AND DATED BY THE PHYSICIAN IS REQUIRED.
PA66	THE SKILLS OF A THERAPIST ARE REQUIRED WHEN ONLY THE THERAPIST CAN SAFELY AND EFFECTIVELY DELIVER THE THERAPEUTIC PROCEDURES BECAUSE OF THEIR UNIQUE KNOWLEDGE, TRAINING, AND EXPERTISE. DESCRIBE THE REASON THAT SOMEONE OTHER THAN A THERAPIST CANNOT SAFELY
PA67	PLEASE SPECIFY IF THE CLIENTS WORK SITE DEMANDS GOOD BINAURAL HEARING.
PA68	DESCRIBE THE REASON, BASED ON THE CLIENTS COGNITIVE, PHYSICAL, COMMUNICATION, OR RESOURCE STATUS, THAT A HOME PROGRAM, EQUIPMENT, OR ENVIRONMENTAL ADAPTATIONS ALONE CANNOT MEET CLIENTS NEEDS.
PA69	PLEASE SPECIFY IF THE CLIENT HAS AN ACCOMPANYING DISABILITY THAT ADDS TO THE HEARING PROBLEM.
PA70	DISTINGUISH REQUESTED PROCEDURES AND GOALS FROM OTHER SERVICES THIS CLIENT RECEIVES. THEY MAY NOT BE DUPLICATIVE.
PA71	PLEASE INDICATE THE NUMBER OF DAYS REQUESTED.
PA73	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA74	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA75	PLEASE DOCUMENT CARRYOVER OF THE THERAPY PROGRAM TO NURSING.
PA76	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA79	PROVIDE EVIDENCE OF SIGNIFICANT FUNCTIONAL PROGRESS IN LAST SIX MONTHS.
PA84	THE GRANT DATE OF THIS REQUEST CANNOT BE PRIOR TO THE SIGNATURE DATE OF THE PRESCRIBING PHYSICIAN.
PA86	PROVIDE EVIDENCE OF SKILLS GAINED IN THERAPY CARRYING OVER TO OTHER SETTINGS WITHIN SIX MONTHS.
PA87	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE NUMBER OF SESSIONS REQUESTED.
PA88	THE REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL SCOPE OF PRACTICE.
PA89	PRIOR AUTHORIZATION IS NOT REQUIRED UNTIL LIMITATION OF SERVICE HAS BEEN REACHED.
PA91	PLEASE SUBMIT REQUIRED X-RAYS.
PA92	PLEASE PROVIDE AN EXPLANATION FOR THE MATERIAL SUBMITTED WITH THE REQUEST.
PA95	PLEASE DESCRIBE HOW THE PROVISION OF THIS SERVICE WOULD PREVENT INSTITUTIONALIZATION OF THE CLIENT.
PA96	COULD THE EXISTING DENTURE(S) BE RELINED OR REBASED? IF NOT, PLEASE EXPLAIN WHY NOT.
PA97	REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL STANDARDS OF PRACTICE.

Denial Code	Long Description
PA98	PLEASE INDICATE IF THE CLIENT IS CURRENTLY BEING TUBE FED.
PB02	PLEASE PROVIDE THE REQUIRED DATED SIGNATURES ON THE ATTACHMENTS.
PB03	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING THE LOSS/DESTRUCTION/THEFT OF THE HEARING AID.
PB04	DESCRIBE THE CLIENTS ABILITY TO STAND OR AMBULATE SUFFICIENTLY TO ACCOMPLISH SELF-CARE ACTIVITIES.
PB07	PLEASE SUBMIT AN ORTHODONTIC STUDY MODEL OR DIAGNOSTIC CASTS.
PB09	PLEASE PROVIDE A PHOTOGRAPH OF THE INVOLVED AREA(S).
PB10	PLEASE PROVIDE AN ESTIMATION (IN GRAMS) OF THE TOTAL AMOUNT OF TISSUE TO BE RESECTED.
PB11	PLEASE SUBMIT THE PLAN OF CARE FOR CO-TREATMENT.
PB12	FURNISH A DETAILED DESCRIPTION FOR THE PROCEDURE CODE REQUESTED.
PB13	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB15	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB18	PLEASE COMPLETE THE ATTACHED OUT-OF-STATE PROVIDER DATA SHEET, F-11001, AND RESUBMIT.
PB20	A SIGNED AND DATED PRESCRIPTION IS REQUIRED WITHIN THREE MONTHS OF RECEIPT BY COLORADO MEDICAID FOR INITIAL REQUESTS AND WITHIN 12 MONTHS OF RECEIPT BY COLORADO MEDICAID FOR SUBSEQUENT REQUESTS.
PB21	PLEASE COMPLETE THE APPROPRIATE PRIOR AUTHORIZATION ATTACHMENT. CONTACT PROVIDER SERVICES OR THE PRIOR AUTHORIZATION UNIT FOR ASSISTANCE.
PB23	PHYSICAL THERAPY ASSISTANT NOTES AND ALL FORMS SUBMITTED MUST BE COSIGNED BY A REGISTERED PHYSICAL THERAPIST.
PB31	ARE YOU REQUESTING A COMPLETE APPLIANCE, OR REPLACEMENT PARTS?
PB32	THE PROCEDURE CODE INDICATED ON THE REQUEST DOES NOT MATCH THE DESCRIPTION OF SERVICE; PLEASE CORRECT AND RESUBMIT.
PB35	THE SERVICE REQUESTED DOES NOT REQUIRE PRIOR AUTHORIZATION.
PB41	PLEASE FURNISH A CURRENT MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT, F-11090 (DATED WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID).
PB45	THE CERTIFICATION PERIOD ON THE PLAN OF CARE (POC) DOES NOT COVER THE REQUESTED GRANT/START DATE. PLEASE RESUBMIT YOUR REQUEST WITH A NEW POC.
PB49	A CERTIFIED OCCUPATIONAL THERAPY ASSISTANTS NOTES MUST BE COSIGNED BY AN OCCUPATIONAL THERAPIST REGISTERED.
PB51	ADDITIONAL INFORMATION IS REQUIRED ON PRIOR AUTHORIZATION TO ENABLE PRICING.
PB54	REQUESTED SERVICES DO NOT MATCH SERVICES ON THE PHYSICIANS ORDERS.
PB59	PLEASE PROVIDE AN INDIVIDUAL EDUCATIONAL PLAN (IEP), WHICH HAS BEEN SIGNED BY THE PROVIDER NO EARLIER THAN NINE MONTHS PRIOR TO RECEIPT AT COLORADO MEDICAID; OTHERWISE, DOCUMENT WHY NO IEP EXISTS.
PB65	PLEASE FURNISH THE ANTICIPATED TOTAL CHARGES FOR THIS REQUEST.
PB66	A PHOTOCOPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED; THE DATE MUST BE WITHIN SIX MONTHS OF RECEIPT BY COLORADO MEDICAID.
PB67	THE PRESCRIPTION DATE MUST INCLUDE MONTH, DAY, AND YEAR.
PB68	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID.
PB73	THE SERVICES IDENTIFIED ON THE PLAN OF CARE DO NOT APPEAR APPROPRIATE FOR THE PROCEDURE CODE(S) REQUESTED ON THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018.
PB74	THE CLIENT/PROVIDER DOES NOT HAVE RETROACTIVE ENROLLMENT.
PB75	THE REQUESTED START DATE IS MORE THAN 14 DAYS BEFORE OR 62 DAYS AFTER RECEIPT.
PB82	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
PB83	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A HOME HEALTH AIDE. PLEASE RESUBMIT AS A PERSONAL CARE WORKER OR PROVIDE ADDITIONAL DOCUMENTATION.
PB86	THE SERVICES REQUESTED ARE NOT BEING PROVIDED IN THE CLIENTS RESIDENCE. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL.
PB87	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A NURSE. PLEASE RESUBMIT AS A HOME HEALTH AIDE OR PROVIDE ADDITIONAL DOCUMENTATION.
PB92	PLEASE FURNISH THE CLIENTS COMPLETE ADDRESS.

Denial Code	Long Description
PB94	IF THE CLIENT IS A RESIDENT OF A NURSING HOME, SUPPLY THE COMPLETE NAME AND ADDRESS OF THE NURSING HOME.
PB99	THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018, MUST BE SIGNED AND DATED.
PC01	PLEASE SUPPLY THE RENDERING PROVIDERS PROVIDER NUMBER.
PC03	THE DRUG ENFORCEMENT ADMINISTRATION NUMBER IS MISSING OR INVALID.
PC06	PLEASE DESCRIBE YOUR PROGRAM; INCLUDE ENTRY DATE, TERMINATION DATE, HOURS PER WEEK, AND NUMBER OF WEEKS OF PRIMARY INTENSIVE SERVICE REQUESTED.
PC07	PLEASE DESCRIBE YOUR "AFTERCARE/FOLLOW-UP" PLANS FOR THIS CLIENT.
PC08	PLEASE SUPPLY DOCUMENTATION OF PREVIOUS SUBSTANCE ABUSE SERVICES WITH DATE(S) AND OUTCOME.
PC09	PLEASE DESCRIBE IN DETAIL THE TREATMENT OBJECTIVES/GOALS FOR THIS CLIENT.
PC10	PLEASE DESCRIBE THE FAMILY SITUATION/DYNAMICS. EXPLAIN HOW THE FAMILY WILL BE INCORPORATED INTO THE CLIENTS PLAN OF CARE.
PC12	PLEASE EXPLAIN IF YOUR SERVICE ENCOURAGES THE CLIENT TO ATTEND SELF-HELP GROUPS.
PC13	PLEASE SUPPLY A SPECIFIC SCHEDULE OF ACTIVITIES, INCLUDING DAY, TIME OF DAY, LENGTH OF SESSION, AND SERVICE TO BE RENDERED DURING THAT TIME.
PC15	PLEASE FURNISH DIAGNOSTIC RATIONALE.
PC17	PLEASE DOCUMENT IF THE CLIENT EVER RECEIVED SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT.
PC19	PLEASE FURNISH MORE EXTENSIVE AND IN-DEPTH HISTORICAL AND PSYCHOSOCIAL DATA.
PC20	PLEASE SUPPLY THE DATE THE CLIENT BECAME TOTALLY ENDENTULOUS.
PC23	PLEASE SUBMIT A PHYSICIANS STATEMENT REGARDING THE MEDICAL NECESSITY OF DENTURES FOR THIS CLIENT. THE PHYSICIANS STATEMENT MUST DOCUMENT THE MEDICAL NEED FOR DENTURES.
PC24	THE SERVICE REQUESTED WAS PREVIOUSLY AUTHORIZED. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT INDICATING THIS FACT IS REQUIRED.
PC25	PLEASE SUPPLY SUFFICIENT MITIGATING CIRCUMSTANCES TO WARRANT THE CONSTRUCTION OF NEW DENTURES(S).
PC26	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
PC28	PLEASE SUBMIT A PHYSICIANS STATEMENT INDICATING DENTURES ARE NECESSARY FOR THIS NURSING HOME CLIENT.
PC29	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING LOSS OR DESTRUCTION OF DENTURE(S). INCLUDE SIGNED STATEMENT FROM CLIENT OR FACILITY DIRECTOR REGARDING HOW, WHEN AND WHERE LOST.
PC30	PLEASE PROVIDE COMPLETE INTRAORAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PC31	PLEASE DESCRIBE ANY RELATED DEFORMITIES OF THE FEET.
PC34	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD WITH REQUESTED DME ITEM(S) AND DOCUMENT IF THE CLIENT CAN USE SAFELY AND INDEPENDENTLY.
PC35	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD AND DESCRIBE THE RESULTS AND EFFECTIVENESS OF THE SERVICE REQUESTED.
PC39	PLEASE INDICATE LITER FLOW PER MINUTE, HOURS OF USE PER 24 HOUR PERIOD, AND THE EXPECTED DURATION OF NEED.
PC40	THE ITEM DOES NOT REQUIRE PRIOR AUTHORIZATION UNTIL THE LIFE EXPECTANCY HAS BEEN REACHED.
PC41	PLEASE SUPPLY INFORMATION INDICATING THE NECESSITY OF POSITIONING THE CLIENT'S BODY IN MULTIPLE POSITIONS.
PC42	PLEASE INDICATE IF THE BED HEIGHT MUST BE CHANGED TO ALLOW FOR SAFE TRANSFER OR ADEQUATE BED CARE.
PC43	SUPPLY A PHYSICIANS STATEMENT INDICATING TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR UNIT HAS REDUCED PAIN, IMPROVED/INCREASED THE CLIENTS ACTIVITY LEVEL, AND/OR REDUCED CLIENTS USE OF PAIN MEDICATION.
PC44	A CURRENT AUTHORIZATION FOR THIS SERVICE IS ON FILE FOR ANOTHER PROVIDER. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT OF THAT FACT IS REQUIRED BY THE CLIENT OF FIRST PROVIDER.
PC59	DOCUMENT DECLINE OR PROGRESS IN SPECIFIC, MEASURABLE, OBJECTIVE TERMS.
PC60	DOCUMENT IF CLIENT HAS DEMONSTRATED A GOOD APPOINTMENT COMPLIANCE RECORD.

Denial Code	Long Description
PC61	THE PHYSICIANS SIGNATURE DATE MUST NOT EXCEED 90 DAYS FROM THE DATE OF RECEIPT BY COLORADO MEDICAID.
PC62	REQUESTS FOR A CONTINUATION OF THERAPY SHOULD NOT BE SUBMITTED MORE THAN FOUR WEEKS PRIOR TO THE EXPIRATION DATE OF THE CURRENT AUTHORIZATION.
PC63	PLEASE FURNISH THE STYLE AND MANUFACTURER OF THE FRAME.
PC64	PLEASE FURNISH THE CLIENTS LENS FORMULA.
PC66	ALL REQUESTS FOR TINTS REQUIRE DOCUMENTATION OF THE VISUAL OR MEDICAL CONDITION RELATED TO PHOTOPHOBIA.
PC67	PLEASE DOCUMENT THE REASON AND JUSTIFICATION FOR REPLACEMENT BEYOND THE FIRST LENS/FRAME.
PC68	DOCUMENT IF ALL REMAINING MAXILLARY AND/OR MANDIBULAR TEETH ARE DECAY-FREE, PROPERLY RESTORED, AND PERIODONTICALLY SOUND.
PC72	SUPPLY MORE DETAIL REGARDING PROGRESS (ATTACHMENT OF GOALS, ETC.). CORRELATE PROGRESS TO PREVIOUS GOALS AND IDENTIFIED LIMITATIONS.
PC77	PLEASE SUBMIT A PLAN OF CARE DESCRIBING THE SERVICES THAT WOULD BE PROVIDED.
PC78	PLEASE DOCUMENT SPECIFIC, MEASURABLE GOALS.
PC82	THE PRIOR AUTHORIZATION (PA) SYSTEM CAN PROCESS ONLY 26 DETAILS PER PA REQUEST. PLEASE RESUBMIT YOUR REQUEST WITH NO MORE THAN 26 DETAILS.
PC83	PLEASE SUPPLY A PHYSICIANS PRESCRIPTION DATED WITHIN ONE MONTH OF REQUESTED SUBSTANCE ABUSE DAY TREATMENT.
PC84	PLEASE PROVIDE INFORMATION INDICATING THIS CLIENT IS APPROPRIATELY DETOXIFIED FROM ALCOHOL AND/OR OTHER DRUGS.
PC85	PLEASE PROVIDE INFORMATION TO INDICATE THE CLIENTS ABILITY TO ABSTAIN FROM ALCOHOL OR DRUGS WHILE IN THE SUBSTANCE ABUSE DAY TREATMENT PROGRAM.
PC86	PLEASE INDICATE IF THIS CLIENT IS WILLING TO PARTICIPATE IN AFTERCARE OR CONTINUING CARE SERVICES.
PC87	PROVIDE MORE INFORMATION ON TREATMENT HISTORY; INCLUDE SERVICE PROVIDED, DATES, AND OUTCOME. PROVIDE DETAIL OF PREVIOUS TREATMENT.
PC88	PLEASE PROVIDE MORE RATIONALE FOR THE APPROPRIATENESS AND MEDICAL NECESSITY OF SUBSTANCE ABUSE DAY TREATMENT.
PC89	PROVIDE A TREATMENT PLAN THAT CONTAINS MEASURABLE GOALS AND OBJECTIVES CORRESPONDING TO THE IDENTIFIED DEFICIT.
PC91	PLEASE PROVIDE MORE INFORMATION ON FAMILY INVOLVEMENT TREATMENT.
PC92	PLEASE PROVIDE MORE HISTORY AND EXPLANATION ABOUT THE ISSUE OF ABSTINENCE FOR THIS CLIENT.
PC94	PLEASE PROVIDE THE ANTICIPATED BEGINNING DATE AND/OR THE ESTIMATED SUBSTANCE ABUSE DAY TREATMENT DISCHARGE DATE.
PC95	PLEASE SUPPLY JUSTIFICATION FOR BEGINNING CLIENT IN SERVICE PRIOR TO AUTHORIZATION BEING OBTAINED.
PC96	THE INITIAL THREE HOURS OF SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IN A CALENDAR YEAR DO NOT REQUIRE PRIOR AUTHORIZATION.
PC97	REIMBURSEMENT FOR INITIAL SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IS LIMITED TO THREE HOURS IN A CALENDAR YEAR AND DOES NOT REQUIRE PRIOR AUTHORIZATION.
PC98	THIS DRUG IS CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE BILL USING THE APPROPRIATE NATIONAL DRUG CODE (NDC) OR SUBMIT A COMPLETED DRUG ADDITION REQUEST FORM IF THE NDC IS NOT LISTED IN THE DRUG INDEX.
PC99	THIS DRUG IS NOT CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL, CURRENT ADMINISTRATIVE RULE, OR COLORADO DRUG INDEX FOR COVERAGE LIMITATIONS.
PD01	DOCUMENT THAT CLIENT HAS ACHIEVED GOOD ORAL HYGIENE, PERIODONTAL CASE TYPE 1 OR 2, AND IS MOTIVATED TO MAINTAIN SAME.
PD03	PLEASE PROVIDE AN ARTERIAL BLOOD GAS READING OR PULSE OXIMETRY RESULTS DONE ON ROOM AIR SIGNED AND DATED BY A MEDICAL DOCTOR. THIS SHOULD BE DONE WITHIN 60 DAYS OF REQUESTED SERVICE.

Denial Code	Long Description
PD04	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 30 DAYS OF RECEIPT BY COLORADO MEDICAID.
PD07	SUBMIT A PHOTOCOPY OF A VALID PRESCRIPTION, ISSUED WITHIN THE PAST YEAR, OR COMPLETE SECTION B OF THE PRIOR AUTHORIZATION/DRUG ATTACHMENT (PA/DGA), F-11049.
PD10	BRAND MEDICALLY NECESSARY MUST BE IN THE PRESCRIBERS OWN HANDWRITING AND WRITTEN DIRECTLY ON THE PRESCRIPTION OR A SEPARATE ORDER ATTACHED TO THE ORIGINAL PRESCRIPTION.
PD12	COMPLETE DENTURES, PARTIAL DENTURES, DENTURE RELINES, AND FIXED PROSTHODONTIC SERVICES ARE NOT COVERED SERVICES FOR ADULTS FOR DATES OF SERVICE ON AND AFTER OCTOBER 1, 1995.
PD22	PLEASE COMPLETE ALL REQUIRED ELEMENTS ON THE PERSONAL CARE SCREENING TOOL (PCST), F-11133.
PD24	THIS PRIOR AUTHORIZATION REQUEST IS UNABLE TO BE PROCESSED. PLEASE RESUBMIT WITH ADDITIONAL REQUIRED FORMS, INCLUDING THE ENTIRE PERSONAL CARE SCREENING TOOL (PCST), F-11133; PERSONAL CARE ADDENDUM, F-11136; AND SUPPORTING DOCUMENTATION, AS DIRECTED.
PD25	THERE IS A PERSONAL CARE SCREENING TOOL (PCST), F-11133, COMPLETED BY ANOTHER AGENCY. CONTACT THE AGENCY TO TRANSFER SCREEN.
PD26	THERE IS A LIMITED TERM CARE FUNCTIONAL SCREEN (LTC-FS) COMPLETED BY ANOTHER AGENCY. THE PERSONAL CARE SCREENING TOOL (PCST), F-11133, INFORMATION IS IN CONFLICT WITH LTC-FS.
PD27	ONLY ONE LEVEL OF FUNCTION MAY BE SELECTED FOR ALL ELEMENTS EXCEPT TOILETING. COLORADO MEDICAID IS UNABLE TO PROCESS THE PRIOR AUTHORIZATION REQUEST.
PD28	NO UNITS MAY BE REQUESTED USING THIS PRIOR AUTHORIZATION PROCESS. PLEASE SUBMIT WITH THE APPROPRIATE ATTACHMENTS FOR REQUESTING SPECIFIC PERSONAL CARE WORKER UNITS.
PD29	CLIENT IS NOT ELIGIBLE FOR THE REQUESTED SERVICE(S) AS OF THE REQUESTED START DATE.
PD30	NO TRAVEL TIME MAY BE AUTHORIZED WHEN NO PERSONAL CARE WORKER SERVICE IS AUTHORIZED.
PD32	PROVIDER NOT CERTIFIED TO RENDER THE SERVICE(S) REQUESTED.
PD34	BASED ON THE DOCUMENTATION SUBMITTED, THIS REQUEST CAN NOT BE PRIOR AUTHORIZED. REFER TO THE PA MESSAGES FROM THE CONSULTANT FOR COMPLETE EXPLANATION.
PD98	PLEASE DOCUMENT HOW AND WHEN EACH PREVIOUSLY AUTHORIZED PRO RE NATA VISIT WAS USED.

Lymphedema Pumps, Compressors

Denial Code	Long Description
0201	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
0233	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0235	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0237	CLIENT IDENTIFICATION NUMBER DOES NOT MATCH CLIENTS FIRST NAME.
0238	THE CLIENT IDENTIFICATION NUMBER DOES NOT MATCH THE CLIENTS LAST NAME.
0242	SECONDARY DIAGNOSIS CODE IS INVALID.
0248	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0249	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0251	PROCEDURE CODE MODIFIER IN FIRST POSITION IS INVALID.
0252	THE PROCEDURE CODE MODIFIER IN SECOND POSITION IS INVALID FOR REQUESTED START DATE OR DATE OF RECEIPT.
0253	THE PROCEDURE CODE MODIFIER IN THIRD POSITION IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
0258	THE PRIMARY DIAGNOSIS CODE IS REQUIRED.
0272	THE PRIMARY DIAGNSOSIS CODE IS INVALID.
0400	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0853	HCPCS - ANNUAL UPDATE
0885	NEVER EVENTS MODIFIERS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
0886	NEVER EVENTS DIAGNOSIS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.

Denial Code	Long Description
1000	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
1002	RENDERING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1003	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1007	RENDERING PROVIDER ID IS NOT ON FILE.
1047	THE RENDERING PROVIDERS CERTIFICATION HAS BEEN CANCELLED.
1048	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1801	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
1804	A CERTIFIED SUBSTANCE ABUSE DAY TREATMENT PROVIDER MUST SUBMIT A SUBSTANCE ABUSE DAY TREATMENT PROCEDURE CODE.
1806	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
1808	THE BILLING PROVIDER DOES NOT HAVE THE REQUIRED CERTIFICATION ADDENDUM ON FILE.
1900	THE BILLING PROVIDERS TAXONOMY CODE IS INVALID.
1901	THE RENDERING PROVIDERS TAXONOMY CODE IS INVALID.
1927	A NATIONAL PROVIDER IDENTIFIER IS REQUIRED FOR THE BILLING PROVIDER.
1934	A NATIONAL PROVIDER INDENTIFIER IS REQUIRED FOR THE RENDERING PROVIDER.
1936	THE BILLING PROVIDER NUMBER IS INVALID.
1937	THE RENDERING PROVIDER NUMBER IS INVALID.
1960	INTERNAL PROCESSING IS REQUIRED.
1963	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.
1964	THE BILLING PROVIDER INDICATED IS NOT ALLOWABLE AS A BILLING PROVIDER.
1965	RENDERING PROVIDER NUMBER IS MISSING/INVALID FOR THIS PROCEDURE PROVIDER.
1974	PRESCRIBING/REFERRING/ORDERING PROVIDER INDICATED IS NOT CERTIFIED AS A PRESCRIBING/REFERRING/ORDERING PROVIDER.
1975	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
1976	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
2001	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2003	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2017	THE CLIENT IS ENROLLED IN A MEDICAID OR OTHER MANAGED CARE PROGRAM.
2037	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2603	CLIENT LOCKED-IN TO A PROVIDER OR ENROLLED IN A HOSPICE. CONTACT CLIENTS HOSPICE FOR PAYMENT OF SERVICES OR RESUBMIT WITH DOCUMENTATION OF UNRELATED NATURE OF CARE.
3324	THE MODIFIER HAS BEEN DISCONTINUED BY THE CENTERS OF MEDICARE AND MEDICAID SERVICES OR THE AMERICAN MEDICAL ASSOCIATION FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
3337	THE PROCEDURE CODE HAS BEEN TERMINATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AMERICAN MEDICAL ASSOCIATION, OR AMERICAN DENTAL ASSOCIATION FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT. RESUBMIT WITH VALID A PROCEDURE CODE.
3339	THE PROCEDURE BILLED IS NOT PAYABLE ACCORDING TO DEFICIT REDUCTION ACT (DEFRA) GUIDELINES.
3351	THE PROCEDURE IS NOT COVERED FOR CLIENTS WITH A NURSING HOME AUTHORIZATION ON THE REQUESTED START DATE OR DATE OF RECEIPT.
3353	THE PROCEDURE IS NOT A COVERED SERVICE FOR HOME AND COMMUNITY-BASED WAIVER CLIENTS.
4021	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4027	THE DIAGNOSIS CODE IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
4031	THE PROCEDURE SUBMITTED IS NOT APPROPRIATE FOR CLIENTS GENDER.
4032	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4034	THE PROCEDURE CODE HAS AN AGE RESTRICTION.
4036	THE PLACE OF SERVICE CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4040	THE PRIMARY DIAGNOSIS CODE IS NOT ON FILE.
4041	THE SECONDARY DIAGNOSIS IS NOT ON FILE.
4046	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4127	INTERNAL PROCESSING IS REQUIRED.
4131	INTERNAL PROCESSING IS REQUIRED.
4141	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.

Denial Code	Long Description
4149	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4150	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4236	ETIOLOGY DIAGNOSIS CODE(S) (E-CODES) ARE INVALID AS THE PRIMARY DIAGNOSIS.
4244	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4245	THE FOURTH POSITION MODIFIER IS INVALID FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT.
4256	THE PROCEDURE CODE AND MODIFIER COMBINATION IS NOT PAYABLE FOR THE CLIENTS BENEFIT PLAN.
4257	THE MODIFIERS SUBMITTED ARE EITHER INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT OR THE MODIFIERS ARE MISSING.
4311	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4315	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4316	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4371	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4372	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4711	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR CLIENTS AGE.
4714	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS AGE.
4731	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS DIAGNOSIS.
4742	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4743	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4744	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4745	DIAGNOSIS AND/OR PROCEDURE AND/OR PLACE OF SERVICE (POS) CODE IS NOT COVERED FOR EXPRESS ENROLLMENT CLIENTS.
4746	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4801	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4802	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
4821	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
4871	PLEASE REFER TO PA MESSAGES FOR RETURN INFORMATION.
4963	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS GENDER.
4990	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
7500	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
7509	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
P001	THE BILLING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THE SERVICES.
P002	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P003	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P005	THE PRIOR AUTHORIZATION CAN NOT BE END DATED. THE PRIOR AUTHORIZATION STATUS IS NOT APPROVED OR APPROVED WITH REVISIONS.
P006	PLEASE FURNISH THE PROCEDURE CODE AND CORRESPONDING DESCRIPTION.
P008	THE BILLING PROVIDER NUMBER IS INVALID.
P009	THE BILLING PROVIDER NUMBER IS INVALID.
P010	THE REQUESTED END DATE IS INVALID.
P011	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P012	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P013	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P014	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P015	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P016	THE REQUESTED START DATE IS MISSING OR INVALID.

Denial Code	Long Description
P019	THE REQUESTED START DATE IS MISSING OR INVALID.
P020	THE RENDERING PROVIDER NUMBER IS INVALID.
P021	THE RENDERING PROVIDER NUMBER IS INVALID.
P022	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P023	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P024	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P026	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P027	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P030	FIRST MODIFIER IS INVALID.
P031	FIRST MODIFIER IS INVALID.
P032	SECOND MODIFIER IS INVALID.
P033	SECOND MODIFIER IS INVALID.
P034	THIRD MODIFIER IS INVALID.
P035	THIRD MODIFIER IS INVALID.
P036	FOURTH MODIFIER IS INVALID.
P037	FOURTH MODIFIER IS INVALID.
P038	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P039	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P040	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P041	CLIENTS FIRST NAME IS MISSING.
P042	CLIENTS LAST NAME IS MISSING.
P043	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P044	BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES REQUESTED.
P045	FIRST MODIFIER IS INVALID.
P046	SECOND MODIFIER IS INVALID.
P047	THIRD MODIFIER IS INVALID.
P048	FOURTH MODIFIER IS INVALID.
P052	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P053	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P054	RENDERING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES FOR THE BENEFIT PLAN.
P055	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P061	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P062	THE CLIENT ID AND/OR NAME INDICATED ON THE PA REQUEST IS INCORRECT. THE CLIENT ID AND/OR NAME HAS BEEN UPDATED. PLEASE VERIFY THE ID AND/OR NAME IS CORRECT.
P064	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
P067	THE FREQUENCY OF HOURS REQUESTED ARE NOT APPROPRIATE FOR THIS CLIENT AND HAVE BEEN MODIFIED ACCORDINGLY.
P079	BILLING PROVIDER IS ON PAYMENT SUSPENSION DUE TO CREDIBLE ALLEGATION OF FRAUD.
P120	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAS BEEN REDUCED.
P121	THE SERVICE/ PROCEDURE REQUESTED IS NOT SUPPORTED BY SUBMITTED DOCUMENTATION.
P126	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
P128	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.
P138	SERVICE(S) DO NOT MEET COLORADO MEDICAID GUIDELINES.
P167	REQUESTED DOCUMENTATION HAS NOT BEEN SUBMITTED.
P178	THE SERVICE REQUESTED IS NOT MEDICALLY NECESSARY.
P179	THE MEDICAL NECESSITY FOR THIS SERVICE IS NOT SUPPORTED BY THE SUBMITTED DOCUMENTATION.
P233	THE DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE ADDITIONAL CARE.

Denial Code	Long Description
P257	THIS CLIENTS FUNCTIONAL ASSESSMENT SCORES PLACE THIS CLIENT OUTSIDE ELIGIBILITY FOR DAY TREATMENT.
P274	OUR RECORDS INDICATE THIS CLIENT IS INVOLVED IN EFFECTIVE AND APPROPRIATE SERVICE ELSEWHERE.
P292	INTENSIVE REHABILITATION HOURS ARE NO LONGER APPROPRIATE AS INDICATED BY HISTORY, DIAGNOSIS, AND/ OR FUNCTIONAL ASSESSMENT SCORES.
P328	THE SERVICES REQUESTED INCLUDE NON-COVERED SERVICES, AND HOURS ARE REDUCED ACCORDINGLY.
P339	THE CLIENTS PAST HISTORY INDICATES REDUCED TREATMENT HOURS ARE WARRANTED.
P342	THE REQUEST DOES NOT MEET GENERALLY ACCEPTED CONDITIONS REQUIRING FLUORIDE TREATMENTS.
P346	SERVICES EXCEED COLORADO MEDICAID LIMITATION AND DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE MEDICAL NECESSITY OF THE SERVICE.
P349	THE SERVICE REQUESTED WAS PERFORMED LESS THAN FIVE YEARS AGO.
P353	THE EXISTING APPLIANCE HAS NOT BEEN WORN FOR THREE YEARS.
P367	THE CLIENT HAS BEEN TOTALLY WITHOUT TEETH AND AN APPLIANCE FOR FIVE YEARS.
P392	THE CLIENT IS MISSING AN ANTERIOR TOOTH AND/OR HAS TWO OR MORE POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P405	THE SERVICE(S) REQUESTED COULD ADEQUATELY BE PERFORMED IN THE DENTAL OFFICE.
P406	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE OF GOOD PERIODONTAL HEALTH (AMERICAN ACADEMY OF PERIODONTOLOGY PERIODONTAL CLASSIFICATION OF TYPE I OR II).
P407	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE VISIBLE ON RADIOGRAPHS THAT AT LEAST 50 PERCENT OF THE CLINICAL CROWN IS INTACT.
P409	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING SIX OR MORE TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED, INCLUDING THIRD MOLARS.
P410	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING ONE OR MORE ANTERIOR TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED.
P411	DOCUMENTATION DOES NOT SUPPORT THE NEED FOR PERIODONTIC SERVICES. POCKETS ARE LESS THAN 4MM AND/OR GREATER THAN 6MM FOR CLIENT AND/OR THE CLIENT IS UNDER THE AGE OF 13.
P412	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA.
P413	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA. THIS PA HAS BEEN GRANTED AS APPROVED NOT APPROVED WITH REVISIONS. THE DURATION REQUESTED MAY HAVE BEEN REDUCED TO REFLECT COVERAGE LIMITATIONS, PRESCRIBER ORDERS, CONFLICTI
P417	THE SERVICE(S) REQUESTED COULD BE ADEQUATELY PERFORMED WITH LOCAL ANESTHESIA.
P437	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO POOR ORAL HYGIENE.
P444	THIS LINE ITEM IS A DUPLICATE OF ANOTHER LINE ITEM ON THIS PRIOR AUTHORIZATION (PA) REQUEST. PLEASE CORRECT.
P446	THIS IS A DUPLICATE OF AN EXISTING PRIOR AUTHORIZATION (PA) REQUEST. YOU MAY CONTACT PROVIDER SERVICES IF YOU REQUIRE ASSISTANCE. DUPLICATE PA REQUEST
P448	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO DECAY HISTORY.
P449	QUESTIONABLE LONG TERM PROGNOSIS DUE TO GUM AND BONE DISEASE.
P456	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO APPARENT ROOT INFECTION.
P457	OUR RECORDS INDICATE THIS CLIENT HAS EXCEEDED ESTABLISHED PROGRAM LIMITATIONS. COLORADO MEDICAID WILL NOT AUTHORIZE NEW DENTURES.
P458	DOCUMENTATION PROVIDED INDICATES A LESS ELABORATE PROCEDURE SHOULD BE CONSIDERED.
P502	RENTAL ONLY ALLOWED; MEDICAL NEED FOR PURCHASE HAS NOT BEEN DOCUMENTED.
P503	PURCHASE ONLY ALLOWED; MEDICAL NEED FOR RENTAL HAS NOT BEEN DOCUMENTED.
P504	OCCUPATIONAL THERAPY GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P505	THE SERVICE REQUESTED IS INCLUDED IN THE NURSING HOME RATE STRUCTURE.
P511	THIS NATIONAL DRUG CODE IS ONLY BILLABLE AS PART OF A COMPOUND DRUG.
P515	THE PRESENCE OF A HANDICAPPING MALOCCLUSION OR HANDICAPPING DENTOFACIAL DEFORMITY IS NOT SUPPORTED BY THE DOCUMENTATION SUBMITTED.
P521	THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVERED BY COLORADO MEDICAID.

Denial Code	Long Description
P522	GASTRO-INTESTINAL SURGERY FOR THE PURPOSE OF WEIGHT CONTROL IS COVERED ONLY AS A LIFE THREATENING PROCEDURE.
P523	THE TREATMENT REQUEST IS NOT CONSISTENT WITH THE CLIENT'S DIAGNOSIS.
P524	PSYCHOTHERAPY PROVIDED IN THE CLIENTS HOME IS NOT A COVERED BENEFIT OF COLORADO MEDICAID.
P525	THE INFORMATION PROVIDED IS NOT CONSISTENT WITH THE INTENSITY OF SERVICES REQUESTED.
P526	INTENSIVE MULTIPLE MODALITY TREATMENT IS NOT CONSISTENT WITH THE INFORMATION PROVIDED.
P527	MULTIPLE PROVIDERS OF TREATMENT ARE NOT INDICATED FOR THIS CLIENT.
P528	THE DURATION OF TREATMENT SESSIONS EXCEED CURRENT COLORADO MEDICAID GUIDELINES.
P534	DOCUMENTATION OF POOR PHYSICAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P535	OTHER PHYSICAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P536	THE PHYSICAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P537	USE OF PHYSICAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P538	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF A PHYSICAL THERAPIST.
P539	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS AND LIVING ARRANGEMENT.
P540	GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P541	THE PROCEDURE(S) REQUESTED ARE NOT MEDICAL IN NATURE.
P542	DOCUMENTATION OF POOR OCCUPATIONAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P543	DOCUMENTATION OF POOR SPEECH THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P544	OTHER OCCUPATIONAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P546	THE OCCUPATIONAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P547	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF PHYSICAL THERAPY.
P548	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P549	ACTIVITIES TO PROMOTE DIVERSION OR GENERAL MOTIVATION ARE NONCOVERED COLORADO MEDICAID SERVICES.
P550	REVISIONS OF THE REQUEST IS NECESSITATED BY THE CLIENTS MINIMAL PROGRESS.
P551	RESTORATIVE NURSING INVOLVEMENT COULD BE INCREASED.
P552	CLIENTS DEMONSTRATED RESPONSE TO CURRENT THERAPY DOES NOT WARRANT THE INTENSE FREQUENCY REQUESTED.
P553	MAINTENANCE IS TWO TIMES PER WEEK OR LESS.
P554	THE SPEECH THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P555	USE OF OCCUPATIONAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P556	USE OF SPEECH THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P557	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF AN OCCUPATIONAL THERAPIST.
P558	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
P559	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P560	THE MATERIALS/ SERVICES REQUESTED ARE PRINCIPALLY COSMETIC IN NATURE.
P561	THE LENS FORMULA DOES NOT JUSTIFY REPLACEMENT.
P562	THE CHANGE IN THE LENS FORMULA DOES NOT WARRANT MULTIPLE REPLACEMENTS.
P563	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P564	LENSES ONLY ARE APPROVED; PLEASE DISPENSE A CONTRACTED FRAME. THE NON-CONTRACTED FRAME IS NOT MEDICALLY JUSTIFIED.
P565	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.

Denial Code	Long Description
P566	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P567	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF OCCUPATIONAL THERAPY.
P568	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF SPEECH THERAPY.
P569	LEVEL, INTENSITY, OR EXTENT OF SERVICE(S) REQUESTED HAS BEEN MODIFIED CONSISTENT WITH MEDICAL NEED AS DEFINED IN THE PLAN OF CARE.
P570	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P571	THE SERVICE ASKED FOR IS NOT COVERED BY COLORADO MEDICAID AS THESE TASKS CAN BE DONE BY NURSES OR ACTIVITY STAFF.
P572	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P573	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.
P574	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P575	MEDICAL NEED FOR EQUIPMENT/ SUPPLY REQUESTED IS NOT SUPPORTED BY DOCUMENTATION SUBMITTED.
P576	OTHER SPEECH THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P577	DOCUMENTATION SUBMITTED IDENTIFIES THAT THE CLIENT HAS FEWER THAN TWO POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P582	LESS EXPENSIVE ALTERNATIVE SERVICES ARE AVAILABLE FOR THIS CLIENT.
P634	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P711	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING PERIODONTAL SCALING AND ROOT PLANNING.
P712	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING GINGIVECTOMY.
P754	AN APPROVED SUBSTANCE ABUSE DAY TREATMENT PROGRAM CANNOT EXCEED A SIX WEEK PERIOD.
P761	THE CLIENT DOES NOT APPEAR TO BE ABLE OR WILLING TO ABSTAIN FROM ALCOHOL/DRUG USAGE WHILE IN TREATMENT. THEREFORE, SUBSTANCE ABUSE DAY TREATMENT SERVICES ARE NOT APPROVED.
P764	THIS CLIENT HAS COMPLETED INTENSIVE SUBSTANCE ABUSE TREATMENT WITHIN THE PAST 12 MONTHS. THE DOCUMENTATION PROVIDED IS NOT ADEQUATE TO JUSTIFY ADDITIONAL INTENSIVE TREATMENT AT THIS TIME.
P785	A LESS THAN SIX-WEEK HEALING PERIOD HAS BEEN SPECIFIED FOR THIS PRIOR AUTHORIZATION. THEREFORE IT IS NOT NECESSARY TO WAIT THE FULL SIX WEEKS AFTER EXTRACTIONS BEFORE TAKING DENTURE IMPRESSIONS.
P818	SIX-WEEK HEALING TIME IS REQUIRED BETWEEN EDENTULATION AND FINAL IMPRESSIONS. PAYMENT FOR DENTURES WILL BE DENIED OR RECOUPED IF HEALING PERIOD IS NOT OBSERVED.
P849	COLORADO MEDICAID HAS DETERMINED THERE WERE (ARE) SEVERAL HOME HEALTH AGENCIES WILLING TO PROVIDE MEDICALLY NECESSARY SKILLED NURSING SERVICES TO THIS CLIENT.
P864	THE DOCUMENTATION YOU HAVE SUBMITTED DOES NOT MEET THE REQUIREMENTS OF COLORADO MEDICAID.
P873	THE MEDICAL NECESSITY FOR THE HOURS REQUESTED IS NOT SUPPORTED BY THE INFORMATION SUBMITTED.
P874	THE DOCUMENTATION SUBMITTED INDICATES THE TASKS SPECIFIED CAN BE COMPLETED DURING THE VISITS APPROVED.
P878	THE DOCUMENTATION SUBMITTED DOES NOT INDICATE THAT MEDICALLY ORIENTED TASKS ARE MEDICALLY NECESSARY; THEREFORE PERSONAL CARE SERVICES HAVE BEEN APPROVED.
P880	THE QUANTITY OF SERVICES AUTHORIZED FOR THIS CLIENTS PERSONAL CARE HAS BEEN AMENDED BASED ON INFORMATION RECEIVED FROM ONE OR MORE OF THESE SOURCES: THE CLIENT, THEIR PHYSICIAN, AND/OR THE IN-HOME VISIT BY STAFF OF THE OIG (OFFICE OF INSPECTOR GENERAL).
P885	THE USE OF THIS DRUG FOR THE INTENDED PURPOSE IS NOT COVERED BY COLORADO MEDICAID, CONSISTENT WITH COLORADO ADMINISTRATIVE CODE AND FEDERAL LAW.

Denial Code	Long Description
P924	THE MEDICAL RECORDS SUBMITTED WITH THE CURRENT REQUEST CONFLICT OR DISAGREE WITH OUR MEDICAL RECORDS ON THIS CLIENT.
P950	INDEPENDENT NURSES, PLEASE NOTE PAYABLE SERVICES MAY NOT EXCEED 12 HOURS/DAY OR 60 HOURS/WEEK.
P951	SERVICES CAN ONLY BE AUTHORIZED THROUGH ONE YEAR FROM THE PRESCRIPTION DATE.
P952	LEAD INSPECTION IS A COVERED COLORADO MEDICAID SERVICE WHEN THE CHILD HAS BEEN SHOWN TO HAVE LEAD POISONING (E.G., CHILD HAS A BLOOD LEAD LEVEL > 19 UG/DL OR TWO CONSECUTIVE BLOOD LEAD LEVELS OF 15-19 UG/DL DONE AT LEAST 90 DAYS APART). THE INSPECTION MUS
P953	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P954	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P956	THE REQUEST CAN ONLY BE BACKDATED A MAXIMUM OF 14 DAYS FROM FIRST DATE RECEIVED BY COLORADO MEDICAID.
P957	COMPLETE PERIODONTAL CHARTING AT TIME OF SERVICE, AND SUBMIT CHARTING, COPY OF OPERATIVE REPORT, TOGETHER WITH A COPY OF THE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF), F-11035, TO PA UNIT ATTENTION DENTAL CONTSULTANT.
P958	NOTE THAT CODE D4341 HAS BEEN CHANGED. REFER TO THE DECISION NOTICE FOR AUTHORIZED QUANTITY.
P960	YOUR PA HAS BEEN APPROVED FOR 90 DAYS. THE 90 DAY APPROVAL DOES NOT IMPLY THE PA REQUEST MEETS PRIOR AUTHORIZATION CRITERIA. AFTER ADDITIONAL INFORMATION IS AVAILABLE IN INTERCHANGE, COLORADO MEDICAID WILL CREATE AN AMENDMENT REQUEST TO EXTEND THE PA FOR
P961	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P962	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
PA10	THE REQUESTED END DATE IS INVALID.
PA12	PLEASE FURNISH A WRITTEN DESCRIPTION OF THE CLIENTS DIAGNOSIS.
PA13	PROVIDE DIAGNOSES WITH DATES OF ONSET.
PA14	IDENTIFY PROBLEMS TO BE TREATED.
PA15	THE AUDIOLOGISTS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1), F-11020, AND PRIOR AUTHORIZATION REQUEST/HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2), F-11021.
PA16	THE PHYSICIANS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION/PHYSICIAN OTOLOGICAL REPORT (PA/POR), F-11019.
PA17	SUBMIT BRIEF HISTORY WITH REFERRAL INFORMATION, LIVING SITUATION, FUNCTIONAL STATUS, AND OTHER PERTINENT INFORMATION. WHAT CHANGE OF STATUS RESULTED IN REFERRAL AT THIS TIME?
PA18	PLEASE FURNISH THE CLIENTS HEIGHT AND WEIGHT.
PA19	PLEASE SUBMIT CLINICAL INFORMATION SUFFICIENT TO VERIFY THE NEED FOR THE REQUESTED SERVICE(S).
PA20	PLEASE RESUBMIT WITH COMPLETE PERIODONTAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PA21	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL EDUCATIONAL PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA22	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL PROGRAM PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA23	REFER TO THE DURABLE MEDICAL EQUIPMENT INDEX FOR APPROPRIATE CODE AND DESCRIPTION. DO NOT USE AN "UNLISTED" CODE.
PA24	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUALIZED FAMILY SERVICE PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA25	INFORMATION ON THE REQUEST FORM IS ILLEGIBLE, AND THE REQUEST CANNOT BE PROCESSED.
PA26	RE-EVALUATE YOUR GOALS. EMPHASIS SHOULD BE ON FUNCTIONAL SELF-CARE. GOALS MUST BE RELATED TO FUNCTIONAL OUTCOME.

Denial Code	Long Description
PA27	PLEASE CLARIFY THE NUMBER OF HOURS PER WEEK REQUESTED.
PA28	PLEASE CLARIFY THE NUMBER OF HOURS PER DAY REQUESTED.
PA29	PLEASE CLARIFY THE NUMBER OF VISITS PER DAY REQUESTED.
PA30	ATTACH SUPPORTIVE DOCUMENTATION; HOME EXERCISE PROGRAM AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA31	THE DIAGNOSIS CODE INDICATED ON THE REQUEST DOES NOT CORRESPOND TO THE DIAGNOSIS CODE DESCRIPTION.
PA32	PLEASE SUBMIT ADDITIONAL INFORMATION SUFFICIENT TO VERIFY APPROPRIATENESS AND NEED FOR TRANSPLANT.
PA33	PLEASE SUBMIT THE INITIAL AND PROGRESSIVE OBJECTIVE FINDINGS.
PA34	ATTACH SUPPORTIVE DOCUMENTATION, FACILITY PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA35	PLEASE SUBMIT THE CLIENTS ORIGINAL COMPLAINTS AND EXAMINATION FINDINGS.
PA36	ATTACH SUPPORTIVE DOCUMENTATION, IN-HOME AUTISM PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA37	PLEASE SUBMIT YOUR TREATMENT PLAN FOR THIS CLIENT.
PA38	ATTACH SUPPORTIVE DOCUMENTATION AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA39	INITIAL EVALUATIONS MUST BE PERFORMED BY AN OCCUPATIONAL THERAPIST REGISTERED (OTR), PER AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA) STANDARDS.
PA41	IDENTIFY THE PLACE OF SERVICE AND ITS EFFECT ON SUPPORTING THE DESIRED TREATMENT OUTCOME.
PA42	PLEASE INDICATE THE HOURS OF USE OF OXYGEN PER 24-HOUR PERIOD.
PA43	PROVIDE BASELINE DOCUMENTATION FOR THIS CLIENTS LIMITATIONS USING UNITS OF MEASUREMENT THAT ARE APPLIED CONSISTENTLY WHEN REPORTING STATUS.
PA44	IDENTIFY FUNCTIONAL LIMITATIONS AS THEY ARE RELATED TO IDENTIFIED CONDITIONS.
PA46	CORRELATE PLAN OF CARE TO REQUESTED PROCEDURE CODES.
PA47	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE FREQUENCY/DURATION REQUESTED.
PA48	PLEASE PROVIDE THE NAME AND CREDENTIALS OF THE RENDERING PROVIDER.
PA50	COLORADO MEDICAID RECORDS INDICATE THE CLIENT OWNS A WHEELCHAIR. DOCUMENT THE REASON AND NEED FOR REPLACEMENT AND COST TO REPAIR CURRENT WHEELCHAIR.
PA51	PLEASE DISTINGUISH PRIMARY AND SUPPORTIVE MODALITIES.
PA52	PLEASE SUBMIT A PROGRESS REPORT.
PA53	MULTIPLE FAMILY CLIENTS TREATMENT BY THE SAME PROVIDER REQUIRES FURTHER INFORMATION DOCUMENTING COORDINATION OF TREATMENT PLAN.
PA54	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE MINUTES REQUESTED.
PA55	MEDICAL NECESSITY OF TREATMENT REQUIRES ADDITIONAL DOCUMENTATION.
PA56	GIVEN AGE, DIAGNOSES, CURRENT LEVEL OF FUNCTION, PAST RESPONSE TO TREATMENT, AND LIVING SITUATION, EXPAND ON POTENTIAL FOR SIGNIFICANT FUNCTIONAL PROGRESS WITHIN THE NEXT SIX MONTHS. EMPHASIZE WHY PROGRESS IS EXPECTED WITH SERVICES AT THIS TIME.
PA57	SUBMIT THE INITIAL FINDINGS. INCLUDE A COMPREHENSIVE EVALUATION.
PA58	SUBMIT PROGRESSIVE, OBJECTIVE FINDINGS. INCLUDE A PERTINENT RE-EVALUATION.
PA59	PLEASE SUPPLY INFORMATION REGARDING THE CLIENTS MEDICATION REQUIREMENTS, IF ANY.
PA60	PLEASE SPECIFY IF THE CLIENT IS IN AN EDUCATIONAL SETTING.
PA61	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA62	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
PA63	THE SKILLS OF A THERAPIST ARE PURPOSEFUL AND SKILLED INTERVENTIONS REQUIRED TO CONTINUALLY DESIGN, IMPLEMENT, REASSESS, MODIFY/GRADE, AND/OR DISCONTINUE A PLAN OF CARE IN A TIMELY MANNER, BASED ON THE COMPLEXITY OF THE CLIENTS MEDICAL CONDITION AND/OR CO
PA64	PLEASE SUBMIT A THERAPY PLAN OF CARE, INCLUDING A CURRENT, DATED EVALUATION.
PA65	A PLAN OF CARE SIGNED AND DATED BY THE PHYSICIAN IS REQUIRED.

Denial Code	Long Description
PA66	THE SKILLS OF A THERAPIST ARE REQUIRED WHEN ONLY THE THERAPIST CAN SAFELY AND EFFECTIVELY DELIVER THE THERAPEUTIC PROCEDURES BECAUSE OF THEIR UNIQUE KNOWLEDGE, TRAINING, AND EXPERTISE. DESCRIBE THE REASON THAT SOMEONE OTHER THAN A THERAPIST CANNOT SAFELY
PA67	PLEASE SPECIFY IF THE CLIENTS WORK SITE DEMANDS GOOD BINAURAL HEARING.
PA68	DESCRIBE THE REASON, BASED ON THE CLIENTS COGNITIVE, PHYSICAL, COMMUNICATION, OR RESOURCE STATUS, THAT A HOME PROGRAM, EQUIPMENT, OR ENVIRONMENTAL ADAPTATIONS ALONE CANNOT MEET CLIENTS NEEDS.
PA69	PLEASE SPECIFY IF THE CLIENT HAS AN ACCOMPANYING DISABILITY THAT ADDS TO THE HEARING PROBLEM.
PA70	DISTINGUISH REQUESTED PROCEDURES AND GOALS FROM OTHER SERVICES THIS CLIENT RECEIVES. THEY MAY NOT BE DUPLICATIVE.
PA71	PLEASE INDICATE THE NUMBER OF DAYS REQUESTED.
PA73	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA74	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA75	PLEASE DOCUMENT CARRYOVER OF THE THERAPY PROGRAM TO NURSING.
PA76	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA79	PROVIDE EVIDENCE OF SIGNIFICANT FUNCTIONAL PROGRESS IN LAST SIX MONTHS.
PA84	THE GRANT DATE OF THIS REQUEST CANNOT BE PRIOR TO THE SIGNATURE DATE OF THE PRESCRIBING PHYSICIAN.
PA86	PROVIDE EVIDENCE OF SKILLS GAINED IN THERAPY CARRYING OVER TO OTHER SETTINGS WITHIN SIX MONTHS.
PA87	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE NUMBER OF SESSIONS REQUESTED.
PA88	THE REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL SCOPE OF PRACTICE.
PA89	PRIOR AUTHORIZATION IS NOT REQUIRED UNTIL LIMITATION OF SERVICE HAS BEEN REACHED.
PA91	PLEASE SUBMIT REQUIRED X-RAYS.
PA92	PLEASE PROVIDE AN EXPLANATION FOR THE MATERIAL SUBMITTED WITH THE REQUEST.
PA95	PLEASE DESCRIBE HOW THE PROVISION OF THIS SERVICE WOULD PREVENT INSTITUTIONALIZATION OF THE CLIENT.
PA96	COULD THE EXISTING DENTURE(S) BE RELINED OR REBASED? IF NOT, PLEASE EXPLAIN WHY NOT.
PA97	REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL STANDARDS OF PRACTICE.
PA98	PLEASE INDICATE IF THE CLIENT IS CURRENTLY BEING TUBE FED.
PB02	PLEASE PROVIDE THE REQUIRED DATED SIGNATURES ON THE ATTACHMENTS.
PB03	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING THE LOSS/DESTRUCTION/THEFT OF THE HEARING AID.
PB04	DESCRIBE THE CLIENTS ABILITY TO STAND OR AMBULATE SUFFICIENTLY TO ACCOMPLISH SELF-CARE ACTIVITIES.
PB07	PLEASE SUBMIT AN ORTHODONTIC STUDY MODEL OR DIAGNOSTIC CASTS.
PB09	PLEASE PROVIDE A PHOTOGRAPH OF THE INVOLVED AREA(S).
PB10	PLEASE PROVIDE AN ESTIMATION (IN GRAMS) OF THE TOTAL AMOUNT OF TISSUE TO BE RESECTED.
PB11	PLEASE SUBMIT THE PLAN OF CARE FOR CO-TREATMENT.
PB12	FURNISH A DETAILED DESCRIPTION FOR THE PROCEDURE CODE REQUESTED.
PB13	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB15	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB18	PLEASE COMPLETE THE ATTACHED OUT-OF-STATE PROVIDER DATA SHEET, F-11001, AND RESUBMIT.
PB20	A SIGNED AND DATED PRESCRIPTION IS REQUIRED WITHIN THREE MONTHS OF RECEIPT BY COLORADO MEDICAID FOR INITIAL REQUESTS AND WITHIN 12 MONTHS OF RECEIPT BY COLORADO MEDICAID FOR SUBSEQUENT REQUESTS.
PB21	PLEASE COMPLETE THE APPROPRIATE PRIOR AUTHORIZATION ATTACHMENT. CONTACT PROVIDER SERVICES OR THE PRIOR AUTHORIZATION UNIT FOR ASSISTANCE.
PB23	PHYSICAL THERAPY ASSISTANT NOTES AND ALL FORMS SUBMITTED MUST BE COSIGNED BY A REGISTERED PHYSICAL THERAPIST.

Denial Code	Long Description
PB31	ARE YOU REQUESTING A COMPLETE APPLIANCE, OR REPLACEMENT PARTS?
PB32	THE PROCEDURE CODE INDICATED ON THE REQUEST DOES NOT MATCH THE DESCRIPTION OF SERVICE; PLEASE CORRECT AND RESUBMIT.
PB35	THE SERVICE REQUESTED DOES NOT REQUIRE PRIOR AUTHORIZATION.
PB41	PLEASE FURNISH A CURRENT MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT, F-11090 (DATED WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID).
PB45	THE CERTIFICATION PERIOD ON THE PLAN OF CARE (POC) DOES NOT COVER THE REQUESTED GRANT/START DATE. PLEASE RESUBMIT YOUR REQUEST WITH A NEW POC.
PB49	A CERTIFIED OCCUPATIONAL THERAPY ASSISTANTS NOTES MUST BE COSIGNED BY AN OCCUPATIONAL THERAPIST REGISTERED.
PB51	ADDITIONAL INFORMATION IS REQUIRED ON PRIOR AUTHORIZATION TO ENABLE PRICING.
PB54	REQUESTED SERVICES DO NOT MATCH SERVICES ON THE PHYSICIANS ORDERS.
PB59	PLEASE PROVIDE AN INDIVIDUAL EDUCATIONAL PLAN (IEP), WHICH HAS BEEN SIGNED BY THE PROVIDER NO EARLIER THAN NINE MONTHS PRIOR TO RECEIPT AT COLORADO MEDICAID; OTHERWISE, DOCUMENT WHY NO IEP EXISTS.
PB65	PLEASE FURNISH THE ANTICIPATED TOTAL CHARGES FOR THIS REQUEST.
PB66	A PHOTOCOPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED; THE DATE MUST BE WITHIN SIX MONTHS OF RECEIPT BY COLORADO MEDICAID.
PB67	THE PRESCRIPTION DATE MUST INCLUDE MONTH, DAY, AND YEAR.
PB68	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID.
PB73	THE SERVICES IDENTIFIED ON THE PLAN OF CARE DO NOT APPEAR APPROPRIATE FOR THE PROCEDURE CODE(S) REQUESTED ON THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018.
PB74	THE CLIENT/PROVIDER DOES NOT HAVE RETROACTIVE ENROLLMENT.
PB75	THE REQUESTED START DATE IS MORE THAN 14 DAYS BEFORE OR 62 DAYS AFTER RECEIPT.
PB82	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
PB83	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A HOME HEALTH AIDE. PLEASE RESUBMIT AS A PERSONAL CARE WORKER OR PROVIDE ADDITIONAL DOCUMENTATION.
PB86	THE SERVICES REQUESTED ARE NOT BEING PROVIDED IN THE CLIENTS RESIDENCE. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL.
PB87	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A NURSE. PLEASE RESUBMIT AS A HOME HEALTH AIDE OR PROVIDE ADDITIONAL DOCUMENTATION.
PB92	PLEASE FURNISH THE CLIENTS COMPLETE ADDRESS.
PB94	IF THE CLIENT IS A RESIDENT OF A NURSING HOME, SUPPLY THE COMPLETE NAME AND ADDRESS OF THE NURSING HOME.
PB99	THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018, MUST BE SIGNED AND DATED.
PC01	PLEASE SUPPLY THE RENDERING PROVIDERS PROVIDER NUMBER.
PC03	THE DRUG ENFORCEMENT ADMINISTRATION NUMBER IS MISSING OR INVALID.
PC06	PLEASE DESCRIBE YOUR PROGRAM; INCLUDE ENTRY DATE, TERMINATION DATE, HOURS PER WEEK, AND NUMBER OF WEEKS OF PRIMARY INTENSIVE SERVICE REQUESTED.
PC07	PLEASE DESCRIBE YOUR "AFTERCARE/FOLLOW-UP" PLANS FOR THIS CLIENT.
PC08	PLEASE SUPPLY DOCUMENTATION OF PREVIOUS SUBSTANCE ABUSE SERVICES WITH DATE(S) AND OUTCOME.
PC09	PLEASE DESCRIBE IN DETAIL THE TREATMENT OBJECTIVES/GOALS FOR THIS CLIENT.
PC10	PLEASE DESCRIBE THE FAMILY SITUATION/DYNAMICS. EXPLAIN HOW THE FAMILY WILL BE INCORPORATED INTO THE CLIENTS PLAN OF CARE.
PC12	PLEASE EXPLAIN IF YOUR SERVICE ENCOURAGES THE CLIENT TO ATTEND SELF-HELP GROUPS.
PC13	PLEASE SUPPLY A SPECIFIC SCHEDULE OF ACTIVITIES, INCLUDING DAY, TIME OF DAY, LENGTH OF SESSION, AND SERVICE TO BE RENDERED DURING THAT TIME.
PC15	PLEASE FURNISH DIAGNOSTIC RATIONALE.
PC17	PLEASE DOCUMENT IF THE CLIENT EVER RECEIVED SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT.
PC19	PLEASE FURNISH MORE EXTENSIVE AND IN-DEPTH HISTORICAL AND PSYCHOSOCIAL DATA.
PC20	PLEASE SUPPLY THE DATE THE CLIENT BECAME TOTALLY ENDENTULOUS.

Denial Code	Long Description
PC23	PLEASE SUBMIT A PHYSICIANS STATEMENT REGARDING THE MEDICAL NECESSITY OF DENTURES FOR THIS CLIENT. THE PHYSICIANS STATEMENT MUST DOCUMENT THE MEDICAL NEED FOR DENTURES.
PC24	THE SERVICE REQUESTED WAS PREVIOUSLY AUTHORIZED. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT INDICATING THIS FACT IS REQUIRED.
PC25	PLEASE SUPPLY SUFFICIENT MITIGATING CIRCUMSTANCES TO WARRANT THE CONSTRUCTION OF NEW DENTURES(S).
PC26	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
PC28	PLEASE SUBMIT A PHYSICIANS STATEMENT INDICATING DENTURES ARE NECESSARY FOR THIS NURSING HOME CLIENT.
PC29	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING LOSS OR DESTRUCTION OF DENTURE(S). INCLUDE SIGNED STATEMENT FROM CLIENT OR FACILITY DIRECTOR REGARDING HOW, WHEN AND WHERE LOST.
PC30	PLEASE PROVIDE COMPLETE INTRAORAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PC31	PLEASE DESCRIBE ANY RELATED DEFORMITIES OF THE FEET.
PC34	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD WITH REQUESTED DME ITEM(S) AND DOCUMENT IF THE CLIENT CAN USE SAFELY AND INDEPENDENTLY.
PC35	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD AND DESCRIBE THE RESULTS AND EFFECTIVENESS OF THE SERVICE REQUESTED.
PC39	PLEASE INDICATE LITER FLOW PER MINUTE, HOURS OF USE PER 24 HOUR PERIOD, AND THE EXPECTED DURATION OF NEED.
PC40	THE ITEM DOES NOT REQUIRE PRIOR AUTHORIZATION UNTIL THE LIFE EXPECTANCY HAS BEEN REACHED.
PC41	PLEASE SUPPLY INFORMATION INDICATING THE NECESSITY OF POSITIONING THE CLIENT'S BODY IN MULTIPLE POSITIONS.
PC42	PLEASE INDICATE IF THE BED HEIGHT MUST BE CHANGED TO ALLOW FOR SAFE TRANSFER OR ADEQUATE BED CARE.
PC43	SUPPLY A PHYSICIANS STATEMENT INDICATING TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR UNIT HAS REDUCED PAIN, IMPROVED/INCREASED THE CLIENTS ACTIVITY LEVEL, AND/OR REDUCED CLIENTS USE OF PAIN MEDICATION.
PC44	A CURRENT AUTHORIZATION FOR THIS SERVICE IS ON FILE FOR ANOTHER PROVIDER. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT OF THAT FACT IS REQUIRED BY THE CLIENT OF FIRST PROVIDER.
PC59	DOCUMENT DECLINE OR PROGRESS IN SPECIFIC, MEASURABLE, OBJECTIVE TERMS.
PC60	DOCUMENT IF CLIENT HAS DEMONSTRATED A GOOD APPOINTMENT COMPLIANCE RECORD.
PC61	THE PHYSICIANS SIGNATURE DATE MUST NOT EXCEED 90 DAYS FROM THE DATE OF RECEIPT BY COLORADO MEDICAID.
PC62	REQUESTS FOR A CONTINUATION OF THERAPY SHOULD NOT BE SUBMITTED MORE THAN FOUR WEEKS PRIOR TO THE EXPIRATION DATE OF THE CURRENT AUTHORIZATION.
PC63	PLEASE FURNISH THE STYLE AND MANUFACTURER OF THE FRAME.
PC64	PLEASE FURNISH THE CLIENTS LENS FORMULA.
PC66	ALL REQUESTS FOR TINTS REQUIRE DOCUMENTATION OF THE VISUAL OR MEDICAL CONDITION RELATED TO PHOTOPHOBIA.
PC67	PLEASE DOCUMENT THE REASON AND JUSTIFICATION FOR REPLACEMENT BEYOND THE FIRST LENS/FRAME.
PC68	DOCUMENT IF ALL REMAINING MAXILLARY AND/OR MANDIBULAR TEETH ARE DECAY-FREE, PROPERLY RESTORED, AND PERIODONTICALLY SOUND.
PC72	SUPPLY MORE DETAIL REGARDING PROGRESS (ATTACHMENT OF GOALS, ETC.). CORRELATE PROGRESS TO PREVIOUS GOALS AND IDENTIFIED LIMITATIONS.
PC77	PLEASE SUBMIT A PLAN OF CARE DESCRIBING THE SERVICES THAT WOULD BE PROVIDED.
PC78	PLEASE DOCUMENT SPECIFIC, MEASURABLE GOALS.
PC82	THE PRIOR AUTHORIZATION (PA) SYSTEM CAN PROCESS ONLY 26 DETAILS PER PA REQUEST. PLEASE RESUBMIT YOUR REQUEST WITH NO MORE THAN 26 DETAILS.
PC83	PLEASE SUPPLY A PHYSICIANS PRESCRIPTION DATED WITHIN ONE MONTH OF REQUESTED SUBSTANCE ABUSE DAY TREATMENT.

Denial Code	Long Description
PC84	PLEASE PROVIDE INFORMATION INDICATING THIS CLIENT IS APPROPRIATELY DETOXIFIED FROM ALCOHOL AND/OR OTHER DRUGS.
PC85	PLEASE PROVIDE INFORMATION TO INDICATE THE CLIENTS ABILITY TO ABSTAIN FROM ALCOHOL OR DRUGS WHILE IN THE SUBSTANCE ABUSE DAY TREATMENT PROGRAM.
PC86	PLEASE INDICATE IF THIS CLIENT IS WILLING TO PARTICIPATE IN AFTERCARE OR CONTINUING CARE SERVICES.
PC87	PROVIDE MORE INFORMATION ON TREATMENT HISTORY; INCLUDE SERVICE PROVIDED, DATES, AND OUTCOME. PROVIDE DETAIL OF PREVIOUS TREATMENT.
PC88	PLEASE PROVIDE MORE RATIONALE FOR THE APPROPRIATENESS AND MEDICAL NECESSITY OF SUBSTANCE ABUSE DAY TREATMENT.
PC89	PROVIDE A TREATMENT PLAN THAT CONTAINS MEASURABLE GOALS AND OBJECTIVES CORRESPONDING TO THE IDENTIFIED DEFICIT.
PC91	PLEASE PROVIDE MORE INFORMATION ON FAMILY INVOLVEMENT TREATMENT.
PC92	PLEASE PROVIDE MORE HISTORY AND EXPLANATION ABOUT THE ISSUE OF ABSTINENCE FOR THIS CLIENT.
PC94	PLEASE PROVIDE THE ANTICIPATED BEGINNING DATE AND/OR THE ESTIMATED SUBSTANCE ABUSE DAY TREATMENT DISCHARGE DATE.
PC95	PLEASE SUPPLY JUSTIFICATION FOR BEGINNING CLIENT IN SERVICE PRIOR TO AUTHORIZATION BEING OBTAINED.
PC96	THE INITIAL THREE HOURS OF SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IN A CALENDAR YEAR DO NOT REQUIRE PRIOR AUTHORIZATION.
PC97	REIMBURSEMENT FOR INITIAL SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IS LIMITED TO THREE HOURS IN A CALENDAR YEAR AND DOES NOT REQUIRE PRIOR AUTHORIZATION.
PC98	THIS DRUG IS CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE BILL USING THE APPROPRIATE NATIONAL DRUG CODE (NDC) OR SUBMIT A COMPLETED DRUG ADDITION REQUEST FORM IF THE NDC IS NOT LISTED IN THE DRUG INDEX.
PC99	THIS DRUG IS NOT CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL, CURRENT ADMINISTRATIVE RULE, OR COLORADO DRUG INDEX FOR COVERAGE LIMITATIONS.
PD01	DOCUMENT THAT CLIENT HAS ACHIEVED GOOD ORAL HYGIENE, PERIODONTAL CASE TYPE 1 OR 2, AND IS MOTIVATED TO MAINTAIN SAME.
PD03	PLEASE PROVIDE AN ARTERIAL BLOOD GAS READING OR PULSE OXIMETRY RESULTS DONE ON ROOM AIR SIGNED AND DATED BY A MEDICAL DOCTOR. THIS SHOULD BE DONE WITHIN 60 DAYS OF REQUESTED SERVICE.
PD04	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 30 DAYS OF RECEIPT BY COLORADO MEDICAID.
PD07	SUBMIT A PHOTOCOPY OF A VALID PRESCRIPTION, ISSUED WITHIN THE PAST YEAR, OR COMPLETE SECTION B OF THE PRIOR AUTHORIZATION/DRUG ATTACHMENT (PA/DGA), F-11049.
PD10	BRAND MEDICALLY NECESSARY MUST BE IN THE PRESCRIBERS OWN HANDWRITING AND WRITTEN DIRECTLY ON THE PRESCRIPTION OR A SEPARATE ORDER ATTACHED TO THE ORIGINAL PRESCRIPTION.
PD12	COMPLETE DENTURES, PARTIAL DENTURES, DENTURE RELINES, AND FIXED PROSTHODONTIC SERVICES ARE NOT COVERED SERVICES FOR ADULTS FOR DATES OF SERVICE ON AND AFTER OCTOBER 1, 1995.
PD22	PLEASE COMPLETE ALL REQUIRED ELEMENTS ON THE PERSONAL CARE SCREENING TOOL (PCST), F-11133.
PD24	THIS PRIOR AUTHORIZATION REQUEST IS UNABLE TO BE PROCESSED. PLEASE RESUBMIT WITH ADDITIONAL REQUIRED FORMS, INCLUDING THE ENTIRE PERSONAL CARE SCREENING TOOL (PCST), F-11133; PERSONAL CARE ADDENDUM, F-11136; AND SUPPORTING DOCUMENTATION, AS DIRECTED.
PD25	THERE IS A PERSONAL CARE SCREENING TOOL (PCST), F-11133, COMPLETED BY ANOTHER AGENCY. CONTACT THE AGENCY TO TRANSFER SCREEN.
PD26	THERE IS A LIMITED TERM CARE FUNCTIONAL SCREEN (LTC-FS) COMPLETED BY ANOTHER AGENCY. THE PERSONAL CARE SCREENING TOOL (PCST), F-11133, INFORMATION IS IN CONFLICT WITH LTC-FS.
PD27	ONLY ONE LEVEL OF FUNCTION MAY BE SELECTED FOR ALL ELEMENTS EXCEPT TOILETING. COLORADO MEDICAID IS UNABLE TO PROCESS THE PRIOR AUTHORIZATION REQUEST.
PD28	NO UNITS MAY BE REQUESTED USING THIS PRIOR AUTHORIZATION PROCESS. PLEASE SUBMIT WITH THE APPROPRIATE ATTACHMENTS FOR REQUESTING SPECIFIC PERSONAL CARE WORKER UNITS.

Denial Code	Long Description
PD29	CLIENT IS NOT ELIGIBLE FOR THE REQUESTED SERVICE(S) AS OF THE REQUESTED START DATE.
PD30	NO TRAVEL TIME MAY BE AUTHORIZED WHEN NO PERSONAL CARE WORKER SERVICE IS AUTHORIZED.
PD32	PROVIDER NOT CERTIFIED TO RENDER THE SERVICE(S) REQUESTED.
PD34	BASED ON THE DOCUMENTATION SUBMITTED, THIS REQUEST CAN NOT BE PRIOR AUTHORIZED. REFER TO THE PA MESSAGES FROM THE CONSULTANT FOR COMPLETE EXPLANATION.
PD98	PLEASE DOCUMENT HOW AND WHEN EACH PREVIOUSLY AUTHORIZED PRO RE NATA VISIT WAS USED.

Mental Health Day Treatment

Denial Code	Long Description
0201	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
0233	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0235	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0237	CLIENT IDENTIFICATION NUMBER DOES NOT MATCH CLIENTS FIRST NAME.
0238	THE CLIENT IDENTIFICATION NUMBER DOES NOT MATCH THE CLIENTS LAST NAME.
0242	SECONDARY DIAGNOSIS CODE IS INVALID.
0248	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0249	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0251	PROCEDURE CODE MODIFIER IN FIRST POSITION IS INVALID.
0252	THE PROCEDURE CODE MODIFIER IN SECOND POSITION IS INVALID FOR REQUESTED START DATE OR DATE OF RECEIPT.
0253	THE PROCEDURE CODE MODIFIER IN THIRD POSITION IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
0258	THE PRIMARY DIAGNOSIS CODE IS REQUIRED.
0272	THE PRIMARY DIAGNSOSIS CODE IS INVALID.
0400	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0853	HCPCS - ANNUAL UPDATE
0885	NEVER EVENTS MODIFIERS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
0886	NEVER EVENTS DIAGNOSIS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
1000	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
1002	RENDERING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1003	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1007	RENDERING PROVIDER ID IS NOT ON FILE.
1047	THE RENDERING PROVIDERS CERTIFICATION HAS BEEN CANCELLED.
1048	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1801	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
1804	A CERTIFIED SUBSTANCE ABUSE DAY TREATMENT PROVIDER MUST SUBMIT A SUBSTANCE ABUSE DAY TREATMENT PROCEDURE CODE.
1806	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
1808	THE BILLING PROVIDER DOES NOT HAVE THE REQUIRED CERTIFICATION ADDENDUM ON FILE.
1900	THE BILLING PROVIDERS TAXONOMY CODE IS INVALID.
1901	THE RENDERING PROVIDERS TAXONOMY CODE IS INVALID.
1927	A NATIONAL PROVIDER IDENTIFIER IS REQUIRED FOR THE BILLING PROVIDER.
1934	A NATIONAL PROVIDER INDENTIFIER IS REQUIRED FOR THE RENDERING PROVIDER.
1936	THE BILLING PROVIDER NUMBER IS INVALID.
1937	THE RENDERING PROVIDER NUMBER IS INVALID.
1960	INTERNAL PROCESSING IS REQUIRED.
1963	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.

Denial Code	Long Description
1964	THE BILLING PROVIDER INDICATED IS NOT ALLOWABLE AS A BILLING PROVIDER.
1965	RENDERING PROVIDER NUMBER IS MISSING/INVALID FOR THIS PROCEDURE PROVIDER.
1974	PRESCRIBING/REFERRING/ORDERING PROVIDER INDICATED IS NOT CERTIFIED AS A PRESCRIBING/REFERRING/ORDERING PROVIDER.
1975	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
1976	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
2001	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2003	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2017	THE CLIENT IS ENROLLED IN A MEDICAID OR OTHER MANAGED CARE PROGRAM.
2037	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2603	CLIENT LOCKED-IN TO A PROVIDER OR ENROLLED IN A HOSPICE. CONTACT CLIENTS HOSPICE FOR PAYMENT OF SERVICES OR RESUBMIT WITH DOCUMENTATION OF UNRELATED NATURE OF CARE.
3324	THE MODIFIER HAS BEEN DISCONTINUED BY THE CENTERS OF MEDICARE AND MEDICAID SERVICES OR THE AMERICAN MEDICAL ASSOCIATION FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
3337	THE PROCEDURE CODE HAS BEEN TERMINATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AMERICAN MEDICAL ASSOCIATION, OR AMERICAN DENTAL ASSOCIATION FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT. RESUBMIT WITH VALID A PROCEDURE CODE.
3339	THE PROCEDURE BILLED IS NOT PAYABLE ACCORDING TO DEFICIT REDUCTION ACT (DEFRA) GUIDELINES.
3351	THE PROCEDURE IS NOT COVERED FOR CLIENTS WITH A NURSING HOME AUTHORIZATION ON THE REQUESTED START DATE OR DATE OF RECEIPT.
3353	THE PROCEDURE IS NOT A COVERED SERVICE FOR HOME AND COMMUNITY-BASED WAIVER CLIENTS.
4021	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4027	THE DIAGNOSIS CODE IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
4031	THE PROCEDURE SUBMITTED IS NOT APPROPRIATE FOR CLIENTS GENDER.
4032	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4034	THE PROCEDURE CODE HAS AN AGE RESTRICTION.
4036	THE PLACE OF SERVICE CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4040	THE PRIMARY DIAGNOSIS CODE IS NOT ON FILE.
4041	THE SECONDARY DIAGNOSIS IS NOT ON FILE.
4046	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4127	INTERNAL PROCESSING IS REQUIRED.
4131	INTERNAL PROCESSING IS REQUIRED.
4141	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4149	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4150	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4236	ETIOLOGY DIAGNOSIS CODE(S) (E-CODES) ARE INVALID AS THE PRIMARY DIAGNOSIS.
4244	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4245	THE FOURTH POSITION MODIFIER IS INVALID FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT.
4256	THE PROCEDURE CODE AND MODIFIER COMBINATION IS NOT PAYABLE FOR THE CLIENTS BENEFIT PLAN.
4257	THE MODIFIERS SUBMITTED ARE EITHER INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT OR THE MODIFIERS ARE MISSING.
4311	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4315	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4316	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4371	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4372	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4711	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR CLIENTS AGE.
4714	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS AGE.
4731	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS DIAGNOSIS.
4742	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4743	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4744	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.

Denial Code	Long Description
4745	DIAGNOSIS AND/OR PROCEDURE AND/OR PLACE OF SERVICE (POS) CODE IS NOT COVERED FOR EXPRESS ENROLLMENT CLIENTS.
4746	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4801	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4802	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
4821	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
4871	PLEASE REFER TO PA MESSAGES FOR RETURN INFORMATION.
4963	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS GENDER.
4990	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
7500	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
7509	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
P001	THE BILLING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THE SERVICES.
P002	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P003	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P005	THE PRIOR AUTHORIZATION CAN NOT BE END DATED. THE PRIOR AUTHORIZATION STATUS IS NOT APPROVED OR APPROVED WITH REVISIONS.
P006	PLEASE FURNISH THE PROCEDURE CODE AND CORRESPONDING DESCRIPTION.
P008	THE BILLING PROVIDER NUMBER IS INVALID.
P009	THE BILLING PROVIDER NUMBER IS INVALID.
P010	THE REQUESTED END DATE IS INVALID.
P011	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P012	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P013	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P014	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P015	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P016	THE REQUESTED START DATE IS MISSING OR INVALID.
P019	THE REQUESTED START DATE IS MISSING OR INVALID.
P020	THE RENDERING PROVIDER NUMBER IS INVALID.
P021	THE RENDERING PROVIDER NUMBER IS INVALID.
P022	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P023	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P024	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P026	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P027	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P030	FIRST MODIFIER IS INVALID.
P031	FIRST MODIFIER IS INVALID.
P032	SECOND MODIFIER IS INVALID.
P033	SECOND MODIFIER IS INVALID.
P034	THIRD MODIFIER IS INVALID.
P035	THIRD MODIFIER IS INVALID.
P036	FOURTH MODIFIER IS INVALID.
P037	FOURTH MODIFIER IS INVALID.
P038	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P039	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.

Denial Code	Long Description
P040	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P041	CLIENTS FIRST NAME IS MISSING.
P042	CLIENTS LAST NAME IS MISSING.
P043	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P044	BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES REQUESTED.
P045	FIRST MODIFIER IS INVALID.
P046	SECOND MODIFIER IS INVALID.
P047	THIRD MODIFIER IS INVALID.
P048	FOURTH MODIFIER IS INVALID.
P052	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P053	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P054	RENDERING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES FOR THE BENEFIT PLAN.
P055	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P061	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P062	THE CLIENT ID AND/OR NAME INDICATED ON THE PA REQUEST IS INCORRECT. THE CLIENT ID AND/OR NAME HAS BEEN UPDATED. PLEASE VERIFY THE ID AND/OR NAME IS CORRECT.
P064	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
P067	THE FREQUENCY OF HOURS REQUESTED ARE NOT APPROPRIATE FOR THIS CLIENT AND HAVE BEEN MODIFIED ACCORDINGLY.
P079	BILLING PROVIDER IS ON PAYMENT SUSPENSION DUE TO CREDIBLE ALLEGATION OF FRAUD.
P120	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAS BEEN REDUCED.
P121	THE SERVICE/ PROCEDURE REQUESTED IS NOT SUPPORTED BY SUBMITTED DOCUMENTATION.
P126	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
P128	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.
P138	SERVICE(S) DO NOT MEET COLORADO MEDICAID GUIDELINES.
P167	REQUESTED DOCUMENTATION HAS NOT BEEN SUBMITTED.
P178	THE SERVICE REQUESTED IS NOT MEDICALLY NECESSARY.
P179	THE MEDICAL NECESSITY FOR THIS SERVICE IS NOT SUPPORTED BY THE SUBMITTED DOCUMENTATION.
P233	THE DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE ADDITIONAL CARE.
P257	THIS CLIENTS FUNCTIONAL ASSESSMENT SCORES PLACE THIS CLIENT OUTSIDE ELIGIBILITY FOR DAY TREATMENT.
P274	OUR RECORDS INDICATE THIS CLIENT IS INVOLVED IN EFFECTIVE AND APPROPRIATE SERVICE ELSEWHERE.
P292	INTENSIVE REHABILITATION HOURS ARE NO LONGER APPROPRIATE AS INDICATED BY HISTORY, DIAGNOSIS, AND/ OR FUNCTIONAL ASSESSMENT SCORES.
P328	THE SERVICES REQUESTED INCLUDE NON-COVERED SERVICES, AND HOURS ARE REDUCED ACCORDINGLY.
P339	THE CLIENTS PAST HISTORY INDICATES REDUCED TREATMENT HOURS ARE WARRANTED.
P342	THE REQUEST DOES NOT MEET GENERALLY ACCEPTED CONDITIONS REQUIRING FLUORIDE TREATMENTS.
P346	SERVICES EXCEED COLORADO MEDICAID LIMITATION AND DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE MEDICAL NECESSITY OF THE SERVICE.
P349	THE SERVICE REQUESTED WAS PERFORMED LESS THAN FIVE YEARS AGO.
P353	THE EXISTING APPLIANCE HAS NOT BEEN WORN FOR THREE YEARS.
P367	THE CLIENT HAS BEEN TOTALLY WITHOUT TEETH AND AN APPLIANCE FOR FIVE YEARS.
P392	THE CLIENT IS MISSING AN ANTERIOR TOOTH AND/OR HAS TWO OR MORE POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P405	THE SERVICE(S) REQUESTED COULD ADEQUATELY BE PERFORMED IN THE DENTAL OFFICE.
P406	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE OF GOOD PERIODONTAL HEALTH (AMERICAN ACADEMY OF PERIODONTOLOGY PERIODONTAL CLASSIFICATION OF TYPE I OR II).
P407	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE VISIBLE ON RADIOGRAPHS THAT AT LEAST 50 PERCENT OF THE CLINICAL CROWN IS INTACT.

Denial Code	Long Description
P409	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING SIX OR MORE TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED, INCLUDING THIRD MOLARS.
P410	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING ONE OR MORE ANTERIOR TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED.
P411	DOCUMENTATION DOES NOT SUPPORT THE NEED FOR PERIODONTIC SERVICES. POCKETS ARE LESS THAN 4MM AND/OR GREATER THAN 6MM FOR CLIENT AND/OR THE CLIENT IS UNDER THE AGE OF 13.
P412	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA.
P413	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA. THIS PA HAS BEEN GRANTED AS APPROVED NOT APPROVED WITH REVISIONS. THE DURATION REQUESTED MAY HAVE BEEN REDUCED TO REFLECT COVERAGE LIMITATIONS, PRESCRIBER ORDERS, CONFLICTI
P417	THE SERVICE(S) REQUESTED COULD BE ADEQUATELY PERFORMED WITH LOCAL ANESTHESIA.
P437	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO POOR ORAL HYGIENE.
P444	THIS LINE ITEM IS A DUPLICATE OF ANOTHER LINE ITEM ON THIS PRIOR AUTHORIZATION (PA) REQUEST. PLEASE CORRECT.
P446	THIS IS A DUPLICATE OF AN EXISTING PRIOR AUTHORIZATION (PA) REQUEST. YOU MAY CONTACT PROVIDER SERVICES IF YOU REQUIRE ASSISTANCE. DUPLICATE PA REQUEST
P448	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO DECAY HISTORY.
P449	QUESTIONABLE LONG TERM PROGNOSIS DUE TO GUM AND BONE DISEASE.
P456	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO APPARENT ROOT INFECTION.
P457	OUR RECORDS INDICATE THIS CLIENT HAS EXCEEDED ESTABLISHED PROGRAM LIMITATIONS. COLORADO MEDICAID WILL NOT AUTHORIZE NEW DENTURES.
P458	DOCUMENTATION PROVIDED INDICATES A LESS ELABORATE PROCEDURE SHOULD BE CONSIDERED.
P502	RENTAL ONLY ALLOWED; MEDICAL NEED FOR PURCHASE HAS NOT BEEN DOCUMENTED.
P503	PURCHASE ONLY ALLOWED; MEDICAL NEED FOR RENTAL HAS NOT BEEN DOCUMENTED.
P504	OCCUPATIONAL THERAPY GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P505	THE SERVICE REQUESTED IS INCLUDED IN THE NURSING HOME RATE STRUCTURE.
P511	THIS NATIONAL DRUG CODE IS ONLY BILLABLE AS PART OF A COMPOUND DRUG.
P515	THE PRESENCE OF A HANDICAPPING MALOCCLUSION OR HANDICAPPING DENTOFACIAL DEFORMITY IS NOT SUPPORTED BY THE DOCUMENTATION SUBMITTED.
P521	THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVERED BY COLORADO MEDICAID.
P522	GASTRO-INTESTINAL SURGERY FOR THE PURPOSE OF WEIGHT CONTROL IS COVERED ONLY AS A LIFE THREATENING PROCEDURE.
P523	THE TREATMENT REQUEST IS NOT CONSISTENT WITH THE CLIENT'S DIAGNOSIS.
P524	PSYCHOTHERAPY PROVIDED IN THE CLIENTS HOME IS NOT A COVERED BENEFIT OF COLORADO MEDICAID.
P525	THE INFORMATION PROVIDED IS NOT CONSISTENT WITH THE INTENSITY OF SERVICES REQUESTED.
P526	INTENSIVE MULTIPLE MODALITY TREATMENT IS NOT CONSISTENT WITH THE INFORMATION PROVIDED.
P527	MULTIPLE PROVIDERS OF TREATMENT ARE NOT INDICATED FOR THIS CLIENT.
P528	THE DURATION OF TREATMENT SESSIONS EXCEED CURRENT COLORADO MEDICAID GUIDELINES.
P534	DOCUMENTATION OF POOR PHYSICAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P535	OTHER PHYSICAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P536	THE PHYSICAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P537	USE OF PHYSICAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P538	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF A PHYSICAL THERAPIST.
P539	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS AND LIVING ARRANGEMENT.
P540	GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P541	THE PROCEDURE(S) REQUESTED ARE NOT MEDICAL IN NATURE.

Denial Code	Long Description
P542	DOCUMENTATION OF POOR OCCUPATIONAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P543	DOCUMENTATION OF POOR SPEECH THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P544	OTHER OCCUPATIONAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P546	THE OCCUPATIONAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P547	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF PHYSICAL THERAPY.
P548	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P549	ACTIVITIES TO PROMOTE DIVERSION OR GENERAL MOTIVATION ARE NONCOVERED COLORADO MEDICAID SERVICES.
P550	REVISIONS OF THE REQUEST IS NECESSITATED BY THE CLIENTS MINIMAL PROGRESS.
P551	RESTORATIVE NURSING INVOLVEMENT COULD BE INCREASED.
P552	CLIENTS DEMONSTRATED RESPONSE TO CURRENT THERAPY DOES NOT WARRANT THE INTENSE FREQUENCY REQUESTED.
P553	MAINTENANCE IS TWO TIMES PER WEEK OR LESS.
P554	THE SPEECH THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P555	USE OF OCCUPATIONAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P556	USE OF SPEECH THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P557	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF AN OCCUPATIONAL THERAPIST.
P558	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
P559	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P560	THE MATERIALS/ SERVICES REQUESTED ARE PRINCIPALLY COSMETIC IN NATURE.
P561	THE LENS FORMULA DOES NOT JUSTIFY REPLACEMENT.
P562	THE CHANGE IN THE LENS FORMULA DOES NOT WARRANT MULTIPLE REPLACEMENTS.
P563	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P564	LENSES ONLY ARE APPROVED; PLEASE DISPENSE A CONTRACTED FRAME. THE NON-CONTRACTED FRAME IS NOT MEDICALLY JUSTIFIED.
P565	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P566	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P567	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF OCCUPATIONAL THERAPY.
P568	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF SPEECH THERAPY.
P569	LEVEL, INTENSITY, OR EXTENT OF SERVICE(S) REQUESTED HAS BEEN MODIFIED CONSISTENT WITH MEDICAL NEED AS DEFINED IN THE PLAN OF CARE.
P570	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P571	THE SERVICE ASKED FOR IS NOT COVERED BY COLORADO MEDICAID AS THESE TASKS CAN BE DONE BY NURSES OR ACTIVITY STAFF.
P572	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P573	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.
P574	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P575	MEDICAL NEED FOR EQUIPMENT/ SUPPLY REQUESTED IS NOT SUPPORTED BY DOCUMENTATION SUBMITTED.
P576	OTHER SPEECH THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.

Denial Code	Long Description
P577	DOCUMENTATION SUBMITTED IDENTIFIES THAT THE CLIENT HAS FEWER THAN TWO POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P582	LESS EXPENSIVE ALTERNATIVE SERVICES ARE AVAILABLE FOR THIS CLIENT.
P634	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P711	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING PERIODONTAL SCALING AND ROOT PLANNING.
P712	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING GINGIVECTOMY.
P754	AN APPROVED SUBSTANCE ABUSE DAY TREATMENT PROGRAM CANNOT EXCEED A SIX WEEK PERIOD.
P761	THE CLIENT DOES NOT APPEAR TO BE ABLE OR WILLING TO ABSTAIN FROM ALCOHOL/DRUG USAGE WHILE IN TREATMENT. THEREFORE, SUBSTANCE ABUSE DAY TREATMENT SERVICES ARE NOT APPROVED.
P764	THIS CLIENT HAS COMPLETED INTENSIVE SUBSTANCE ABUSE TREATMENT WITHIN THE PAST 12 MONTHS. THE DOCUMENTATION PROVIDED IS NOT ADEQUATE TO JUSTIFY ADDITIONAL INTENSIVE TREATMENT AT THIS TIME.
P785	A LESS THAN SIX-WEEK HEALING PERIOD HAS BEEN SPECIFIED FOR THIS PRIOR AUTHORIZATION. THEREFORE IT IS NOT NECESSARY TO WAIT THE FULL SIX WEEKS AFTER EXTRACTIONS BEFORE TAKING DENTURE IMPRESSIONS.
P818	SIX-WEEK HEALING TIME IS REQUIRED BETWEEN EDENTULATION AND FINAL IMPRESSIONS. PAYMENT FOR DENTURES WILL BE DENIED OR RECOUPED IF HEALING PERIOD IS NOT OBSERVED.
P849	COLORADO MEDICAID HAS DETERMINED THERE WERE (ARE) SEVERAL HOME HEALTH AGENCIES WILLING TO PROVIDE MEDICALLY NECESSARY SKILLED NURSING SERVICES TO THIS CLIENT.
P864	THE DOCUMENTATION YOU HAVE SUBMITTED DOES NOT MEET THE REQUIREMENTS OF COLORADO MEDICAID.
P873	THE MEDICAL NECESSITY FOR THE HOURS REQUESTED IS NOT SUPPORTED BY THE INFORMATION SUBMITTED.
P874	THE DOCUMENTATION SUBMITTED INDICATES THE TASKS SPECIFIED CAN BE COMPLETED DURING THE VISITS APPROVED.
P878	THE DOCUMENTATION SUBMITTED DOES NOT INDICATE THAT MEDICALLY ORIENTED TASKS ARE MEDICALLY NECESSARY; THEREFORE PERSONAL CARE SERVICES HAVE BEEN APPROVED.
P880	THE QUANTITY OF SERVICES AUTHORIZED FOR THIS CLIENTS PERSONAL CARE HAS BEEN AMENDED BASED ON INFORMATION RECEIVED FROM ONE OR MORE OF THESE SOURCES: THE CLIENT, THEIR PHYSICIAN, AND/OR THE IN-HOME VISIT BY STAFF OF THE OIG (OFFICE OF INSPECTOR GENERAL).
P885	THE USE OF THIS DRUG FOR THE INTENDED PURPOSE IS NOT COVERED BY COLORADO MEDICAID, CONSISTENT WITH COLORADO ADMINISTRATIVE CODE AND FEDERAL LAW.
P924	THE MEDICAL RECORDS SUBMITTED WITH THE CURRENT REQUEST CONFLICT OR DISAGREE WITH OUR MEDICAL RECORDS ON THIS CLIENT.
P950	INDEPENDENT NURSES, PLEASE NOTE PAYABLE SERVICES MAY NOT EXCEED 12 HOURS/DAY OR 60 HOURS/WEEK.
P951	SERVICES CAN ONLY BE AUTHORIZED THROUGH ONE YEAR FROM THE PRESCRIPTION DATE.
P952	LEAD INSPECTION IS A COVERED COLORADO MEDICAID SERVICE WHEN THE CHILD HAS BEEN SHOWN TO HAVE LEAD POISONING (E.G., CHILD HAS A BLOOD LEAD LEVEL > 19 UG/DL OR TWO CONSECUTIVE BLOOD LEAD LEVELS OF 15-19 UG/DL DONE AT LEAST 90 DAYS APART). THE INSPECTION MUS
P953	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P954	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P956	THE REQUEST CAN ONLY BE BACKDATED A MAXIMUM OF 14 DAYS FROM FIRST DATE RECEIVED BY COLORADO MEDICAID.
P957	COMPLETE PERIODONTAL CHARTING AT TIME OF SERVICE, AND SUBMIT CHARTING, COPY OF OPERATIVE REPORT, TOGETHER WITH A COPY OF THE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF), F-11035, TO PA UNIT ATTENTION DENTAL CONTSULTANT.
P958	NOTE THAT CODE D4341 HAS BEEN CHANGED. REFER TO THE DECISION NOTICE FOR AUTHORIZED QUANTITY.

Denial Code	Long Description
P960	YOUR PA HAS BEEN APPROVED FOR 90 DAYS. THE 90 DAY APPROVAL DOES NOT IMPLY THE PA REQUEST MEETS PRIOR AUTHORIZATION CRITERIA. AFTER ADDITIONAL INFORMATION IS AVAILABLE IN INTERCHANGE, COLORADO MEDICAID WILL CREATE AN AMENDMENT REQUEST TO EXTEND THE PA FOR
P961	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P962	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
PA10	THE REQUESTED END DATE IS INVALID.
PA12	PLEASE FURNISH A WRITTEN DESCRIPTION OF THE CLIENTS DIAGNOSIS.
PA13	PROVIDE DIAGNOSES WITH DATES OF ONSET.
PA14	IDENTIFY PROBLEMS TO BE TREATED.
PA15	THE AUDIOLOGISTS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1), F-11020, AND PRIOR AUTHORIZATION REQUEST/HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2), F-11021.
PA16	THE PHYSICIANS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION/PHYSICIAN OTOLOGICAL REPORT (PA/POR), F-11019.
PA17	SUBMIT BRIEF HISTORY WITH REFERRAL INFORMATION, LIVING SITUATION, FUNCTIONAL STATUS, AND OTHER PERTINENT INFORMATION. WHAT CHANGE OF STATUS RESULTED IN REFERRAL AT THIS TIME?
PA18	PLEASE FURNISH THE CLIENTS HEIGHT AND WEIGHT.
PA19	PLEASE SUBMIT CLINICAL INFORMATION SUFFICIENT TO VERIFY THE NEED FOR THE REQUESTED SERVICE(S).
PA20	PLEASE RESUBMIT WITH COMPLETE PERIODONTAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PA21	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL EDUCATIONAL PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA22	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL PROGRAM PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA23	REFER TO THE DURABLE MEDICAL EQUIPMENT INDEX FOR APPROPRIATE CODE AND DESCRIPTION. DO NOT USE AN "UNLISTED" CODE.
PA24	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUALIZED FAMILY SERVICE PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA25	INFORMATION ON THE REQUEST FORM IS ILLEGIBLE, AND THE REQUEST CANNOT BE PROCESSED.
PA26	RE-EVALUATE YOUR GOALS. EMPHASIS SHOULD BE ON FUNCTIONAL SELF-CARE. GOALS MUST BE RELATED TO FUNCTIONAL OUTCOME.
PA27	PLEASE CLARIFY THE NUMBER OF HOURS PER WEEK REQUESTED.
PA28	PLEASE CLARIFY THE NUMBER OF HOURS PER DAY REQUESTED.
PA29	PLEASE CLARIFY THE NUMBER OF VISITS PER DAY REQUESTED.
PA30	ATTACH SUPPORTIVE DOCUMENTATION; HOME EXERCISE PROGRAM AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA31	THE DIAGNOSIS CODE INDICATED ON THE REQUEST DOES NOT CORRESPOND TO THE DIAGNOSIS CODE DESCRIPTION.
PA32	PLEASE SUBMIT ADDITIONAL INFORMATION SUFFICIENT TO VERIFY APPROPRIATENESS AND NEED FOR TRANSPLANT.
PA33	PLEASE SUBMIT THE INITIAL AND PROGRESSIVE OBJECTIVE FINDINGS.
PA34	ATTACH SUPPORTIVE DOCUMENTATION, FACILITY PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA35	PLEASE SUBMIT THE CLIENTS ORIGINAL COMPLAINTS AND EXAMINATION FINDINGS.
PA36	ATTACH SUPPORTIVE DOCUMENTATION, IN-HOME AUTISM PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA37	PLEASE SUBMIT YOUR TREATMENT PLAN FOR THIS CLIENT.
PA38	ATTACH SUPPORTIVE DOCUMENTATION AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.

Denial Code	Long Description
PA39	INITIAL EVALUATIONS MUST BE PERFORMED BY AN OCCUPATIONAL THERAPIST REGISTERED (OTR), PER AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA) STANDARDS.
PA41	IDENTIFY THE PLACE OF SERVICE AND ITS EFFECT ON SUPPORTING THE DESIRED TREATMENT OUTCOME.
PA42	PLEASE INDICATE THE HOURS OF USE OF OXYGEN PER 24-HOUR PERIOD.
PA43	PROVIDE BASELINE DOCUMENTATION FOR THIS CLIENTS LIMITATIONS USING UNITS OF MEASUREMENT THAT ARE APPLIED CONSISTENTLY WHEN REPORTING STATUS.
PA44	IDENTIFY FUNCTIONAL LIMITATIONS AS THEY ARE RELATED TO IDENTIFIED CONDITIONS.
PA46	CORRELATE PLAN OF CARE TO REQUESTED PROCEDURE CODES.
PA47	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE FREQUENCY/DURATION REQUESTED.
PA48	PLEASE PROVIDE THE NAME AND CREDENTIALS OF THE RENDERING PROVIDER.
PA50	COLORADO MEDICAID RECORDS INDICATE THE CLIENT OWNS A WHEELCHAIR. DOCUMENT THE REASON AND NEED FOR REPLACEMENT AND COST TO REPAIR CURRENT WHEELCHAIR.
PA51	PLEASE DISTINGUISH PRIMARY AND SUPPORTIVE MODALITIES.
PA52	PLEASE SUBMIT A PROGRESS REPORT.
PA53	MULTIPLE FAMILY CLIENTS TREATMENT BY THE SAME PROVIDER REQUIRES FURTHER INFORMATION DOCUMENTING COORDINATION OF TREATMENT PLAN.
PA54	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE MINUTES REQUESTED.
PA55	MEDICAL NECESSITY OF TREATMENT REQUIRES ADDITIONAL DOCUMENTATION.
PA56	GIVEN AGE, DIAGNOSES, CURRENT LEVEL OF FUNCTION, PAST RESPONSE TO TREATMENT, AND LIVING SITUATION, EXPAND ON POTENTIAL FOR SIGNIFICANT FUNCTIONAL PROGRESS WITHIN THE NEXT SIX MONTHS. EMPHASIZE WHY PROGRESS IS EXPECTED WITH SERVICES AT THIS TIME.
PA57	SUBMIT THE INITIAL FINDINGS. INCLUDE A COMPREHENSIVE EVALUATION.
PA58	SUBMIT PROGRESSIVE, OBJECTIVE FINDINGS. INCLUDE A PERTINENT RE-EVALUATION.
PA59	PLEASE SUPPLY INFORMATION REGARDING THE CLIENTS MEDICATION REQUIREMENTS, IF ANY.
PA60	PLEASE SPECIFY IF THE CLIENT IS IN AN EDUCATIONAL SETTING.
PA61	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA62	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
PA63	THE SKILLS OF A THERAPIST ARE PURPOSEFUL AND SKILLED INTERVENTIONS REQUIRED TO CONTINUALLY DESIGN, IMPLEMENT, REASSESS, MODIFY/GRADE, AND/OR DISCONTINUE A PLAN OF CARE IN A TIMELY MANNER, BASED ON THE COMPLEXITY OF THE CLIENTS MEDICAL CONDITION AND/OR CO
PA64	PLEASE SUBMIT A THERAPY PLAN OF CARE, INCLUDING A CURRENT, DATED EVALUATION.
PA65	A PLAN OF CARE SIGNED AND DATED BY THE PHYSICIAN IS REQUIRED.
PA66	THE SKILLS OF A THERAPIST ARE REQUIRED WHEN ONLY THE THERAPIST CAN SAFELY AND EFFECTIVELY DELIVER THE THERAPEUTIC PROCEDURES BECAUSE OF THEIR UNIQUE KNOWLEDGE, TRAINING, AND EXPERTISE. DESCRIBE THE REASON THAT SOMEONE OTHER THAN A THERAPIST CANNOT SAFELY
PA67	PLEASE SPECIFY IF THE CLIENTS WORK SITE DEMANDS GOOD BINAURAL HEARING.
PA68	DESCRIBE THE REASON, BASED ON THE CLIENTS COGNITIVE, PHYSICAL, COMMUNICATION, OR RESOURCE STATUS, THAT A HOME PROGRAM, EQUIPMENT, OR ENVIRONMENTAL ADAPTATIONS ALONE CANNOT MEET CLIENTS NEEDS.
PA69	PLEASE SPECIFY IF THE CLIENT HAS AN ACCOMPANYING DISABILITY THAT ADDS TO THE HEARING PROBLEM.
PA70	DISTINGUISH REQUESTED PROCEDURES AND GOALS FROM OTHER SERVICES THIS CLIENT RECEIVES. THEY MAY NOT BE DUPLICATIVE.
PA71	PLEASE INDICATE THE NUMBER OF DAYS REQUESTED.
PA73	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA74	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA75	PLEASE DOCUMENT CARRYOVER OF THE THERAPY PROGRAM TO NURSING.
PA76	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).

Denial Code	Long Description
PA79	PROVIDE EVIDENCE OF SIGNIFICANT FUNCTIONAL PROGRESS IN LAST SIX MONTHS.
PA84	THE GRANT DATE OF THIS REQUEST CANNOT BE PRIOR TO THE SIGNATURE DATE OF THE PRESCRIBING PHYSICIAN.
PA86	PROVIDE EVIDENCE OF SKILLS GAINED IN THERAPY CARRYING OVER TO OTHER SETTINGS WITHIN SIX MONTHS.
PA87	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE NUMBER OF SESSIONS REQUESTED.
PA88	THE REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL SCOPE OF PRACTICE.
PA89	PRIOR AUTHORIZATION IS NOT REQUIRED UNTIL LIMITATION OF SERVICE HAS BEEN REACHED.
PA91	PLEASE SUBMIT REQUIRED X-RAYS.
PA92	PLEASE PROVIDE AN EXPLANATION FOR THE MATERIAL SUBMITTED WITH THE REQUEST.
PA95	PLEASE DESCRIBE HOW THE PROVISION OF THIS SERVICE WOULD PREVENT INSTITUTIONALIZATION OF THE CLIENT.
PA96	COULD THE EXISTING DENTURE(S) BE RELINED OR REBASED? IF NOT, PLEASE EXPLAIN WHY NOT.
PA97	REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL STANDARDS OF PRACTICE.
PA98	PLEASE INDICATE IF THE CLIENT IS CURRENTLY BEING TUBE FED.
PB02	PLEASE PROVIDE THE REQUIRED DATED SIGNATURES ON THE ATTACHMENTS.
PB03	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING THE LOSS/DESTRUCTION/THEFT OF THE HEARING AID.
PB04	DESCRIBE THE CLIENTS ABILITY TO STAND OR AMBULATE SUFFICIENTLY TO ACCOMPLISH SELF-CARE ACTIVITIES.
PB07	PLEASE SUBMIT AN ORTHODONTIC STUDY MODEL OR DIAGNOSTIC CASTS.
PB09	PLEASE PROVIDE A PHOTOGRAPH OF THE INVOLVED AREA(S).
PB10	PLEASE PROVIDE AN ESTIMATION (IN GRAMS) OF THE TOTAL AMOUNT OF TISSUE TO BE RESECTED.
PB11	PLEASE SUBMIT THE PLAN OF CARE FOR CO-TREATMENT.
PB12	FURNISH A DETAILED DESCRIPTION FOR THE PROCEDURE CODE REQUESTED.
PB13	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB15	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB18	PLEASE COMPLETE THE ATTACHED OUT-OF-STATE PROVIDER DATA SHEET, F-11001, AND RESUBMIT.
PB20	A SIGNED AND DATED PRESCRIPTION IS REQUIRED WITHIN THREE MONTHS OF RECEIPT BY COLORADO MEDICAID FOR INITIAL REQUESTS AND WITHIN 12 MONTHS OF RECEIPT BY COLORADO MEDICAID FOR SUBSEQUENT REQUESTS.
PB21	PLEASE COMPLETE THE APPROPRIATE PRIOR AUTHORIZATION ATTACHMENT. CONTACT PROVIDER SERVICES OR THE PRIOR AUTHORIZATION UNIT FOR ASSISTANCE.
PB23	PHYSICAL THERAPY ASSISTANT NOTES AND ALL FORMS SUBMITTED MUST BE COSIGNED BY A REGISTERED PHYSICAL THERAPIST.
PB31	ARE YOU REQUESTING A COMPLETE APPLIANCE, OR REPLACEMENT PARTS?
PB32	THE PROCEDURE CODE INDICATED ON THE REQUEST DOES NOT MATCH THE DESCRIPTION OF SERVICE; PLEASE CORRECT AND RESUBMIT.
PB35	THE SERVICE REQUESTED DOES NOT REQUIRE PRIOR AUTHORIZATION.
PB41	PLEASE FURNISH A CURRENT MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT, F-11090 (DATED WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID).
PB45	THE CERTIFICATION PERIOD ON THE PLAN OF CARE (POC) DOES NOT COVER THE REQUESTED GRANT/START DATE. PLEASE RESUBMIT YOUR REQUEST WITH A NEW POC.
PB49	A CERTIFIED OCCUPATIONAL THERAPY ASSISTANTS NOTES MUST BE COSIGNED BY AN OCCUPATIONAL THERAPIST REGISTERED.
PB51	ADDITIONAL INFORMATION IS REQUIRED ON PRIOR AUTHORIZATION TO ENABLE PRICING.
PB54	REQUESTED SERVICES DO NOT MATCH SERVICES ON THE PHYSICIANS ORDERS.
PB59	PLEASE PROVIDE AN INDIVIDUAL EDUCATIONAL PLAN (IEP), WHICH HAS BEEN SIGNED BY THE PROVIDER NO EARLIER THAN NINE MONTHS PRIOR TO RECEIPT AT COLORADO MEDICAID; OTHERWISE, DOCUMENT WHY NO IEP EXISTS.
PB65	PLEASE FURNISH THE ANTICIPATED TOTAL CHARGES FOR THIS REQUEST.
PB66	A PHOTOCOPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED; THE DATE MUST BE WITHIN SIX MONTHS OF RECEIPT BY COLORADO MEDICAID.

Denial Code	Long Description
PB67	THE PRESCRIPTION DATE MUST INCLUDE MONTH, DAY, AND YEAR.
PB68	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID.
PB73	THE SERVICES IDENTIFIED ON THE PLAN OF CARE DO NOT APPEAR APPROPRIATE FOR THE PROCEDURE CODE(S) REQUESTED ON THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018.
PB74	THE CLIENT/PROVIDER DOES NOT HAVE RETROACTIVE ENROLLMENT.
PB75	THE REQUESTED START DATE IS MORE THAN 14 DAYS BEFORE OR 62 DAYS AFTER RECEIPT.
PB82	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
PB83	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A HOME HEALTH AIDE. PLEASE RESUBMIT AS A PERSONAL CARE WORKER OR PROVIDE ADDITIONAL DOCUMENTATION.
PB86	THE SERVICES REQUESTED ARE NOT BEING PROVIDED IN THE CLIENTS RESIDENCE. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL.
PB87	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A NURSE. PLEASE RESUBMIT AS A HOME HEALTH AIDE OR PROVIDE ADDITIONAL DOCUMENTATION.
PB92	PLEASE FURNISH THE CLIENTS COMPLETE ADDRESS.
PB94	IF THE CLIENT IS A RESIDENT OF A NURSING HOME, SUPPLY THE COMPLETE NAME AND ADDRESS OF THE NURSING HOME.
PB99	THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018, MUST BE SIGNED AND DATED.
PC01	PLEASE SUPPLY THE RENDERING PROVIDERS PROVIDER NUMBER.
PC03	THE DRUG ENFORCEMENT ADMINISTRATION NUMBER IS MISSING OR INVALID.
PC06	PLEASE DESCRIBE YOUR PROGRAM; INCLUDE ENTRY DATE, TERMINATION DATE, HOURS PER WEEK, AND NUMBER OF WEEKS OF PRIMARY INTENSIVE SERVICE REQUESTED.
PC07	PLEASE DESCRIBE YOUR "AFTERCARE/FOLLOW-UP" PLANS FOR THIS CLIENT.
PC08	PLEASE SUPPLY DOCUMENTATION OF PREVIOUS SUBSTANCE ABUSE SERVICES WITH DATE(S) AND OUTCOME.
PC09	PLEASE DESCRIBE IN DETAIL THE TREATMENT OBJECTIVES/GOALS FOR THIS CLIENT.
PC10	PLEASE DESCRIBE THE FAMILY SITUATION/DYNAMICS. EXPLAIN HOW THE FAMILY WILL BE INCORPORATED INTO THE CLIENTS PLAN OF CARE.
PC12	PLEASE EXPLAIN IF YOUR SERVICE ENCOURAGES THE CLIENT TO ATTEND SELF-HELP GROUPS.
PC13	PLEASE SUPPLY A SPECIFIC SCHEDULE OF ACTIVITIES, INCLUDING DAY, TIME OF DAY, LENGTH OF SESSION, AND SERVICE TO BE RENDERED DURING THAT TIME.
PC15	PLEASE FURNISH DIAGNOSTIC RATIONALE.
PC17	PLEASE DOCUMENT IF THE CLIENT EVER RECEIVED SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT.
PC19	PLEASE FURNISH MORE EXTENSIVE AND IN-DEPTH HISTORICAL AND PSYCHOSOCIAL DATA.
PC20	PLEASE SUPPLY THE DATE THE CLIENT BECAME TOTALLY ENDENTULOUS.
PC23	PLEASE SUBMIT A PHYSICIANS STATEMENT REGARDING THE MEDICAL NECESSITY OF DENTURES FOR THIS CLIENT. THE PHYSICIANS STATEMENT MUST DOCUMENT THE MEDICAL NEED FOR DENTURES.
PC24	THE SERVICE REQUESTED WAS PREVIOUSLY AUTHORIZED. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT INDICATING THIS FACT IS REQUIRED.
PC25	PLEASE SUPPLY SUFFICIENT MITIGATING CIRCUMSTANCES TO WARRANT THE CONSTRUCTION OF NEW DENTURES(S).
PC26	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
PC28	PLEASE SUBMIT A PHYSICIANS STATEMENT INDICATING DENTURES ARE NECESSARY FOR THIS NURSING HOME CLIENT.
PC29	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING LOSS OR DESTRUCTION OF DENTURE(S). INCLUDE SIGNED STATEMENT FROM CLIENT OR FACILITY DIRECTOR REGARDING HOW, WHEN AND WHERE LOST.
PC30	PLEASE PROVIDE COMPLETE INTRAORAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PC31	PLEASE DESCRIBE ANY RELATED DEFORMITIES OF THE FEET.
PC34	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD WITH REQUESTED DME ITEM(S) AND DOCUMENT IF THE CLIENT CAN USE SAFELY AND INDEPENDENTLY.
PC35	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD AND DESCRIBE THE RESULTS AND EFFECTIVENESS OF THE SERVICE REQUESTED.

Denial Code	Long Description
PC39	PLEASE INDICATE LITER FLOW PER MINUTE, HOURS OF USE PER 24 HOUR PERIOD, AND THE EXPECTED DURATION OF NEED.
PC40	THE ITEM DOES NOT REQUIRE PRIOR AUTHORIZATION UNTIL THE LIFE EXPECTANCY HAS BEEN REACHED.
PC41	PLEASE SUPPLY INFORMATION INDICATING THE NECESSITY OF POSITIONING THE CLIENT'S BODY IN MULTIPLE POSITIONS.
PC42	PLEASE INDICATE IF THE BED HEIGHT MUST BE CHANGED TO ALLOW FOR SAFE TRANSFER OR ADEQUATE BED CARE.
PC43	SUPPLY A PHYSICIANS STATEMENT INDICATING TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR UNIT HAS REDUCED PAIN, IMPROVED/INCREASED THE CLIENTS ACTIVITY LEVEL, AND/OR REDUCED CLIENTS USE OF PAIN MEDICATION.
PC44	A CURRENT AUTHORIZATION FOR THIS SERVICE IS ON FILE FOR ANOTHER PROVIDER. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT OF THAT FACT IS REQUIRED BY THE CLIENT OF FIRST PROVIDER.
PC59	DOCUMENT DECLINE OR PROGRESS IN SPECIFIC, MEASURABLE, OBJECTIVE TERMS.
PC60	DOCUMENT IF CLIENT HAS DEMONSTRATED A GOOD APPOINTMENT COMPLIANCE RECORD.
PC61	THE PHYSICIANS SIGNATURE DATE MUST NOT EXCEED 90 DAYS FROM THE DATE OF RECEIPT BY COLORADO MEDICAID.
PC62	REQUESTS FOR A CONTINUATION OF THERAPY SHOULD NOT BE SUBMITTED MORE THAN FOUR WEEKS PRIOR TO THE EXPIRATION DATE OF THE CURRENT AUTHORIZATION.
PC63	PLEASE FURNISH THE STYLE AND MANUFACTURER OF THE FRAME.
PC64	PLEASE FURNISH THE CLIENTS LENS FORMULA.
PC66	ALL REQUESTS FOR TINTS REQUIRE DOCUMENTATION OF THE VISUAL OR MEDICAL CONDITION RELATED TO PHOTOPHOBIA.
PC67	PLEASE DOCUMENT THE REASON AND JUSTIFICATION FOR REPLACEMENT BEYOND THE FIRST LENS/FRAME.
PC68	DOCUMENT IF ALL REMAINING MAXILLARY AND/OR MANDIBULAR TEETH ARE DECAY-FREE, PROPERLY RESTORED, AND PERIODONTICALLY SOUND.
PC72	SUPPLY MORE DETAIL REGARDING PROGRESS (ATTACHMENT OF GOALS, ETC.). CORRELATE PROGRESS TO PREVIOUS GOALS AND IDENTIFIED LIMITATIONS.
PC77	PLEASE SUBMIT A PLAN OF CARE DESCRIBING THE SERVICES THAT WOULD BE PROVIDED.
PC78	PLEASE DOCUMENT SPECIFIC, MEASURABLE GOALS.
PC82	THE PRIOR AUTHORIZATION (PA) SYSTEM CAN PROCESS ONLY 26 DETAILS PER PA REQUEST. PLEASE RESUBMIT YOUR REQUEST WITH NO MORE THAN 26 DETAILS.
PC83	PLEASE SUPPLY A PHYSICIANS PRESCRIPTION DATED WITHIN ONE MONTH OF REQUESTED SUBSTANCE ABUSE DAY TREATMENT.
PC84	PLEASE PROVIDE INFORMATION INDICATING THIS CLIENT IS APPROPRIATELY DETOXIFIED FROM ALCOHOL AND/OR OTHER DRUGS.
PC85	PLEASE PROVIDE INFORMATION TO INDICATE THE CLIENTS ABILITY TO ABSTAIN FROM ALCOHOL OR DRUGS WHILE IN THE SUBSTANCE ABUSE DAY TREATMENT PROGRAM.
PC86	PLEASE INDICATE IF THIS CLIENT IS WILLING TO PARTICIPATE IN AFTERCARE OR CONTINUING CARE SERVICES.
PC87	PROVIDE MORE INFORMATION ON TREATMENT HISTORY; INCLUDE SERVICE PROVIDED, DATES, AND OUTCOME. PROVIDE DETAIL OF PREVIOUS TREATMENT.
PC88	PLEASE PROVIDE MORE RATIONALE FOR THE APPROPRIATENESS AND MEDICAL NECESSITY OF SUBSTANCE ABUSE DAY TREATMENT.
PC89	PROVIDE A TREATMENT PLAN THAT CONTAINS MEASURABLE GOALS AND OBJECTIVES CORRESPONDING TO THE IDENTIFIED DEFICIT.
PC91	PLEASE PROVIDE MORE INFORMATION ON FAMILY INVOLVEMENT TREATMENT.
PC92	PLEASE PROVIDE MORE HISTORY AND EXPLANATION ABOUT THE ISSUE OF ABSTINENCE FOR THIS CLIENT.
PC94	PLEASE PROVIDE THE ANTICIPATED BEGINNING DATE AND/OR THE ESTIMATED SUBSTANCE ABUSE DAY TREATMENT DISCHARGE DATE.
PC95	PLEASE SUPPLY JUSTIFICATION FOR BEGINNING CLIENT IN SERVICE PRIOR TO AUTHORIZATION BEING OBTAINED.
PC96	THE INITIAL THREE HOURS OF SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IN A CALENDAR YEAR DO NOT REQUIRE PRIOR AUTHORIZATION.

Denial Code	Long Description
PC97	REIMBURSEMENT FOR INITIAL SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IS LIMITED TO THREE HOURS IN A CALENDAR YEAR AND DOES NOT REQUIRE PRIOR AUTHORIZATION.
PC98	THIS DRUG IS CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE BILL USING THE APPROPRIATE NATIONAL DRUG CODE (NDC) OR SUBMIT A COMPLETED DRUG ADDITION REQUEST FORM IF THE NDC IS NOT LISTED IN THE DRUG INDEX.
PC99	THIS DRUG IS NOT CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL, CURRENT ADMINISTRATIVE RULE, OR COLORADO DRUG INDEX FOR COVERAGE LIMITATIONS.
PD01	DOCUMENT THAT CLIENT HAS ACHIEVED GOOD ORAL HYGIENE, PERIODONTAL CASE TYPE 1 OR 2, AND IS MOTIVATED TO MAINTAIN SAME.
PD03	PLEASE PROVIDE AN ARTERIAL BLOOD GAS READING OR PULSE OXIMETRY RESULTS DONE ON ROOM AIR SIGNED AND DATED BY A MEDICAL DOCTOR. THIS SHOULD BE DONE WITHIN 60 DAYS OF REQUESTED SERVICE.
PD04	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 30 DAYS OF RECEIPT BY COLORADO MEDICAID.
PD07	SUBMIT A PHOTOCOPY OF A VALID PRESCRIPTION, ISSUED WITHIN THE PAST YEAR, OR COMPLETE SECTION B OF THE PRIOR AUTHORIZATION/DRUG ATTACHMENT (PA/DGA), F-11049.
PD10	BRAND MEDICALLY NECESSARY MUST BE IN THE PRESCRIBERS OWN HANDWRITING AND WRITTEN DIRECTLY ON THE PRESCRIPTION OR A SEPARATE ORDER ATTACHED TO THE ORIGINAL PRESCRIPTION.
PD12	COMPLETE DENTURES, PARTIAL DENTURES, DENTURE RELINES, AND FIXED PROSTHODONTIC SERVICES ARE NOT COVERED SERVICES FOR ADULTS FOR DATES OF SERVICE ON AND AFTER OCTOBER 1, 1995.
PD22	PLEASE COMPLETE ALL REQUIRED ELEMENTS ON THE PERSONAL CARE SCREENING TOOL (PCST), F-11133.
PD24	THIS PRIOR AUTHORIZATION REQUEST IS UNABLE TO BE PROCESSED. PLEASE RESUBMIT WITH ADDITIONAL REQUIRED FORMS, INCLUDING THE ENTIRE PERSONAL CARE SCREENING TOOL (PCST), F-11133; PERSONAL CARE ADDENDUM, F-11136; AND SUPPORTING DOCUMENTATION, AS DIRECTED.
PD25	THERE IS A PERSONAL CARE SCREENING TOOL (PCST), F-11133, COMPLETED BY ANOTHER AGENCY. CONTACT THE AGENCY TO TRANSFER SCREEN.
PD26	THERE IS A LIMITED TERM CARE FUNCTIONAL SCREEN (LTC-FS) COMPLETED BY ANOTHER AGENCY. THE PERSONAL CARE SCREENING TOOL (PCST), F-11133, INFORMATION IS IN CONFLICT WITH LTC-FS.
PD27	ONLY ONE LEVEL OF FUNCTION MAY BE SELECTED FOR ALL ELEMENTS EXCEPT TOILETING. COLORADO MEDICAID IS UNABLE TO PROCESS THE PRIOR AUTHORIZATION REQUEST.
PD28	NO UNITS MAY BE REQUESTED USING THIS PRIOR AUTHORIZATION PROCESS. PLEASE SUBMIT WITH THE APPROPRIATE ATTACHMENTS FOR REQUESTING SPECIFIC PERSONAL CARE WORKER UNITS.
PD29	CLIENT IS NOT ELIGIBLE FOR THE REQUESTED SERVICE(S) AS OF THE REQUESTED START DATE.
PD30	NO TRAVEL TIME MAY BE AUTHORIZED WHEN NO PERSONAL CARE WORKER SERVICE IS AUTHORIZED.
PD32	PROVIDER NOT CERTIFIED TO RENDER THE SERVICE(S) REQUESTED.
PD34	BASED ON THE DOCUMENTATION SUBMITTED, THIS REQUEST CAN NOT BE PRIOR AUTHORIZED. REFER TO THE PA MESSAGES FROM THE CONSULTANT FOR COMPLETE EXPLANATION.
PD98	PLEASE DOCUMENT HOW AND WHEN EACH PREVIOUSLY AUTHORIZED PRO RE NATA VISIT WAS USED.

Monitoring Equipment and Diabetic Supplies

Denial Code	Long Description
0201	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
0233	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0235	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0237	CLIENT IDENTIFICATION NUMBER DOES NOT MATCH CLIENTS FIRST NAME.
0238	THE CLIENT IDENTIFICATION NUMBER DOES NOT MATCH THE CLIENTS LAST NAME.
0242	SECONDARY DIAGNOSIS CODE IS INVALID.
0248	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.

Denial Code	Long Description
0249	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0251	PROCEDURE CODE MODIFIER IN FIRST POSITION IS INVALID.
0252	THE PROCEDURE CODE MODIFIER IN SECOND POSITION IS INVALID FOR REQUESTED START DATE OR DATE OF RECEIPT.
0253	THE PROCEDURE CODE MODIFIER IN THIRD POSITION IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
0258	THE PRIMARY DIAGNOSIS CODE IS REQUIRED.
0272	THE PRIMARY DIAGNSOSIS CODE IS INVALID.
0400	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0853	HCPCS - ANNUAL UPDATE
0885	NEVER EVENTS MODIFIERS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
0886	NEVER EVENTS DIAGNOSIS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
1000	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
1002	RENDERING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1003	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1007	RENDERING PROVIDER ID IS NOT ON FILE.
1047	THE RENDERING PROVIDERS CERTIFICATION HAS BEEN CANCELLED.
1048	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1801	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
1804	A CERTIFIED SUBSTANCE ABUSE DAY TREATMENT PROVIDER MUST SUBMIT A SUBSTANCE ABUSE DAY TREATMENT PROCEDURE CODE.
1806	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
1808	THE BILLING PROVIDER DOES NOT HAVE THE REQUIRED CERTIFICATION ADDENDUM ON FILE.
1900	THE BILLING PROVIDERS TAXONOMY CODE IS INVALID.
1901	THE RENDERING PROVIDERS TAXONOMY CODE IS INVALID.
1927	A NATIONAL PROVIDER IDENTIFIER IS REQUIRED FOR THE BILLING PROVIDER.
1934	A NATIONAL PROVIDER INDENTIFIER IS REQUIRED FOR THE RENDERING PROVIDER.
1936	THE BILLING PROVIDER NUMBER IS INVALID.
1937	THE RENDERING PROVIDER NUMBER IS INVALID.
1960	INTERNAL PROCESSING IS REQUIRED.
1963	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.
1964	THE BILLING PROVIDER INDICATED IS NOT ALLOWABLE AS A BILLING PROVIDER.
1965	RENDERING PROVIDER NUMBER IS MISSING/INVALID FOR THIS PROCEDURE PROVIDER.
1974	PRESCRIBING/REFERRING/ORDERING PROVIDER INDICATED IS NOT CERTIFIED AS A PRESCRIBING/REFERRING/ORDERING PROVIDER.
1975	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
1976	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
2001	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2003	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2017	THE CLIENT IS ENROLLED IN A MEDICAID OR OTHER MANAGED CARE PROGRAM.
2037	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2603	CLIENT LOCKED-IN TO A PROVIDER OR ENROLLED IN A HOSPICE. CONTACT CLIENTS HOSPICE FOR PAYMENT OF SERVICES OR RESUBMIT WITH DOCUMENTATION OF UNRELATED NATURE OF CARE.
3324	THE MODIFIER HAS BEEN DISCONTINUED BY THE CENTERS OF MEDICARE AND MEDICAID SERVICES OR THE AMERICAN MEDICAL ASSOCIATION FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
3337	THE PROCEDURE CODE HAS BEEN TERMINATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AMERICAN MEDICAL ASSOCIATION, OR AMERICAN DENTAL ASSOCIATION FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT. RESUBMIT WITH VALID A PROCEDURE CODE.
3339	THE PROCEDURE BILLED IS NOT PAYABLE ACCORDING TO DEFICIT REDUCTION ACT (DEFRA) GUIDELINES.
3351	THE PROCEDURE IS NOT COVERED FOR CLIENTS WITH A NURSING HOME AUTHORIZATION ON THE REQUESTED START DATE OR DATE OF RECEIPT.

Denial Code	Long Description
3353	THE PROCEDURE IS NOT A COVERED SERVICE FOR HOME AND COMMUNITY-BASED WAIVER CLIENTS.
4021	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4027	THE DIAGNOSIS CODE IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
4031	THE PROCEDURE SUBMITTED IS NOT APPROPRIATE FOR CLIENTS GENDER.
4032	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4034	THE PROCEDURE CODE HAS AN AGE RESTRICTION.
4036	THE PLACE OF SERVICE CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4040	THE PRIMARY DIAGNOSIS CODE IS NOT ON FILE.
4041	THE SECONDARY DIAGNOSIS IS NOT ON FILE.
4046	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4127	INTERNAL PROCESSING IS REQUIRED.
4131	INTERNAL PROCESSING IS REQUIRED.
4141	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4149	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4150	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4236	ETIOLOGY DIAGNOSIS CODE(S) (E-CODES) ARE INVALID AS THE PRIMARY DIAGNOSIS.
4244	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4245	THE FOURTH POSITION MODIFIER IS INVALID FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT.
4256	THE PROCEDURE CODE AND MODIFIER COMBINATION IS NOT PAYABLE FOR THE CLIENTS BENEFIT PLAN.
4257	THE MODIFIERS SUBMITTED ARE EITHER INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT OR THE MODIFIERS ARE MISSING.
4311	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4315	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4316	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4371	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4372	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4711	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR CLIENTS AGE.
4714	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS AGE.
4731	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS DIAGNOSIS.
4742	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4743	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4744	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4745	DIAGNOSIS AND/OR PROCEDURE AND/OR PLACE OF SERVICE (POS) CODE IS NOT COVERED FOR EXPRESS ENROLLMENT CLIENTS.
4746	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4801	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4802	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
4821	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
4871	PLEASE REFER TO PA MESSAGES FOR RETURN INFORMATION.
4963	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS GENDER.
4990	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
7500	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
7509	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
P001	THE BILLING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THE SERVICES.
P002	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P003	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P005	THE PRIOR AUTHORIZATION CAN NOT BE END DATED. THE PRIOR AUTHORIZATION STATUS IS NOT APPROVED OR APPROVED WITH REVISIONS.

Denial Code	Long Description
P006	PLEASE FURNISH THE PROCEDURE CODE AND CORRESPONDING DESCRIPTION.
P008	THE BILLING PROVIDER NUMBER IS INVALID.
P009	THE BILLING PROVIDER NUMBER IS INVALID.
P010	THE REQUESTED END DATE IS INVALID.
P011	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P012	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P013	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P014	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P015	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P016	THE REQUESTED START DATE IS MISSING OR INVALID.
P019	THE REQUESTED START DATE IS MISSING OR INVALID.
P020	THE RENDERING PROVIDER NUMBER IS INVALID.
P021	THE RENDERING PROVIDER NUMBER IS INVALID.
P022	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P023	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P024	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P026	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P027	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P030	FIRST MODIFIER IS INVALID.
P031	FIRST MODIFIER IS INVALID.
P032	SECOND MODIFIER IS INVALID.
P033	SECOND MODIFIER IS INVALID.
P034	THIRD MODIFIER IS INVALID.
P035	THIRD MODIFIER IS INVALID.
P036	FOURTH MODIFIER IS INVALID.
P037	FOURTH MODIFIER IS INVALID.
P038	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P039	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P040	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P041	CLIENTS FIRST NAME IS MISSING.
P042	CLIENTS LAST NAME IS MISSING.
P043	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P044	BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES REQUESTED.
P045	FIRST MODIFIER IS INVALID.
P046	SECOND MODIFIER IS INVALID.
P047	THIRD MODIFIER IS INVALID.
P048	FOURTH MODIFIER IS INVALID.
P052	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P053	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P054	RENDERING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES FOR THE BENEFIT PLAN.
P055	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P061	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P062	THE CLIENT ID AND/OR NAME INDICATED ON THE PA REQUEST IS INCORRECT. THE CLIENT ID AND/OR NAME HAS BEEN UPDATED. PLEASE VERIFY THE ID AND/OR NAME IS CORRECT.
P064	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.

Denial Code	Long Description
P067	THE FREQUENCY OF HOURS REQUESTED ARE NOT APPROPRIATE FOR THIS CLIENT AND HAVE BEEN MODIFIED ACCORDINGLY.
P079	BILLING PROVIDER IS ON PAYMENT SUSPENSION DUE TO CREDIBLE ALLEGATION OF FRAUD.
P120	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAS BEEN REDUCED.
P121	THE SERVICE/ PROCEDURE REQUESTED IS NOT SUPPORTED BY SUBMITTED DOCUMENTATION.
P126	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
P128	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.
P138	SERVICE(S) DO NOT MEET COLORADO MEDICAID GUIDELINES.
P167	REQUESTED DOCUMENTATION HAS NOT BEEN SUBMITTED.
P178	THE SERVICE REQUESTED IS NOT MEDICALLY NECESSARY.
P179	THE MEDICAL NECESSITY FOR THIS SERVICE IS NOT SUPPORTED BY THE SUBMITTED DOCUMENTATION.
P233	THE DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE ADDITIONAL CARE.
P257	THIS CLIENTS FUNCTIONAL ASSESSMENT SCORES PLACE THIS CLIENT OUTSIDE ELIGIBILITY FOR DAY TREATMENT.
P274	OUR RECORDS INDICATE THIS CLIENT IS INVOLVED IN EFFECTIVE AND APPROPRIATE SERVICE ELSEWHERE.
P292	INTENSIVE REHABILITATION HOURS ARE NO LONGER APPROPRIATE AS INDICATED BY HISTORY, DIAGNOSIS, AND/ OR FUNCTIONAL ASSESSMENT SCORES.
P328	THE SERVICES REQUESTED INCLUDE NON-COVERED SERVICES, AND HOURS ARE REDUCED ACCORDINGLY.
P339	THE CLIENTS PAST HISTORY INDICATES REDUCED TREATMENT HOURS ARE WARRANTED.
P342	THE REQUEST DOES NOT MEET GENERALLY ACCEPTED CONDITIONS REQUIRING FLUORIDE TREATMENTS.
P346	SERVICES EXCEED COLORADO MEDICAID LIMITATION AND DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE MEDICAL NECESSITY OF THE SERVICE.
P349	THE SERVICE REQUESTED WAS PERFORMED LESS THAN FIVE YEARS AGO.
P353	THE EXISTING APPLIANCE HAS NOT BEEN WORN FOR THREE YEARS.
P367	THE CLIENT HAS BEEN TOTALLY WITHOUT TEETH AND AN APPLIANCE FOR FIVE YEARS.
P392	THE CLIENT IS MISSING AN ANTERIOR TOOTH AND/OR HAS TWO OR MORE POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P405	THE SERVICE(S) REQUESTED COULD ADEQUATELY BE PERFORMED IN THE DENTAL OFFICE.
P406	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE OF GOOD PERIODONTAL HEALTH (AMERICAN ACADEMY OF PERIODONTOLOGY PERIODONTAL CLASSIFICATION OF TYPE I OR II).
P407	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE VISIBLE ON RADIOGRAPHS THAT AT LEAST 50 PERCENT OF THE CLINICAL CROWN IS INTACT.
P409	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING SIX OR MORE TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED, INCLUDING THIRD MOLARS.
P410	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING ONE OR MORE ANTERIOR TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED.
P411	DOCUMENTATION DOES NOT SUPPORT THE NEED FOR PERIODONTIC SERVICES. POCKETS ARE LESS THAN 4MM AND/OR GREATER THAN 6MM FOR CLIENT AND/OR THE CLIENT IS UNDER THE AGE OF 13.
P412	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA.
P413	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA. THIS PA HAS BEEN GRANTED AS APPROVED NOT APPROVED WITH REVISIONS. THE DURATION REQUESTED MAY HAVE BEEN REDUCED TO REFLECT COVERAGE LIMITATIONS, PRESCRIBER ORDERS, CONFLICTI
P417	THE SERVICE(S) REQUESTED COULD BE ADEQUATELY PERFORMED WITH LOCAL ANESTHESIA.
P437	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO POOR ORAL HYGIENE.
P444	THIS LINE ITEM IS A DUPLICATE OF ANOTHER LINE ITEM ON THIS PRIOR AUTHORIZATION (PA) REQUEST. PLEASE CORRECT.
P446	THIS IS A DUPLICATE OF AN EXISTING PRIOR AUTHORIZATION (PA) REQUEST. YOU MAY CONTACT PROVIDER SERVICES IF YOU REQUIRE ASSISTANCE. DUPLICATE PA REQUEST
P448	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO DECAY HISTORY.
P449	QUESTIONABLE LONG TERM PROGNOSIS DUE TO GUM AND BONE DISEASE.
P456	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO APPARENT ROOT INFECTION.

Denial Code	Long Description
P457	OUR RECORDS INDICATE THIS CLIENT HAS EXCEEDED ESTABLISHED PROGRAM LIMITATIONS. COLORADO MEDICAID WILL NOT AUTHORIZE NEW DENTURES.
P458	DOCUMENTATION PROVIDED INDICATES A LESS ELABORATE PROCEDURE SHOULD BE CONSIDERED.
P502	RENTAL ONLY ALLOWED; MEDICAL NEED FOR PURCHASE HAS NOT BEEN DOCUMENTED.
P503	PURCHASE ONLY ALLOWED; MEDICAL NEED FOR RENTAL HAS NOT BEEN DOCUMENTED.
P504	OCCUPATIONAL THERAPY GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P505	THE SERVICE REQUESTED IS INCLUDED IN THE NURSING HOME RATE STRUCTURE.
P511	THIS NATIONAL DRUG CODE IS ONLY BILLABLE AS PART OF A COMPOUND DRUG.
P515	THE PRESENCE OF A HANDICAPPING MALOCCLUSION OR HANDICAPPING DENTOFACIAL DEFORMITY IS NOT SUPPORTED BY THE DOCUMENTATION SUBMITTED.
P521	THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVERED BY COLORADO MEDICAID.
P522	GASTRO-INTESTINAL SURGERY FOR THE PURPOSE OF WEIGHT CONTROL IS COVERED ONLY AS A LIFE THREATENING PROCEDURE.
P523	THE TREATMENT REQUEST IS NOT CONSISTENT WITH THE CLIENT'S DIAGNOSIS.
P524	PSYCHOTHERAPY PROVIDED IN THE CLIENTS HOME IS NOT A COVERED BENEFIT OF COLORADO MEDICAID.
P525	THE INFORMATION PROVIDED IS NOT CONSISTENT WITH THE INTENSITY OF SERVICES REQUESTED.
P526	INTENSIVE MULTIPLE MODALITY TREATMENT IS NOT CONSISTENT WITH THE INFORMATION PROVIDED.
P527	MULTIPLE PROVIDERS OF TREATMENT ARE NOT INDICATED FOR THIS CLIENT.
P528	THE DURATION OF TREATMENT SESSIONS EXCEED CURRENT COLORADO MEDICAID GUIDELINES.
P534	DOCUMENTATION OF POOR PHYSICAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P535	OTHER PHYSICAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P536	THE PHYSICAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P537	USE OF PHYSICAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P538	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF A PHYSICAL THERAPIST.
P539	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS AND LIVING ARRANGEMENT.
P540	GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P541	THE PROCEDURE(S) REQUESTED ARE NOT MEDICAL IN NATURE.
P542	DOCUMENTATION OF POOR OCCUPATIONAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P543	DOCUMENTATION OF POOR SPEECH THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P544	OTHER OCCUPATIONAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P546	THE OCCUPATIONAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P547	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF PHYSICAL THERAPY.
P548	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P549	ACTIVITIES TO PROMOTE DIVERSION OR GENERAL MOTIVATION ARE NONCOVERED COLORADO MEDICAID SERVICES.
P550	REVISIONS OF THE REQUEST IS NECESSITATED BY THE CLIENTS MINIMAL PROGRESS.
P551	RESTORATIVE NURSING INVOLVEMENT COULD BE INCREASED.
P552	CLIENTS DEMONSTRATED RESPONSE TO CURRENT THERAPY DOES NOT WARRANT THE INTENSE FREQUENCY REQUESTED.
P553	MAINTENANCE IS TWO TIMES PER WEEK OR LESS.
P554	THE SPEECH THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.

Denial Code	Long Description
P555	USE OF OCCUPATIONAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P556	USE OF SPEECH THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P557	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF AN OCCUPATIONAL THERAPIST.
P558	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
P559	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P560	THE MATERIALS/ SERVICES REQUESTED ARE PRINCIPALLY COSMETIC IN NATURE.
P561	THE LENS FORMULA DOES NOT JUSTIFY REPLACEMENT.
P562	THE CHANGE IN THE LENS FORMULA DOES NOT WARRANT MULTIPLE REPLACEMENTS.
P563	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P564	LENSES ONLY ARE APPROVED; PLEASE DISPENSE A CONTRACTED FRAME. THE NON-CONTRACTED FRAME IS NOT MEDICALLY JUSTIFIED.
P565	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P566	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P567	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF OCCUPATIONAL THERAPY.
P568	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF SPEECH THERAPY.
P569	LEVEL, INTENSITY, OR EXTENT OF SERVICE(S) REQUESTED HAS BEEN MODIFIED CONSISTENT WITH MEDICAL NEED AS DEFINED IN THE PLAN OF CARE.
P570	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P571	THE SERVICE ASKED FOR IS NOT COVERED BY COLORADO MEDICAID AS THESE TASKS CAN BE DONE BY NURSES OR ACTIVITY STAFF.
P572	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P573	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.
P574	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P575	MEDICAL NEED FOR EQUIPMENT/ SUPPLY REQUESTED IS NOT SUPPORTED BY DOCUMENTATION SUBMITTED.
P576	OTHER SPEECH THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P577	DOCUMENTATION SUBMITTED IDENTIFIES THAT THE CLIENT HAS FEWER THAN TWO POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P582	LESS EXPENSIVE ALTERNATIVE SERVICES ARE AVAILABLE FOR THIS CLIENT.
P634	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P711	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING PERIODONTAL SCALING AND ROOT PLANNING.
P712	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING GINGIVECTOMY.
P754	AN APPROVED SUBSTANCE ABUSE DAY TREATMENT PROGRAM CANNOT EXCEED A SIX WEEK PERIOD.
P761	THE CLIENT DOES NOT APPEAR TO BE ABLE OR WILLING TO ABSTAIN FROM ALCOHOL/DRUG USAGE WHILE IN TREATMENT. THEREFORE, SUBSTANCE ABUSE DAY TREATMENT SERVICES ARE NOT APPROVED.
P764	THIS CLIENT HAS COMPLETED INTENSIVE SUBSTANCE ABUSE TREATMENT WITHIN THE PAST 12 MONTHS. THE DOCUMENTATION PROVIDED IS NOT ADEQUATE TO JUSTIFY ADDITIONAL INTENSIVE TREATMENT AT THIS TIME.
P785	A LESS THAN SIX-WEEK HEALING PERIOD HAS BEEN SPECIFIED FOR THIS PRIOR AUTHORIZATION. THEREFORE IT IS NOT NECESSARY TO WAIT THE FULL SIX WEEKS AFTER EXTRACTIONS BEFORE TAKING DENTURE IMPRESSIONS.
P818	SIX-WEEK HEALING TIME IS REQUIRED BETWEEN EDENTULATION AND FINAL IMPRESSIONS. PAYMENT FOR DENTURES WILL BE DENIED OR RECOUPED IF HEALING PERIOD IS NOT OBSERVED.
P849	COLORADO MEDICAID HAS DETERMINED THERE WERE (ARE) SEVERAL HOME HEALTH AGENCIES WILLING TO PROVIDE MEDICALLY NECESSARY SKILLED NURSING SERVICES TO THIS CLIENT.

Denial Code	Long Description
P864	THE DOCUMENTATION YOU HAVE SUBMITTED DOES NOT MEET THE REQUIREMENTS OF COLORADO MEDICAID.
P873	THE MEDICAL NECESSITY FOR THE HOURS REQUESTED IS NOT SUPPORTED BY THE INFORMATION SUBMITTED.
P874	THE DOCUMENTATION SUBMITTED INDICATES THE TASKS SPECIFIED CAN BE COMPLETED DURING THE VISITS APPROVED.
P878	THE DOCUMENTATION SUBMITTED DOES NOT INDICATE THAT MEDICALLY ORIENTED TASKS ARE MEDICALLY NECESSARY; THEREFORE PERSONAL CARE SERVICES HAVE BEEN APPROVED.
P880	THE QUANTITY OF SERVICES AUTHORIZED FOR THIS CLIENTS PERSONAL CARE HAS BEEN AMENDED BASED ON INFORMATION RECEIVED FROM ONE OR MORE OF THESE SOURCES: THE CLIENT, THEIR PHYSICIAN, AND/OR THE IN-HOME VISIT BY STAFF OF THE OIG (OFFICE OF INSPECTOR GENERAL).
P885	THE USE OF THIS DRUG FOR THE INTENDED PURPOSE IS NOT COVERED BY COLORADO MEDICAID, CONSISTENT WITH COLORADO ADMINISTRATIVE CODE AND FEDERAL LAW.
P924	THE MEDICAL RECORDS SUBMITTED WITH THE CURRENT REQUEST CONFLICT OR DISAGREE WITH OUR MEDICAL RECORDS ON THIS CLIENT.
P950	INDEPENDENT NURSES, PLEASE NOTE PAYABLE SERVICES MAY NOT EXCEED 12 HOURS/DAY OR 60 HOURS/WEEK.
P951	SERVICES CAN ONLY BE AUTHORIZED THROUGH ONE YEAR FROM THE PRESCRIPTION DATE.
P952	LEAD INSPECTION IS A COVERED COLORADO MEDICAID SERVICE WHEN THE CHILD HAS BEEN SHOWN TO HAVE LEAD POISONING (E.G., CHILD HAS A BLOOD LEAD LEVEL > 19 UG/DL OR TWO CONSECUTIVE BLOOD LEAD LEVELS OF 15-19 UG/DL DONE AT LEAST 90 DAYS APART). THE INSPECTION MUS
P953	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P954	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P956	THE REQUEST CAN ONLY BE BACKDATED A MAXIMUM OF 14 DAYS FROM FIRST DATE RECEIVED BY COLORADO MEDICAID.
P957	COMPLETE PERIODONTAL CHARTING AT TIME OF SERVICE, AND SUBMIT CHARTING, COPY OF OPERATIVE REPORT, TOGETHER WITH A COPY OF THE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF), F-11035, TO PA UNIT ATTENTION DENTAL CONTSULTANT.
P958	NOTE THAT CODE D4341 HAS BEEN CHANGED. REFER TO THE DECISION NOTICE FOR AUTHORIZED QUANTITY.
P960	YOUR PA HAS BEEN APPROVED FOR 90 DAYS. THE 90 DAY APPROVAL DOES NOT IMPLY THE PA REQUEST MEETS PRIOR AUTHORIZATION CRITERIA. AFTER ADDITIONAL INFORMATION IS AVAILABLE IN INTERCHANGE, COLORADO MEDICAID WILL CREATE AN AMENDMENT REQUEST TO EXTEND THE PA FOR
P961	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P962	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
PA10	THE REQUESTED END DATE IS INVALID.
PA12	PLEASE FURNISH A WRITTEN DESCRIPTION OF THE CLIENTS DIAGNOSIS.
PA13	PROVIDE DIAGNOSES WITH DATES OF ONSET.
PA14	IDENTIFY PROBLEMS TO BE TREATED.
PA15	THE AUDIOLOGISTS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1), F-11020, AND PRIOR AUTHORIZATION REQUEST/HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2), F-11021.
PA16	THE PHYSICIANS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION/PHYSICIAN OTOLOGICAL REPORT (PA/POR), F-11019.
PA17	SUBMIT BRIEF HISTORY WITH REFERRAL INFORMATION, LIVING SITUATION, FUNCTIONAL STATUS, AND OTHER PERTINENT INFORMATION. WHAT CHANGE OF STATUS RESULTED IN REFERRAL AT THIS TIME?
PA18	PLEASE FURNISH THE CLIENTS HEIGHT AND WEIGHT.
PA19	PLEASE SUBMIT CLINICAL INFORMATION SUFFICIENT TO VERIFY THE NEED FOR THE REQUESTED SERVICE(S).

Denial Code	Long Description
PA20	PLEASE RESUBMIT WITH COMPLETE PERIODONTAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PA21	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL EDUCATIONAL PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA22	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL PROGRAM PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA23	REFER TO THE DURABLE MEDICAL EQUIPMENT INDEX FOR APPROPRIATE CODE AND DESCRIPTION. DO NOT USE AN "UNLISTED" CODE.
PA24	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUALIZED FAMILY SERVICE PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA25	INFORMATION ON THE REQUEST FORM IS ILLEGIBLE, AND THE REQUEST CANNOT BE PROCESSED.
PA26	RE-EVALUATE YOUR GOALS. EMPHASIS SHOULD BE ON FUNCTIONAL SELF-CARE. GOALS MUST BE RELATED TO FUNCTIONAL OUTCOME.
PA27	PLEASE CLARIFY THE NUMBER OF HOURS PER WEEK REQUESTED.
PA28	PLEASE CLARIFY THE NUMBER OF HOURS PER DAY REQUESTED.
PA29	PLEASE CLARIFY THE NUMBER OF VISITS PER DAY REQUESTED.
PA30	ATTACH SUPPORTIVE DOCUMENTATION; HOME EXERCISE PROGRAM AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA31	THE DIAGNOSIS CODE INDICATED ON THE REQUEST DOES NOT CORRESPOND TO THE DIAGNOSIS CODE DESCRIPTION.
PA32	PLEASE SUBMIT ADDITIONAL INFORMATION SUFFICIENT TO VERIFY APPROPRIATENESS AND NEED FOR TRANSPLANT.
PA33	PLEASE SUBMIT THE INITIAL AND PROGRESSIVE OBJECTIVE FINDINGS.
PA34	ATTACH SUPPORTIVE DOCUMENTATION, FACILITY PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA35	PLEASE SUBMIT THE CLIENTS ORIGINAL COMPLAINTS AND EXAMINATION FINDINGS.
PA36	ATTACH SUPPORTIVE DOCUMENTATION, IN-HOME AUTISM PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA37	PLEASE SUBMIT YOUR TREATMENT PLAN FOR THIS CLIENT.
PA38	ATTACH SUPPORTIVE DOCUMENTATION AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA39	INITIAL EVALUATIONS MUST BE PERFORMED BY AN OCCUPATIONAL THERAPIST REGISTERED (OTR), PER AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA) STANDARDS.
PA41	IDENTIFY THE PLACE OF SERVICE AND ITS EFFECT ON SUPPORTING THE DESIRED TREATMENT OUTCOME.
PA42	PLEASE INDICATE THE HOURS OF USE OF OXYGEN PER 24-HOUR PERIOD.
PA43	PROVIDE BASELINE DOCUMENTATION FOR THIS CLIENTS LIMITATIONS USING UNITS OF MEASUREMENT THAT ARE APPLIED CONSISTENTLY WHEN REPORTING STATUS.
PA44	IDENTIFY FUNCTIONAL LIMITATIONS AS THEY ARE RELATED TO IDENTIFIED CONDITIONS.
PA46	CORRELATE PLAN OF CARE TO REQUESTED PROCEDURE CODES.
PA47	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE FREQUENCY/DURATION REQUESTED.
PA48	PLEASE PROVIDE THE NAME AND CREDENTIALS OF THE RENDERING PROVIDER.
PA50	COLORADO MEDICAID RECORDS INDICATE THE CLIENT OWNS A WHEELCHAIR. DOCUMENT THE REASON AND NEED FOR REPLACEMENT AND COST TO REPAIR CURRENT WHEELCHAIR.
PA51	PLEASE DISTINGUISH PRIMARY AND SUPPORTIVE MODALITIES.
PA52	PLEASE SUBMIT A PROGRESS REPORT.
PA53	MULTIPLE FAMILY CLIENTS TREATMENT BY THE SAME PROVIDER REQUIRES FURTHER INFORMATION DOCUMENTING COORDINATION OF TREATMENT PLAN.
PA54	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE MINUTES REQUESTED.
PA55	MEDICAL NECESSITY OF TREATMENT REQUIRES ADDITIONAL DOCUMENTATION.
PA56	GIVEN AGE, DIAGNOSES, CURRENT LEVEL OF FUNCTION, PAST RESPONSE TO TREATMENT, AND LIVING SITUATION, EXPAND ON POTENTIAL FOR SIGNIFICANT FUNCTIONAL PROGRESS WITHIN THE NEXT SIX MONTHS. EMPHASIZE WHY PROGRESS IS EXPECTED WITH SERVICES AT THIS TIME.

Denial Code	Long Description
PA57	SUBMIT THE INITIAL FINDINGS. INCLUDE A COMPREHENSIVE EVALUATION.
PA58	SUBMIT PROGRESSIVE, OBJECTIVE FINDINGS. INCLUDE A PERTINENT RE-EVALUATION.
PA59	PLEASE SUPPLY INFORMATION REGARDING THE CLIENTS MEDICATION REQUIREMENTS, IF ANY.
PA60	PLEASE SPECIFY IF THE CLIENT IS IN AN EDUCATIONAL SETTING.
PA61	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA62	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
PA63	THE SKILLS OF A THERAPIST ARE PURPOSEFUL AND SKILLED INTERVENTIONS REQUIRED TO CONTINUALLY DESIGN, IMPLEMENT, REASSESS, MODIFY/GRADE, AND/OR DISCONTINUE A PLAN OF CARE IN A TIMELY MANNER, BASED ON THE COMPLEXITY OF THE CLIENTS MEDICAL CONDITION AND/OR CO
PA64	PLEASE SUBMIT A THERAPY PLAN OF CARE, INCLUDING A CURRENT, DATED EVALUATION.
PA65	A PLAN OF CARE SIGNED AND DATED BY THE PHYSICIAN IS REQUIRED.
PA66	THE SKILLS OF A THERAPIST ARE REQUIRED WHEN ONLY THE THERAPIST CAN SAFELY AND EFFECTIVELY DELIVER THE THERAPEUTIC PROCEDURES BECAUSE OF THEIR UNIQUE KNOWLEDGE, TRAINING, AND EXPERTISE. DESCRIBE THE REASON THAT SOMEONE OTHER THAN A THERAPIST CANNOT SAFELY
PA67	PLEASE SPECIFY IF THE CLIENTS WORK SITE DEMANDS GOOD BINAURAL HEARING.
PA68	DESCRIBE THE REASON, BASED ON THE CLIENTS COGNITIVE, PHYSICAL, COMMUNICATION, OR RESOURCE STATUS, THAT A HOME PROGRAM, EQUIPMENT, OR ENVIRONMENTAL ADAPTATIONS ALONE CANNOT MEET CLIENTS NEEDS.
PA69	PLEASE SPECIFY IF THE CLIENT HAS AN ACCOMPANYING DISABILITY THAT ADDS TO THE HEARING PROBLEM.
PA70	DISTINGUISH REQUESTED PROCEDURES AND GOALS FROM OTHER SERVICES THIS CLIENT RECEIVES. THEY MAY NOT BE DUPLICATIVE.
PA71	PLEASE INDICATE THE NUMBER OF DAYS REQUESTED.
PA73	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA74	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA75	PLEASE DOCUMENT CARRYOVER OF THE THERAPY PROGRAM TO NURSING.
PA76	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA79	PROVIDE EVIDENCE OF SIGNIFICANT FUNCTIONAL PROGRESS IN LAST SIX MONTHS.
PA84	THE GRANT DATE OF THIS REQUEST CANNOT BE PRIOR TO THE SIGNATURE DATE OF THE PRESCRIBING PHYSICIAN.
PA86	PROVIDE EVIDENCE OF SKILLS GAINED IN THERAPY CARRYING OVER TO OTHER SETTINGS WITHIN SIX MONTHS.
PA87	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE NUMBER OF SESSIONS REQUESTED.
PA88	THE REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL SCOPE OF PRACTICE.
PA89	PRIOR AUTHORIZATION IS NOT REQUIRED UNTIL LIMITATION OF SERVICE HAS BEEN REACHED.
PA91	PLEASE SUBMIT REQUIRED X-RAYS.
PA92	PLEASE PROVIDE AN EXPLANATION FOR THE MATERIAL SUBMITTED WITH THE REQUEST.
PA95	PLEASE DESCRIBE HOW THE PROVISION OF THIS SERVICE WOULD PREVENT INSTITUTIONALIZATION OF THE CLIENT.
PA96	COULD THE EXISTING DENTURE(S) BE RELINED OR REBASED? IF NOT, PLEASE EXPLAIN WHY NOT.
PA97	REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL STANDARDS OF PRACTICE.
PA98	PLEASE INDICATE IF THE CLIENT IS CURRENTLY BEING TUBE FED.
PB02	PLEASE PROVIDE THE REQUIRED DATED SIGNATURES ON THE ATTACHMENTS.
PB03	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING THE LOSS/DESTRUCTION/THEFT OF THE HEARING AID.
PB04	DESCRIBE THE CLIENTS ABILITY TO STAND OR AMBULATE SUFFICIENTLY TO ACCOMPLISH SELF-CARE ACTIVITIES.
PB07	PLEASE SUBMIT AN ORTHODONTIC STUDY MODEL OR DIAGNOSTIC CASTS.
PB09	PLEASE PROVIDE A PHOTOGRAPH OF THE INVOLVED AREA(S).

Denial Code	Long Description
PB10	PLEASE PROVIDE AN ESTIMATION (IN GRAMS) OF THE TOTAL AMOUNT OF TISSUE TO BE RESECTED.
PB11	PLEASE SUBMIT THE PLAN OF CARE FOR CO-TREATMENT.
PB12	FURNISH A DETAILED DESCRIPTION FOR THE PROCEDURE CODE REQUESTED.
PB13	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB15	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB18	PLEASE COMPLETE THE ATTACHED OUT-OF-STATE PROVIDER DATA SHEET, F-11001, AND RESUBMIT.
PB20	A SIGNED AND DATED PRESCRIPTION IS REQUIRED WITHIN THREE MONTHS OF RECEIPT BY COLORADO MEDICAID FOR INITIAL REQUESTS AND WITHIN 12 MONTHS OF RECEIPT BY COLORADO MEDICAID FOR SUBSEQUENT REQUESTS.
PB21	PLEASE COMPLETE THE APPROPRIATE PRIOR AUTHORIZATION ATTACHMENT. CONTACT PROVIDER SERVICES OR THE PRIOR AUTHORIZATION UNIT FOR ASSISTANCE.
PB23	PHYSICAL THERAPY ASSISTANT NOTES AND ALL FORMS SUBMITTED MUST BE COSIGNED BY A REGISTERED PHYSICAL THERAPIST.
PB31	ARE YOU REQUESTING A COMPLETE APPLIANCE, OR REPLACEMENT PARTS?
PB32	THE PROCEDURE CODE INDICATED ON THE REQUEST DOES NOT MATCH THE DESCRIPTION OF SERVICE; PLEASE CORRECT AND RESUBMIT.
PB35	THE SERVICE REQUESTED DOES NOT REQUIRE PRIOR AUTHORIZATION.
PB41	PLEASE FURNISH A CURRENT MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT, F-11090 (DATED WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID).
PB45	THE CERTIFICATION PERIOD ON THE PLAN OF CARE (POC) DOES NOT COVER THE REQUESTED GRANT/START DATE. PLEASE RESUBMIT YOUR REQUEST WITH A NEW POC.
PB49	A CERTIFIED OCCUPATIONAL THERAPY ASSISTANTS NOTES MUST BE COSIGNED BY AN OCCUPATIONAL THERAPIST REGISTERED.
PB51	ADDITIONAL INFORMATION IS REQUIRED ON PRIOR AUTHORIZATION TO ENABLE PRICING.
PB54	REQUESTED SERVICES DO NOT MATCH SERVICES ON THE PHYSICIANS ORDERS.
PB59	PLEASE PROVIDE AN INDIVIDUAL EDUCATIONAL PLAN (IEP), WHICH HAS BEEN SIGNED BY THE PROVIDER NO EARLIER THAN NINE MONTHS PRIOR TO RECEIPT AT COLORADO MEDICAID; OTHERWISE, DOCUMENT WHY NO IEP EXISTS.
PB65	PLEASE FURNISH THE ANTICIPATED TOTAL CHARGES FOR THIS REQUEST.
PB66	A PHOTOCOPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED; THE DATE MUST BE WITHIN SIX MONTHS OF RECEIPT BY COLORADO MEDICAID.
PB67	THE PRESCRIPTION DATE MUST INCLUDE MONTH, DAY, AND YEAR.
PB68	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID.
PB73	THE SERVICES IDENTIFIED ON THE PLAN OF CARE DO NOT APPEAR APPROPRIATE FOR THE PROCEDURE CODE(S) REQUESTED ON THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018.
PB74	THE CLIENT/PROVIDER DOES NOT HAVE RETROACTIVE ENROLLMENT.
PB75	THE REQUESTED START DATE IS MORE THAN 14 DAYS BEFORE OR 62 DAYS AFTER RECEIPT.
PB82	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
PB83	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A HOME HEALTH AIDE. PLEASE RESUBMIT AS A PERSONAL CARE WORKER OR PROVIDE ADDITIONAL DOCUMENTATION.
PB86	THE SERVICES REQUESTED ARE NOT BEING PROVIDED IN THE CLIENTS RESIDENCE. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL.
PB87	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A NURSE. PLEASE RESUBMIT AS A HOME HEALTH AIDE OR PROVIDE ADDITIONAL DOCUMENTATION.
PB92	PLEASE FURNISH THE CLIENTS COMPLETE ADDRESS.
PB94	IF THE CLIENT IS A RESIDENT OF A NURSING HOME, SUPPLY THE COMPLETE NAME AND ADDRESS OF THE NURSING HOME.
PB99	THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018, MUST BE SIGNED AND DATED.
PC01	PLEASE SUPPLY THE RENDERING PROVIDERS PROVIDER NUMBER.
PC03	THE DRUG ENFORCEMENT ADMINISTRATION NUMBER IS MISSING OR INVALID.
PC06	PLEASE DESCRIBE YOUR PROGRAM; INCLUDE ENTRY DATE, TERMINATION DATE, HOURS PER WEEK, AND NUMBER OF WEEKS OF PRIMARY INTENSIVE SERVICE REQUESTED.

Denial Code	Long Description
PC07	PLEASE DESCRIBE YOUR "AFTERCARE/FOLLOW-UP" PLANS FOR THIS CLIENT.
PC08	PLEASE SUPPLY DOCUMENTATION OF PREVIOUS SUBSTANCE ABUSE SERVICES WITH DATE(S) AND OUTCOME.
PC09	PLEASE DESCRIBE IN DETAIL THE TREATMENT OBJECTIVES/GOALS FOR THIS CLIENT.
PC10	PLEASE DESCRIBE THE FAMILY SITUATION/DYNAMICS. EXPLAIN HOW THE FAMILY WILL BE INCORPORATED INTO THE CLIENTS PLAN OF CARE.
PC12	PLEASE EXPLAIN IF YOUR SERVICE ENCOURAGES THE CLIENT TO ATTEND SELF-HELP GROUPS.
PC13	PLEASE SUPPLY A SPECIFIC SCHEDULE OF ACTIVITIES, INCLUDING DAY, TIME OF DAY, LENGTH OF SESSION, AND SERVICE TO BE RENDERED DURING THAT TIME.
PC15	PLEASE FURNISH DIAGNOSTIC RATIONALE.
PC17	PLEASE DOCUMENT IF THE CLIENT EVER RECEIVED SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT.
PC19	PLEASE FURNISH MORE EXTENSIVE AND IN-DEPTH HISTORICAL AND PSYCHOSOCIAL DATA.
PC20	PLEASE SUPPLY THE DATE THE CLIENT BECAME TOTALLY ENDENTULOUS.
PC23	PLEASE SUBMIT A PHYSICIANS STATEMENT REGARDING THE MEDICAL NECESSITY OF DENTURES FOR THIS CLIENT. THE PHYSICIANS STATEMENT MUST DOCUMENT THE MEDICAL NEED FOR DENTURES.
PC24	THE SERVICE REQUESTED WAS PREVIOUSLY AUTHORIZED. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT INDICATING THIS FACT IS REQUIRED.
PC25	PLEASE SUPPLY SUFFICIENT MITIGATING CIRCUMSTANCES TO WARRANT THE CONSTRUCTION OF NEW DENTURES(S).
PC26	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
PC28	PLEASE SUBMIT A PHYSICIANS STATEMENT INDICATING DENTURES ARE NECESSARY FOR THIS NURSING HOME CLIENT.
PC29	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING LOSS OR DESTRUCTION OF DENTURE(S). INCLUDE SIGNED STATEMENT FROM CLIENT OR FACILITY DIRECTOR REGARDING HOW, WHEN AND WHERE LOST.
PC30	PLEASE PROVIDE COMPLETE INTRAORAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PC31	PLEASE DESCRIBE ANY RELATED DEFORMITIES OF THE FEET.
PC34	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD WITH REQUESTED DME ITEM(S) AND DOCUMENT IF THE CLIENT CAN USE SAFELY AND INDEPENDENTLY.
PC35	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD AND DESCRIBE THE RESULTS AND EFFECTIVENESS OF THE SERVICE REQUESTED.
PC39	PLEASE INDICATE LITER FLOW PER MINUTE, HOURS OF USE PER 24 HOUR PERIOD, AND THE EXPECTED DURATION OF NEED.
PC40	THE ITEM DOES NOT REQUIRE PRIOR AUTHORIZATION UNTIL THE LIFE EXPECTANCY HAS BEEN REACHED.
PC41	PLEASE SUPPLY INFORMATION INDICATING THE NECESSITY OF POSITIONING THE CLIENT'S BODY IN MULTIPLE POSITIONS.
PC42	PLEASE INDICATE IF THE BED HEIGHT MUST BE CHANGED TO ALLOW FOR SAFE TRANSFER OR ADEQUATE BED CARE.
PC43	SUPPLY A PHYSICIANS STATEMENT INDICATING TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR UNIT HAS REDUCED PAIN, IMPROVED/INCREASED THE CLIENTS ACTIVITY LEVEL, AND/OR REDUCED CLIENTS USE OF PAIN MEDICATION.
PC44	A CURRENT AUTHORIZATION FOR THIS SERVICE IS ON FILE FOR ANOTHER PROVIDER. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT OF THAT FACT IS REQUIRED BY THE CLIENT OF FIRST PROVIDER.
PC59	DOCUMENT DECLINE OR PROGRESS IN SPECIFIC, MEASURABLE, OBJECTIVE TERMS.
PC60	DOCUMENT IF CLIENT HAS DEMONSTRATED A GOOD APPOINTMENT COMPLIANCE RECORD.
PC61	THE PHYSICIANS SIGNATURE DATE MUST NOT EXCEED 90 DAYS FROM THE DATE OF RECEIPT BY COLORADO MEDICAID.
PC62	REQUESTS FOR A CONTINUATION OF THERAPY SHOULD NOT BE SUBMITTED MORE THAN FOUR WEEKS PRIOR TO THE EXPIRATION DATE OF THE CURRENT AUTHORIZATION.
PC63	PLEASE FURNISH THE STYLE AND MANUFACTURER OF THE FRAME.
PC64	PLEASE FURNISH THE CLIENTS LENS FORMULA.
PC66	ALL REQUESTS FOR TINTS REQUIRE DOCUMENTATION OF THE VISUAL OR MEDICAL CONDITION RELATED TO PHOTOPHOBIA.

Denial Code	Long Description
PC67	PLEASE DOCUMENT THE REASON AND JUSTIFICATION FOR REPLACEMENT BEYOND THE FIRST LENS/FRAME.
PC68	DOCUMENT IF ALL REMAINING MAXILLARY AND/OR MANDIBULAR TEETH ARE DECAY-FREE, PROPERLY RESTORED, AND PERIODONTICALLY SOUND.
PC72	SUPPLY MORE DETAIL REGARDING PROGRESS (ATTACHMENT OF GOALS, ETC.). CORRELATE PROGRESS TO PREVIOUS GOALS AND IDENTIFIED LIMITATIONS.
PC77	PLEASE SUBMIT A PLAN OF CARE DESCRIBING THE SERVICES THAT WOULD BE PROVIDED.
PC78	PLEASE DOCUMENT SPECIFIC, MEASURABLE GOALS.
PC82	THE PRIOR AUTHORIZATION (PA) SYSTEM CAN PROCESS ONLY 26 DETAILS PER PA REQUEST. PLEASE RESUBMIT YOUR REQUEST WITH NO MORE THAN 26 DETAILS.
PC83	PLEASE SUPPLY A PHYSICIANS PRESCRIPTION DATED WITHIN ONE MONTH OF REQUESTED SUBSTANCE ABUSE DAY TREATMENT.
PC84	PLEASE PROVIDE INFORMATION INDICATING THIS CLIENT IS APPROPRIATELY DETOXIFIED FROM ALCOHOL AND/OR OTHER DRUGS.
PC85	PLEASE PROVIDE INFORMATION TO INDICATE THE CLIENTS ABILITY TO ABSTAIN FROM ALCOHOL OR DRUGS WHILE IN THE SUBSTANCE ABUSE DAY TREATMENT PROGRAM.
PC86	PLEASE INDICATE IF THIS CLIENT IS WILLING TO PARTICIPATE IN AFTERCARE OR CONTINUING CARE SERVICES.
PC87	PROVIDE MORE INFORMATION ON TREATMENT HISTORY; INCLUDE SERVICE PROVIDED, DATES, AND OUTCOME. PROVIDE DETAIL OF PREVIOUS TREATMENT.
PC88	PLEASE PROVIDE MORE RATIONALE FOR THE APPROPRIATENESS AND MEDICAL NECESSITY OF SUBSTANCE ABUSE DAY TREATMENT.
PC89	PROVIDE A TREATMENT PLAN THAT CONTAINS MEASURABLE GOALS AND OBJECTIVES CORRESPONDING TO THE IDENTIFIED DEFICIT.
PC91	PLEASE PROVIDE MORE INFORMATION ON FAMILY INVOLVEMENT TREATMENT.
PC92	PLEASE PROVIDE MORE HISTORY AND EXPLANATION ABOUT THE ISSUE OF ABSTINENCE FOR THIS CLIENT.
PC94	PLEASE PROVIDE THE ANTICIPATED BEGINNING DATE AND/OR THE ESTIMATED SUBSTANCE ABUSE DAY TREATMENT DISCHARGE DATE.
PC95	PLEASE SUPPLY JUSTIFICATION FOR BEGINNING CLIENT IN SERVICE PRIOR TO AUTHORIZATION BEING OBTAINED.
PC96	THE INITIAL THREE HOURS OF SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IN A CALENDAR YEAR DO NOT REQUIRE PRIOR AUTHORIZATION.
PC97	REIMBURSEMENT FOR INITIAL SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IS LIMITED TO THREE HOURS IN A CALENDAR YEAR AND DOES NOT REQUIRE PRIOR AUTHORIZATION.
PC98	THIS DRUG IS CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE BILL USING THE APPROPRIATE NATIONAL DRUG CODE (NDC) OR SUBMIT A COMPLETED DRUG ADDITION REQUEST FORM IF THE NDC IS NOT LISTED IN THE DRUG INDEX.
PC99	THIS DRUG IS NOT CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL, CURRENT ADMINISTRATIVE RULE, OR COLORADO DRUG INDEX FOR COVERAGE LIMITATIONS.
PD01	DOCUMENT THAT CLIENT HAS ACHIEVED GOOD ORAL HYGIENE, PERIODONTAL CASE TYPE 1 OR 2, AND IS MOTIVATED TO MAINTAIN SAME.
PD03	PLEASE PROVIDE AN ARTERIAL BLOOD GAS READING OR PULSE OXIMETRY RESULTS DONE ON ROOM AIR SIGNED AND DATED BY A MEDICAL DOCTOR. THIS SHOULD BE DONE WITHIN 60 DAYS OF REQUESTED SERVICE.
PD04	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 30 DAYS OF RECEIPT BY COLORADO MEDICAID.
PD07	SUBMIT A PHOTOCOPY OF A VALID PRESCRIPTION, ISSUED WITHIN THE PAST YEAR, OR COMPLETE SECTION B OF THE PRIOR AUTHORIZATION/DRUG ATTACHMENT (PA/DGA), F-11049.
PD10	BRAND MEDICALLY NECESSARY MUST BE IN THE PRESCRIBERS OWN HANDWRITING AND WRITTEN DIRECTLY ON THE PRESCRIPTION OR A SEPARATE ORDER ATTACHED TO THE ORIGINAL PRESCRIPTION.
PD12	COMPLETE DENTURES, PARTIAL DENTURES, DENTURE RELINES, AND FIXED PROSTHODONTIC SERVICES ARE NOT COVERED SERVICES FOR ADULTS FOR DATES OF SERVICE ON AND AFTER OCTOBER 1, 1995.
PD22	PLEASE COMPLETE ALL REQUIRED ELEMENTS ON THE PERSONAL CARE SCREENING TOOL (PCST), F-11133.

Denial Code	Long Description
PD24	THIS PRIOR AUTHORIZATION REQUEST IS UNABLE TO BE PROCESSED. PLEASE RESUBMIT WITH ADDITIONAL REQUIRED FORMS, INCLUDING THE ENTIRE PERSONAL CARE SCREENING TOOL (PCST), F-11133; PERSONAL CARE ADDENDUM, F-11136; AND SUPPORTING DOCUMENTATION, AS DIRECTED.
PD25	THERE IS A PERSONAL CARE SCREENING TOOL (PCST), F-11133, COMPLETED BY ANOTHER AGENCY. CONTACT THE AGENCY TO TRANSFER SCREEN.
PD26	THERE IS A LIMITED TERM CARE FUNCTIONAL SCREEN (LTC-FS) COMPLETED BY ANOTHER AGENCY. THE PERSONAL CARE SCREENING TOOL (PCST), F-11133, INFORMATION IS IN CONFLICT WITH LTC-FS.
PD27	ONLY ONE LEVEL OF FUNCTION MAY BE SELECTED FOR ALL ELEMENTS EXCEPT TOILETING. COLORADO MEDICAID IS UNABLE TO PROCESS THE PRIOR AUTHORIZATION REQUEST.
PD28	NO UNITS MAY BE REQUESTED USING THIS PRIOR AUTHORIZATION PROCESS. PLEASE SUBMIT WITH THE APPROPRIATE ATTACHMENTS FOR REQUESTING SPECIFIC PERSONAL CARE WORKER UNITS.
PD29	CLIENT IS NOT ELIGIBLE FOR THE REQUESTED SERVICE(S) AS OF THE REQUESTED START DATE.
PD30	NO TRAVEL TIME MAY BE AUTHORIZED WHEN NO PERSONAL CARE WORKER SERVICE IS AUTHORIZED.
PD32	PROVIDER NOT CERTIFIED TO RENDER THE SERVICE(S) REQUESTED.
PD34	BASED ON THE DOCUMENTATION SUBMITTED, THIS REQUEST CAN NOT BE PRIOR AUTHORIZED. REFER TO THE PA MESSAGES FROM THE CONSULTANT FOR COMPLETE EXPLANATION.
PD98	PLEASE DOCUMENT HOW AND WHEN EACH PREVIOUSLY AUTHORIZED PRO RE NATA VISIT WAS USED.

Nerve Stimulators

Denial Code	Long Description
0201	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
0233	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0235	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0237	CLIENT IDENTIFICATION NUMBER DOES NOT MATCH CLIENTS FIRST NAME.
0238	THE CLIENT IDENTIFICATION NUMBER DOES NOT MATCH THE CLIENTS LAST NAME.
0242	SECONDARY DIAGNOSIS CODE IS INVALID.
0248	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0249	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0251	PROCEDURE CODE MODIFIER IN FIRST POSITION IS INVALID.
0252	THE PROCEDURE CODE MODIFIER IN SECOND POSITION IS INVALID FOR REQUESTED START DATE OR DATE OF RECEIPT.
0253	THE PROCEDURE CODE MODIFIER IN THIRD POSITION IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
0258	THE PRIMARY DIAGNOSIS CODE IS REQUIRED.
0272	THE PRIMARY DIAGNSOSIS CODE IS INVALID.
0400	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0853	HCPCS - ANNUAL UPDATE
0885	NEVER EVENTS MODIFIERS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
0886	NEVER EVENTS DIAGNOSIS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
1000	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
1002	RENDERING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1003	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1007	RENDERING PROVIDER ID IS NOT ON FILE.
1047	THE RENDERING PROVIDERS CERTIFICATION HAS BEEN CANCELLED.
1048	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1801	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.

Denial Code	Long Description
1804	A CERTIFIED SUBSTANCE ABUSE DAY TREATMENT PROVIDER MUST SUBMIT A SUBSTANCE ABUSE DAY TREATMENT PROCEDURE CODE.
1806	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
1808	THE BILLING PROVIDER DOES NOT HAVE THE REQUIRED CERTIFICATION ADDENDUM ON FILE.
1900	THE BILLING PROVIDERS TAXONOMY CODE IS INVALID.
1901	THE RENDERING PROVIDERS TAXONOMY CODE IS INVALID.
1927	A NATIONAL PROVIDER IDENTIFIER IS REQUIRED FOR THE BILLING PROVIDER.
1934	A NATIONAL PROVIDER INDENTIFIER IS REQUIRED FOR THE RENDERING PROVIDER.
1936	THE BILLING PROVIDER NUMBER IS INVALID.
1937	THE RENDERING PROVIDER NUMBER IS INVALID.
1960	INTERNAL PROCESSING IS REQUIRED.
1963	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.
1964	THE BILLING PROVIDER INDICATED IS NOT ALLOWABLE AS A BILLING PROVIDER.
1965	RENDERING PROVIDER NUMBER IS MISSING/INVALID FOR THIS PROCEDURE PROVIDER.
1974	PRESCRIBING/REFERRING/ORDERING PROVIDER INDICATED IS NOT CERTIFIED AS A PRESCRIBING/REFERRING/ORDERING PROVIDER.
1975	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
1976	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
2001	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2003	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2017	THE CLIENT IS ENROLLED IN A MEDICAID OR OTHER MANAGED CARE PROGRAM.
2037	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2603	CLIENT LOCKED-IN TO A PROVIDER OR ENROLLED IN A HOSPICE. CONTACT CLIENTS HOSPICE FOR PAYMENT OF SERVICES OR RESUBMIT WITH DOCUMENTATION OF UNRELATED NATURE OF CARE.
3324	THE MODIFIER HAS BEEN DISCONTINUED BY THE CENTERS OF MEDICARE AND MEDICAID SERVICES OR THE AMERICAN MEDICAL ASSOCIATION FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
3337	THE PROCEDURE CODE HAS BEEN TERMINATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AMERICAN MEDICAL ASSOCIATION, OR AMERICAN DENTAL ASSOCIATION FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT. RESUBMIT WITH VALID A PROCEDURE CODE.
3339	THE PROCEDURE BILLED IS NOT PAYABLE ACCORDING TO DEFICIT REDUCTION ACT (DEFRA) GUIDELINES.
3351	THE PROCEDURE IS NOT COVERED FOR CLIENTS WITH A NURSING HOME AUTHORIZATION ON THE REQUESTED START DATE OR DATE OF RECEIPT.
3353	THE PROCEDURE IS NOT A COVERED SERVICE FOR HOME AND COMMUNITY-BASED WAIVER CLIENTS.
4021	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4027	THE DIAGNOSIS CODE IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
4031	THE PROCEDURE SUBMITTED IS NOT APPROPRIATE FOR CLIENTS GENDER.
4032	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4034	THE PROCEDURE CODE HAS AN AGE RESTRICTION.
4036	THE PLACE OF SERVICE CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4040	THE PRIMARY DIAGNOSIS CODE IS NOT ON FILE.
4041	THE SECONDARY DIAGNOSIS IS NOT ON FILE.
4046	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4127	INTERNAL PROCESSING IS REQUIRED.
4131	INTERNAL PROCESSING IS REQUIRED.
4141	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4149	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4150	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4236	ETIOLOGY DIAGNOSIS CODE(S) (E-CODES) ARE INVALID AS THE PRIMARY DIAGNOSIS.
4244	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4245	THE FOURTH POSITION MODIFIER IS INVALID FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT.
4256	THE PROCEDURE CODE AND MODIFIER COMBINATION IS NOT PAYABLE FOR THE CLIENTS BENEFIT PLAN.
4257	THE MODIFIERS SUBMITTED ARE EITHER INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT OR THE MODIFIERS ARE MISSING.

Denial Code	Long Description
4311	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4315	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4316	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4371	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4372	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4711	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR CLIENTS AGE.
4714	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS AGE.
4731	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS DIAGNOSIS.
4742	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4743	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4744	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4745	DIAGNOSIS AND/OR PROCEDURE AND/OR PLACE OF SERVICE (POS) CODE IS NOT COVERED FOR EXPRESS ENROLLMENT CLIENTS.
4746	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4801	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4802	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
4821	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
4871	PLEASE REFER TO PA MESSAGES FOR RETURN INFORMATION.
4963	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS GENDER.
4990	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
7500	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
7509	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
P001	THE BILLING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THE SERVICES.
P002	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P003	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P005	THE PRIOR AUTHORIZATION CAN NOT BE END DATED. THE PRIOR AUTHORIZATION STATUS IS NOT APPROVED OR APPROVED WITH REVISIONS.
P006	PLEASE FURNISH THE PROCEDURE CODE AND CORRESPONDING DESCRIPTION.
P008	THE BILLING PROVIDER NUMBER IS INVALID.
P009	THE BILLING PROVIDER NUMBER IS INVALID.
P010	THE REQUESTED END DATE IS INVALID.
P011	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P012	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P013	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P014	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P015	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P016	THE REQUESTED START DATE IS MISSING OR INVALID.
P019	THE REQUESTED START DATE IS MISSING OR INVALID.
P020	THE RENDERING PROVIDER NUMBER IS INVALID.
P021	THE RENDERING PROVIDER NUMBER IS INVALID.
P022	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P023	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P024	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P026	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P027	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.

Denial Code	Long Description
P030	FIRST MODIFIER IS INVALID.
P031	FIRST MODIFIER IS INVALID.
P032	SECOND MODIFIER IS INVALID.
P033	SECOND MODIFIER IS INVALID.
P034	THIRD MODIFIER IS INVALID.
P035	THIRD MODIFIER IS INVALID.
P036	FOURTH MODIFIER IS INVALID.
P037	FOURTH MODIFIER IS INVALID.
P038	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P039	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P040	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P041	CLIENTS FIRST NAME IS MISSING.
P042	CLIENTS LAST NAME IS MISSING.
P043	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P044	BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES REQUESTED.
P045	FIRST MODIFIER IS INVALID.
P046	SECOND MODIFIER IS INVALID.
P047	THIRD MODIFIER IS INVALID.
P048	FOURTH MODIFIER IS INVALID.
P052	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P053	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P054	RENDERING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES FOR THE BENEFIT PLAN.
P055	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P061	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P062	THE CLIENT ID AND/OR NAME INDICATED ON THE PA REQUEST IS INCORRECT. THE CLIENT ID AND/OR NAME HAS BEEN UPDATED. PLEASE VERIFY THE ID AND/OR NAME IS CORRECT.
P064	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
P067	THE FREQUENCY OF HOURS REQUESTED ARE NOT APPROPRIATE FOR THIS CLIENT AND HAVE BEEN MODIFIED ACCORDINGLY.
P079	BILLING PROVIDER IS ON PAYMENT SUSPENSION DUE TO CREDIBLE ALLEGATION OF FRAUD.
P120	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAS BEEN REDUCED.
P121	THE SERVICE/ PROCEDURE REQUESTED IS NOT SUPPORTED BY SUBMITTED DOCUMENTATION.
P126	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
P128	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.
P138	SERVICE(S) DO NOT MEET COLORADO MEDICAID GUIDELINES.
P167	REQUESTED DOCUMENTATION HAS NOT BEEN SUBMITTED.
P178	THE SERVICE REQUESTED IS NOT MEDICALLY NECESSARY.
P179	THE MEDICAL NECESSITY FOR THIS SERVICE IS NOT SUPPORTED BY THE SUBMITTED DOCUMENTATION.
P233	THE DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE ADDITIONAL CARE.
P257	THIS CLIENTS FUNCTIONAL ASSESSMENT SCORES PLACE THIS CLIENT OUTSIDE ELIGIBILITY FOR DAY TREATMENT.
P274	OUR RECORDS INDICATE THIS CLIENT IS INVOLVED IN EFFECTIVE AND APPROPRIATE SERVICE ELSEWHERE.
P292	INTENSIVE REHABILITATION HOURS ARE NO LONGER APPROPRIATE AS INDICATED BY HISTORY, DIAGNOSIS, AND/ OR FUNCTIONAL ASSESSMENT SCORES.
P328	THE SERVICES REQUESTED INCLUDE NON-COVERED SERVICES, AND HOURS ARE REDUCED ACCORDINGLY.
P339	THE CLIENTS PAST HISTORY INDICATES REDUCED TREATMENT HOURS ARE WARRANTED.
P342	THE REQUEST DOES NOT MEET GENERALLY ACCEPTED CONDITIONS REQUIRING FLUORIDE TREATMENTS.

Denial Code	Long Description
P346	SERVICES EXCEED COLORADO MEDICAID LIMITATION AND DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE MEDICAL NECESSITY OF THE SERVICE.
P349	THE SERVICE REQUESTED WAS PERFORMED LESS THAN FIVE YEARS AGO.
P353	THE EXISTING APPLIANCE HAS NOT BEEN WORN FOR THREE YEARS.
P367	THE CLIENT HAS BEEN TOTALLY WITHOUT TEETH AND AN APPLIANCE FOR FIVE YEARS.
P392	THE CLIENT IS MISSING AN ANTERIOR TOOTH AND/OR HAS TWO OR MORE POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P405	THE SERVICE(S) REQUESTED COULD ADEQUATELY BE PERFORMED IN THE DENTAL OFFICE.
P406	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE OF GOOD PERIODONTAL HEALTH (AMERICAN ACADEMY OF PERIODONTOLOGY PERIODONTAL CLASSIFICATION OF TYPE I OR II).
P407	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE VISIBLE ON RADIOGRAPHS THAT AT LEAST 50 PERCENT OF THE CLINICAL CROWN IS INTACT.
P409	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING SIX OR MORE TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED, INCLUDING THIRD MOLARS.
P410	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING ONE OR MORE ANTERIOR TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED.
P411	DOCUMENTATION DOES NOT SUPPORT THE NEED FOR PERIODONTIC SERVICES. POCKETS ARE LESS THAN 4MM AND/OR GREATER THAN 6MM FOR CLIENT AND/OR THE CLIENT IS UNDER THE AGE OF 13.
P412	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA.
P413	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA. THIS PA HAS BEEN GRANTED AS APPROVED NOT APPROVED WITH REVISIONS. THE DURATION REQUESTED MAY HAVE BEEN REDUCED TO REFLECT COVERAGE LIMITATIONS, PRESCRIBER ORDERS, CONFLICTI
P417	THE SERVICE(S) REQUESTED COULD BE ADEQUATELY PERFORMED WITH LOCAL ANESTHESIA.
P437	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO POOR ORAL HYGIENE.
P444	THIS LINE ITEM IS A DUPLICATE OF ANOTHER LINE ITEM ON THIS PRIOR AUTHORIZATION (PA) REQUEST. PLEASE CORRECT.
P446	THIS IS A DUPLICATE OF AN EXISTING PRIOR AUTHORIZATION (PA) REQUEST. YOU MAY CONTACT PROVIDER SERVICES IF YOU REQUIRE ASSISTANCE. DUPLICATE PA REQUEST
P448	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO DECAY HISTORY.
P449	QUESTIONABLE LONG TERM PROGNOSIS DUE TO GUM AND BONE DISEASE.
P456	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO APPARENT ROOT INFECTION.
P457	OUR RECORDS INDICATE THIS CLIENT HAS EXCEEDED ESTABLISHED PROGRAM LIMITATIONS. COLORADO MEDICAID WILL NOT AUTHORIZE NEW DENTURES.
P458	DOCUMENTATION PROVIDED INDICATES A LESS ELABORATE PROCEDURE SHOULD BE CONSIDERED.
P502	RENTAL ONLY ALLOWED; MEDICAL NEED FOR PURCHASE HAS NOT BEEN DOCUMENTED.
P503	PURCHASE ONLY ALLOWED; MEDICAL NEED FOR RENTAL HAS NOT BEEN DOCUMENTED.
P504	OCCUPATIONAL THERAPY GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P505	THE SERVICE REQUESTED IS INCLUDED IN THE NURSING HOME RATE STRUCTURE.
P511	THIS NATIONAL DRUG CODE IS ONLY BILLABLE AS PART OF A COMPOUND DRUG.
P515	THE PRESENCE OF A HANDICAPPING MALOCCLUSION OR HANDICAPPING DENTOFACIAL DEFORMITY IS NOT SUPPORTED BY THE DOCUMENTATION SUBMITTED.
P521	THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVERED BY COLORADO MEDICAID.
P522	GASTRO-INTESTINAL SURGERY FOR THE PURPOSE OF WEIGHT CONTROL IS COVERED ONLY AS A LIFE THREATENING PROCEDURE.
P523	THE TREATMENT REQUEST IS NOT CONSISTENT WITH THE CLIENT'S DIAGNOSIS.
P524	PSYCHOTHERAPY PROVIDED IN THE CLIENTS HOME IS NOT A COVERED BENEFIT OF COLORADO MEDICAID.
P525	THE INFORMATION PROVIDED IS NOT CONSISTENT WITH THE INTENSITY OF SERVICES REQUESTED.
P526	INTENSIVE MULTIPLE MODALITY TREATMENT IS NOT CONSISTENT WITH THE INFORMATION PROVIDED.
P527	MULTIPLE PROVIDERS OF TREATMENT ARE NOT INDICATED FOR THIS CLIENT.
P528	THE DURATION OF TREATMENT SESSIONS EXCEED CURRENT COLORADO MEDICAID GUIDELINES.

Denial Code	Long Description
P534	DOCUMENTATION OF POOR PHYSICAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P535	OTHER PHYSICAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P536	THE PHYSICAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P537	USE OF PHYSICAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P538	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF A PHYSICAL THERAPIST.
P539	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS AND LIVING ARRANGEMENT.
P540	GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P541	THE PROCEDURE(S) REQUESTED ARE NOT MEDICAL IN NATURE.
P542	DOCUMENTATION OF POOR OCCUPATIONAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P543	DOCUMENTATION OF POOR SPEECH THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P544	OTHER OCCUPATIONAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P546	THE OCCUPATIONAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P547	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF PHYSICAL THERAPY.
P548	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P549	ACTIVITIES TO PROMOTE DIVERSION OR GENERAL MOTIVATION ARE NONCOVERED COLORADO MEDICAID SERVICES.
P550	REVISIONS OF THE REQUEST IS NECESSITATED BY THE CLIENTS MINIMAL PROGRESS.
P551	RESTORATIVE NURSING INVOLVEMENT COULD BE INCREASED.
P552	CLIENTS DEMONSTRATED RESPONSE TO CURRENT THERAPY DOES NOT WARRANT THE INTENSE FREQUENCY REQUESTED.
P553	MAINTENANCE IS TWO TIMES PER WEEK OR LESS.
P554	THE SPEECH THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P555	USE OF OCCUPATIONAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P556	USE OF SPEECH THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P557	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF AN OCCUPATIONAL THERAPIST.
P558	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
P559	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P560	THE MATERIALS/ SERVICES REQUESTED ARE PRINCIPALLY COSMETIC IN NATURE.
P561	THE LENS FORMULA DOES NOT JUSTIFY REPLACEMENT.
P562	THE CHANGE IN THE LENS FORMULA DOES NOT WARRANT MULTIPLE REPLACEMENTS.
P563	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P564	LENSES ONLY ARE APPROVED; PLEASE DISPENSE A CONTRACTED FRAME. THE NON-CONTRACTED FRAME IS NOT MEDICALLY JUSTIFIED.
P565	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P566	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P567	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF OCCUPATIONAL THERAPY.
P568	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF SPEECH THERAPY.
P569	LEVEL, INTENSITY, OR EXTENT OF SERVICE(S) REQUESTED HAS BEEN MODIFIED CONSISTENT WITH MEDICAL NEED AS DEFINED IN THE PLAN OF CARE.

Denial Code	Long Description
P570	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P571	THE SERVICE ASKED FOR IS NOT COVERED BY COLORADO MEDICAID AS THESE TASKS CAN BE DONE BY NURSES OR ACTIVITY STAFF.
P572	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P573	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.
P574	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P575	MEDICAL NEED FOR EQUIPMENT/ SUPPLY REQUESTED IS NOT SUPPORTED BY DOCUMENTATION SUBMITTED.
P576	OTHER SPEECH THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P577	DOCUMENTATION SUBMITTED IDENTIFIES THAT THE CLIENT HAS FEWER THAN TWO POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P582	LESS EXPENSIVE ALTERNATIVE SERVICES ARE AVAILABLE FOR THIS CLIENT.
P634	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P711	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING PERIODONTAL SCALING AND ROOT PLANNING.
P712	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING GINGIVECTOMY.
P754	AN APPROVED SUBSTANCE ABUSE DAY TREATMENT PROGRAM CANNOT EXCEED A SIX WEEK PERIOD.
P761	THE CLIENT DOES NOT APPEAR TO BE ABLE OR WILLING TO ABSTAIN FROM ALCOHOL/DRUG USAGE WHILE IN TREATMENT. THEREFORE, SUBSTANCE ABUSE DAY TREATMENT SERVICES ARE NOT APPROVED.
P764	THIS CLIENT HAS COMPLETED INTENSIVE SUBSTANCE ABUSE TREATMENT WITHIN THE PAST 12 MONTHS. THE DOCUMENTATION PROVIDED IS NOT ADEQUATE TO JUSTIFY ADDITIONAL INTENSIVE TREATMENT AT THIS TIME.
P785	A LESS THAN SIX-WEEK HEALING PERIOD HAS BEEN SPECIFIED FOR THIS PRIOR AUTHORIZATION. THEREFORE IT IS NOT NECESSARY TO WAIT THE FULL SIX WEEKS AFTER EXTRACTIONS BEFORE TAKING DENTURE IMPRESSIONS.
P818	SIX-WEEK HEALING TIME IS REQUIRED BETWEEN EDENTULATION AND FINAL IMPRESSIONS. PAYMENT FOR DENTURES WILL BE DENIED OR RECOUPED IF HEALING PERIOD IS NOT OBSERVED.
P849	COLORADO MEDICAID HAS DETERMINED THERE WERE (ARE) SEVERAL HOME HEALTH AGENCIES WILLING TO PROVIDE MEDICALLY NECESSARY SKILLED NURSING SERVICES TO THIS CLIENT.
P864	THE DOCUMENTATION YOU HAVE SUBMITTED DOES NOT MEET THE REQUIREMENTS OF COLORADO MEDICAID.
P873	THE MEDICAL NECESSITY FOR THE HOURS REQUESTED IS NOT SUPPORTED BY THE INFORMATION SUBMITTED.
P874	THE DOCUMENTATION SUBMITTED INDICATES THE TASKS SPECIFIED CAN BE COMPLETED DURING THE VISITS APPROVED.
P878	THE DOCUMENTATION SUBMITTED DOES NOT INDICATE THAT MEDICALLY ORIENTED TASKS ARE MEDICALLY NECESSARY; THEREFORE PERSONAL CARE SERVICES HAVE BEEN APPROVED.
P880	THE QUANTITY OF SERVICES AUTHORIZED FOR THIS CLIENTS PERSONAL CARE HAS BEEN AMENDED BASED ON INFORMATION RECEIVED FROM ONE OR MORE OF THESE SOURCES: THE CLIENT, THEIR PHYSICIAN, AND/OR THE IN-HOME VISIT BY STAFF OF THE OIG (OFFICE OF INSPECTOR GENERAL).
P885	THE USE OF THIS DRUG FOR THE INTENDED PURPOSE IS NOT COVERED BY COLORADO MEDICAID, CONSISTENT WITH COLORADO ADMINISTRATIVE CODE AND FEDERAL LAW.
P924	THE MEDICAL RECORDS SUBMITTED WITH THE CURRENT REQUEST CONFLICT OR DISAGREE WITH OUR MEDICAL RECORDS ON THIS CLIENT.
P950	INDEPENDENT NURSES, PLEASE NOTE PAYABLE SERVICES MAY NOT EXCEED 12 HOURS/DAY OR 60 HOURS/WEEK.
P951	SERVICES CAN ONLY BE AUTHORIZED THROUGH ONE YEAR FROM THE PRESCRIPTION DATE.
P952	LEAD INSPECTION IS A COVERED COLORADO MEDICAID SERVICE WHEN THE CHILD HAS BEEN SHOWN TO HAVE LEAD POISONING (E.G., CHILD HAS A BLOOD LEAD LEVEL > 19 UG/DL OR TWO CONSECUTIVE BLOOD LEAD LEVELS OF 15-19 UG/DL DONE AT LEAST 90 DAYS APART). THE INSPECTION MUS

Denial Code	Long Description
P953	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P954	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P956	THE REQUEST CAN ONLY BE BACKDATED A MAXIMUM OF 14 DAYS FROM FIRST DATE RECEIVED BY COLORADO MEDICAID.
P957	COMPLETE PERIODONTAL CHARTING AT TIME OF SERVICE, AND SUBMIT CHARTING, COPY OF OPERATIVE REPORT, TOGETHER WITH A COPY OF THE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF), F-11035, TO PA UNIT ATTENTION DENTAL CONTSULTANT.
P958	NOTE THAT CODE D4341 HAS BEEN CHANGED. REFER TO THE DECISION NOTICE FOR AUTHORIZED QUANTITY.
P960	YOUR PA HAS BEEN APPROVED FOR 90 DAYS. THE 90 DAY APPROVAL DOES NOT IMPLY THE PA REQUEST MEETS PRIOR AUTHORIZATION CRITERIA. AFTER ADDITIONAL INFORMATION IS AVAILABLE IN INTERCHANGE, COLORADO MEDICAID WILL CREATE AN AMENDMENT REQUEST TO EXTEND THE PA FOR
P961	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P962	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
PA10	THE REQUESTED END DATE IS INVALID.
PA12	PLEASE FURNISH A WRITTEN DESCRIPTION OF THE CLIENTS DIAGNOSIS.
PA13	PROVIDE DIAGNOSES WITH DATES OF ONSET.
PA14	IDENTIFY PROBLEMS TO BE TREATED.
PA15	THE AUDIOLOGISTS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1), F-11020, AND PRIOR AUTHORIZATION REQUEST/HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2), F-11021.
PA16	THE PHYSICIANS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION/PHYSICIAN OTOLOGICAL REPORT (PA/POR), F-11019.
PA17	SUBMIT BRIEF HISTORY WITH REFERRAL INFORMATION, LIVING SITUATION, FUNCTIONAL STATUS, AND OTHER PERTINENT INFORMATION. WHAT CHANGE OF STATUS RESULTED IN REFERRAL AT THIS TIME?
PA18	PLEASE FURNISH THE CLIENTS HEIGHT AND WEIGHT.
PA19	PLEASE SUBMIT CLINICAL INFORMATION SUFFICIENT TO VERIFY THE NEED FOR THE REQUESTED SERVICE(S).
PA20	PLEASE RESUBMIT WITH COMPLETE PERIODONTAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PA21	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL EDUCATIONAL PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA22	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL PROGRAM PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA23	REFER TO THE DURABLE MEDICAL EQUIPMENT INDEX FOR APPROPRIATE CODE AND DESCRIPTION. DO NOT USE AN "UNLISTED" CODE.
PA24	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUALIZED FAMILY SERVICE PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA25	INFORMATION ON THE REQUEST FORM IS ILLEGIBLE, AND THE REQUEST CANNOT BE PROCESSED.
PA26	RE-EVALUATE YOUR GOALS. EMPHASIS SHOULD BE ON FUNCTIONAL SELF-CARE. GOALS MUST BE RELATED TO FUNCTIONAL OUTCOME.
PA27	PLEASE CLARIFY THE NUMBER OF HOURS PER WEEK REQUESTED.
PA28	PLEASE CLARIFY THE NUMBER OF HOURS PER DAY REQUESTED.
PA29	PLEASE CLARIFY THE NUMBER OF VISITS PER DAY REQUESTED.
PA30	ATTACH SUPPORTIVE DOCUMENTATION; HOME EXERCISE PROGRAM AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA31	THE DIAGNOSIS CODE INDICATED ON THE REQUEST DOES NOT CORRESPOND TO THE DIAGNOSIS CODE DESCRIPTION.

Denial Code	Long Description
PA32	PLEASE SUBMIT ADDITIONAL INFORMATION SUFFICIENT TO VERIFY APPROPRIATENESS AND NEED FOR TRANSPLANT.
PA33	PLEASE SUBMIT THE INITIAL AND PROGRESSIVE OBJECTIVE FINDINGS.
PA34	ATTACH SUPPORTIVE DOCUMENTATION, FACILITY PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA35	PLEASE SUBMIT THE CLIENTS ORIGINAL COMPLAINTS AND EXAMINATION FINDINGS.
PA36	ATTACH SUPPORTIVE DOCUMENTATION, IN-HOME AUTISM PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA37	PLEASE SUBMIT YOUR TREATMENT PLAN FOR THIS CLIENT.
PA38	ATTACH SUPPORTIVE DOCUMENTATION AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA39	INITIAL EVALUATIONS MUST BE PERFORMED BY AN OCCUPATIONAL THERAPIST REGISTERED (OTR), PER AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA) STANDARDS.
PA41	IDENTIFY THE PLACE OF SERVICE AND ITS EFFECT ON SUPPORTING THE DESIRED TREATMENT OUTCOME.
PA42	PLEASE INDICATE THE HOURS OF USE OF OXYGEN PER 24-HOUR PERIOD.
PA43	PROVIDE BASELINE DOCUMENTATION FOR THIS CLIENTS LIMITATIONS USING UNITS OF MEASUREMENT THAT ARE APPLIED CONSISTENTLY WHEN REPORTING STATUS.
PA44	IDENTIFY FUNCTIONAL LIMITATIONS AS THEY ARE RELATED TO IDENTIFIED CONDITIONS.
PA46	CORRELATE PLAN OF CARE TO REQUESTED PROCEDURE CODES.
PA47	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE FREQUENCY/DURATION REQUESTED.
PA48	PLEASE PROVIDE THE NAME AND CREDENTIALS OF THE RENDERING PROVIDER.
PA50	COLORADO MEDICAID RECORDS INDICATE THE CLIENT OWNS A WHEELCHAIR. DOCUMENT THE REASON AND NEED FOR REPLACEMENT AND COST TO REPAIR CURRENT WHEELCHAIR.
PA51	PLEASE DISTINGUISH PRIMARY AND SUPPORTIVE MODALITIES.
PA52	PLEASE SUBMIT A PROGRESS REPORT.
PA53	MULTIPLE FAMILY CLIENTS TREATMENT BY THE SAME PROVIDER REQUIRES FURTHER INFORMATION DOCUMENTING COORDINATION OF TREATMENT PLAN.
PA54	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE MINUTES REQUESTED.
PA55	MEDICAL NECESSITY OF TREATMENT REQUIRES ADDITIONAL DOCUMENTATION.
PA56	GIVEN AGE, DIAGNOSES, CURRENT LEVEL OF FUNCTION, PAST RESPONSE TO TREATMENT, AND LIVING SITUATION, EXPAND ON POTENTIAL FOR SIGNIFICANT FUNCTIONAL PROGRESS WITHIN THE NEXT SIX MONTHS. EMPHASIZE WHY PROGRESS IS EXPECTED WITH SERVICES AT THIS TIME.
PA57	SUBMIT THE INITIAL FINDINGS. INCLUDE A COMPREHENSIVE EVALUATION.
PA58	SUBMIT PROGRESSIVE, OBJECTIVE FINDINGS. INCLUDE A PERTINENT RE-EVALUATION.
PA59	PLEASE SUPPLY INFORMATION REGARDING THE CLIENTS MEDICATION REQUIREMENTS, IF ANY.
PA60	PLEASE SPECIFY IF THE CLIENT IS IN AN EDUCATIONAL SETTING.
PA61	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA62	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
PA63	THE SKILLS OF A THERAPIST ARE PURPOSEFUL AND SKILLED INTERVENTIONS REQUIRED TO CONTINUALLY DESIGN, IMPLEMENT, REASSESS, MODIFY/GRADE, AND/OR DISCONTINUE A PLAN OF CARE IN A TIMELY MANNER, BASED ON THE COMPLEXITY OF THE CLIENTS MEDICAL CONDITION AND/OR CO
PA64	PLEASE SUBMIT A THERAPY PLAN OF CARE, INCLUDING A CURRENT, DATED EVALUATION.
PA65	A PLAN OF CARE SIGNED AND DATED BY THE PHYSICIAN IS REQUIRED.
PA66	THE SKILLS OF A THERAPIST ARE REQUIRED WHEN ONLY THE THERAPIST CAN SAFELY AND EFFECTIVELY DELIVER THE THERAPEUTIC PROCEDURES BECAUSE OF THEIR UNIQUE KNOWLEDGE, TRAINING, AND EXPERTISE. DESCRIBE THE REASON THAT SOMEONE OTHER THAN A THERAPIST CANNOT SAFELY
PA67	PLEASE SPECIFY IF THE CLIENTS WORK SITE DEMANDS GOOD BINAURAL HEARING.
PA68	DESCRIBE THE REASON, BASED ON THE CLIENTS COGNITIVE, PHYSICAL, COMMUNICATION, OR RESOURCE STATUS, THAT A HOME PROGRAM, EQUIPMENT, OR ENVIRONMENTAL ADAPTATIONS ALONE CANNOT MEET CLIENTS NEEDS.

Denial Code	Long Description
PA69	PLEASE SPECIFY IF THE CLIENT HAS AN ACCOMPANYING DISABILITY THAT ADDS TO THE HEARING PROBLEM.
PA70	DISTINGUISH REQUESTED PROCEDURES AND GOALS FROM OTHER SERVICES THIS CLIENT RECEIVES. THEY MAY NOT BE DUPLICATIVE.
PA71	PLEASE INDICATE THE NUMBER OF DAYS REQUESTED.
PA73	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA74	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA75	PLEASE DOCUMENT CARRYOVER OF THE THERAPY PROGRAM TO NURSING.
PA76	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA79	PROVIDE EVIDENCE OF SIGNIFICANT FUNCTIONAL PROGRESS IN LAST SIX MONTHS.
PA84	THE GRANT DATE OF THIS REQUEST CANNOT BE PRIOR TO THE SIGNATURE DATE OF THE PRESCRIBING PHYSICIAN.
PA86	PROVIDE EVIDENCE OF SKILLS GAINED IN THERAPY CARRYING OVER TO OTHER SETTINGS WITHIN SIX MONTHS.
PA87	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE NUMBER OF SESSIONS REQUESTED.
PA88	THE REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL SCOPE OF PRACTICE.
PA89	PRIOR AUTHORIZATION IS NOT REQUIRED UNTIL LIMITATION OF SERVICE HAS BEEN REACHED.
PA91	PLEASE SUBMIT REQUIRED X-RAYS.
PA92	PLEASE PROVIDE AN EXPLANATION FOR THE MATERIAL SUBMITTED WITH THE REQUEST.
PA95	PLEASE DESCRIBE HOW THE PROVISION OF THIS SERVICE WOULD PREVENT INSTITUTIONALIZATION OF THE CLIENT.
PA96	COULD THE EXISTING DENTURE(S) BE RELINED OR REBASED? IF NOT, PLEASE EXPLAIN WHY NOT.
PA97	REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL STANDARDS OF PRACTICE.
PA98	PLEASE INDICATE IF THE CLIENT IS CURRENTLY BEING TUBE FED.
PB02	PLEASE PROVIDE THE REQUIRED DATED SIGNATURES ON THE ATTACHMENTS.
PB03	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING THE LOSS/DESTRUCTION/THEFT OF THE HEARING AID.
PB04	DESCRIBE THE CLIENTS ABILITY TO STAND OR AMBULATE SUFFICIENTLY TO ACCOMPLISH SELF-CARE ACTIVITIES.
PB07	PLEASE SUBMIT AN ORTHODONTIC STUDY MODEL OR DIAGNOSTIC CASTS.
PB09	PLEASE PROVIDE A PHOTOGRAPH OF THE INVOLVED AREA(S).
PB10	PLEASE PROVIDE AN ESTIMATION (IN GRAMS) OF THE TOTAL AMOUNT OF TISSUE TO BE RESECTED.
PB11	PLEASE SUBMIT THE PLAN OF CARE FOR CO-TREATMENT.
PB12	FURNISH A DETAILED DESCRIPTION FOR THE PROCEDURE CODE REQUESTED.
PB13	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB15	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB18	PLEASE COMPLETE THE ATTACHED OUT-OF-STATE PROVIDER DATA SHEET, F-11001, AND RESUBMIT.
PB20	A SIGNED AND DATED PRESCRIPTION IS REQUIRED WITHIN THREE MONTHS OF RECEIPT BY COLORADO MEDICAID FOR INITIAL REQUESTS AND WITHIN 12 MONTHS OF RECEIPT BY COLORADO MEDICAID FOR SUBSEQUENT REQUESTS.
PB21	PLEASE COMPLETE THE APPROPRIATE PRIOR AUTHORIZATION ATTACHMENT. CONTACT PROVIDER SERVICES OR THE PRIOR AUTHORIZATION UNIT FOR ASSISTANCE.
PB23	PHYSICAL THERAPY ASSISTANT NOTES AND ALL FORMS SUBMITTED MUST BE COSIGNED BY A REGISTERED PHYSICAL THERAPIST.
PB31	ARE YOU REQUESTING A COMPLETE APPLIANCE, OR REPLACEMENT PARTS?
PB32	THE PROCEDURE CODE INDICATED ON THE REQUEST DOES NOT MATCH THE DESCRIPTION OF SERVICE; PLEASE CORRECT AND RESUBMIT.
PB35	THE SERVICE REQUESTED DOES NOT REQUIRE PRIOR AUTHORIZATION.
PB41	PLEASE FURNISH A CURRENT MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT, F-11090 (DATED WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID).

Denial Code	Long Description
PB45	THE CERTIFICATION PERIOD ON THE PLAN OF CARE (POC) DOES NOT COVER THE REQUESTED GRANT/START DATE. PLEASE RESUBMIT YOUR REQUEST WITH A NEW POC.
PB49	A CERTIFIED OCCUPATIONAL THERAPY ASSISTANTS NOTES MUST BE COSIGNED BY AN OCCUPATIONAL THERAPIST REGISTERED.
PB51	ADDITIONAL INFORMATION IS REQUIRED ON PRIOR AUTHORIZATION TO ENABLE PRICING.
PB54	REQUESTED SERVICES DO NOT MATCH SERVICES ON THE PHYSICIANS ORDERS.
PB59	PLEASE PROVIDE AN INDIVIDUAL EDUCATIONAL PLAN (IEP), WHICH HAS BEEN SIGNED BY THE PROVIDER NO EARLIER THAN NINE MONTHS PRIOR TO RECEIPT AT COLORADO MEDICAID; OTHERWISE, DOCUMENT WHY NO IEP EXISTS.
PB65	PLEASE FURNISH THE ANTICIPATED TOTAL CHARGES FOR THIS REQUEST.
PB66	A PHOTOCOPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED; THE DATE MUST BE WITHIN SIX MONTHS OF RECEIPT BY COLORADO MEDICAID.
PB67	THE PRESCRIPTION DATE MUST INCLUDE MONTH, DAY, AND YEAR.
PB68	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID.
PB73	THE SERVICES IDENTIFIED ON THE PLAN OF CARE DO NOT APPEAR APPROPRIATE FOR THE PROCEDURE CODE(S) REQUESTED ON THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018.
PB74	THE CLIENT/PROVIDER DOES NOT HAVE RETROACTIVE ENROLLMENT.
PB75	THE REQUESTED START DATE IS MORE THAN 14 DAYS BEFORE OR 62 DAYS AFTER RECEIPT.
PB82	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
PB83	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A HOME HEALTH AIDE. PLEASE RESUBMIT AS A PERSONAL CARE WORKER OR PROVIDE ADDITIONAL DOCUMENTATION.
PB86	THE SERVICES REQUESTED ARE NOT BEING PROVIDED IN THE CLIENTS RESIDENCE. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL.
PB87	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A NURSE. PLEASE RESUBMIT AS A HOME HEALTH AIDE OR PROVIDE ADDITIONAL DOCUMENTATION.
PB92	PLEASE FURNISH THE CLIENTS COMPLETE ADDRESS.
PB94	IF THE CLIENT IS A RESIDENT OF A NURSING HOME, SUPPLY THE COMPLETE NAME AND ADDRESS OF THE NURSING HOME.
PB99	THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018, MUST BE SIGNED AND DATED.
PC01	PLEASE SUPPLY THE RENDERING PROVIDERS PROVIDER NUMBER.
PC03	THE DRUG ENFORCEMENT ADMINISTRATION NUMBER IS MISSING OR INVALID.
PC06	PLEASE DESCRIBE YOUR PROGRAM; INCLUDE ENTRY DATE, TERMINATION DATE, HOURS PER WEEK, AND NUMBER OF WEEKS OF PRIMARY INTENSIVE SERVICE REQUESTED.
PC07	PLEASE DESCRIBE YOUR "AFTERCARE/FOLLOW-UP" PLANS FOR THIS CLIENT.
PC08	PLEASE SUPPLY DOCUMENTATION OF PREVIOUS SUBSTANCE ABUSE SERVICES WITH DATE(S) AND OUTCOME.
PC09	PLEASE DESCRIBE IN DETAIL THE TREATMENT OBJECTIVES/GOALS FOR THIS CLIENT.
PC10	PLEASE DESCRIBE THE FAMILY SITUATION/DYNAMICS. EXPLAIN HOW THE FAMILY WILL BE INCORPORATED INTO THE CLIENTS PLAN OF CARE.
PC12	PLEASE EXPLAIN IF YOUR SERVICE ENCOURAGES THE CLIENT TO ATTEND SELF-HELP GROUPS.
PC13	PLEASE SUPPLY A SPECIFIC SCHEDULE OF ACTIVITIES, INCLUDING DAY, TIME OF DAY, LENGTH OF SESSION, AND SERVICE TO BE RENDERED DURING THAT TIME.
PC15	PLEASE FURNISH DIAGNOSTIC RATIONALE.
PC17	PLEASE DOCUMENT IF THE CLIENT EVER RECEIVED SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT.
PC19	PLEASE FURNISH MORE EXTENSIVE AND IN-DEPTH HISTORICAL AND PSYCHOSOCIAL DATA.
PC20	PLEASE SUPPLY THE DATE THE CLIENT BECAME TOTALLY ENDENTULOUS.
PC23	PLEASE SUBMIT A PHYSICIANS STATEMENT REGARDING THE MEDICAL NECESSITY OF DENTURES FOR THIS CLIENT. THE PHYSICIANS STATEMENT MUST DOCUMENT THE MEDICAL NEED FOR DENTURES.
PC24	THE SERVICE REQUESTED WAS PREVIOUSLY AUTHORIZED. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT INDICATING THIS FACT IS REQUIRED.
PC25	PLEASE SUPPLY SUFFICIENT MITIGATING CIRCUMSTANCES TO WARRANT THE CONSTRUCTION OF NEW DENTURES(S).

Denial Code	Long Description
PC26	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
PC28	PLEASE SUBMIT A PHYSICIANS STATEMENT INDICATING DENTURES ARE NECESSARY FOR THIS NURSING HOME CLIENT.
PC29	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING LOSS OR DESTRUCTION OF DENTURE(S). INCLUDE SIGNED STATEMENT FROM CLIENT OR FACILITY DIRECTOR REGARDING HOW, WHEN AND WHERE LOST.
PC30	PLEASE PROVIDE COMPLETE INTRAORAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PC31	PLEASE DESCRIBE ANY RELATED DEFORMITIES OF THE FEET.
PC34	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD WITH REQUESTED DME ITEM(S) AND DOCUMENT IF THE CLIENT CAN USE SAFELY AND INDEPENDENTLY.
PC35	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD AND DESCRIBE THE RESULTS AND EFFECTIVENESS OF THE SERVICE REQUESTED.
PC39	PLEASE INDICATE LITER FLOW PER MINUTE, HOURS OF USE PER 24 HOUR PERIOD, AND THE EXPECTED DURATION OF NEED.
PC40	THE ITEM DOES NOT REQUIRE PRIOR AUTHORIZATION UNTIL THE LIFE EXPECTANCY HAS BEEN REACHED.
PC41	PLEASE SUPPLY INFORMATION INDICATING THE NECESSITY OF POSITIONING THE CLIENT'S BODY IN MULTIPLE POSITIONS.
PC42	PLEASE INDICATE IF THE BED HEIGHT MUST BE CHANGED TO ALLOW FOR SAFE TRANSFER OR ADEQUATE BED CARE.
PC43	SUPPLY A PHYSICIANS STATEMENT INDICATING TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR UNIT HAS REDUCED PAIN, IMPROVED/INCREASED THE CLIENTS ACTIVITY LEVEL, AND/OR REDUCED CLIENTS USE OF PAIN MEDICATION.
PC44	A CURRENT AUTHORIZATION FOR THIS SERVICE IS ON FILE FOR ANOTHER PROVIDER. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT OF THAT FACT IS REQUIRED BY THE CLIENT OF FIRST PROVIDER.
PC59	DOCUMENT DECLINE OR PROGRESS IN SPECIFIC, MEASURABLE, OBJECTIVE TERMS.
PC60	DOCUMENT IF CLIENT HAS DEMONSTRATED A GOOD APPOINTMENT COMPLIANCE RECORD.
PC61	THE PHYSICIANS SIGNATURE DATE MUST NOT EXCEED 90 DAYS FROM THE DATE OF RECEIPT BY COLORADO MEDICAID.
PC62	REQUESTS FOR A CONTINUATION OF THERAPY SHOULD NOT BE SUBMITTED MORE THAN FOUR WEEKS PRIOR TO THE EXPIRATION DATE OF THE CURRENT AUTHORIZATION.
PC63	PLEASE FURNISH THE STYLE AND MANUFACTURER OF THE FRAME.
PC64	PLEASE FURNISH THE CLIENTS LENS FORMULA.
PC66	ALL REQUESTS FOR TINTS REQUIRE DOCUMENTATION OF THE VISUAL OR MEDICAL CONDITION RELATED TO PHOTOPHOBIA.
PC67	PLEASE DOCUMENT THE REASON AND JUSTIFICATION FOR REPLACEMENT BEYOND THE FIRST LENS/FRAME.
PC68	DOCUMENT IF ALL REMAINING MAXILLARY AND/OR MANDIBULAR TEETH ARE DECAY-FREE, PROPERLY RESTORED, AND PERIODONTICALLY SOUND.
PC72	SUPPLY MORE DETAIL REGARDING PROGRESS (ATTACHMENT OF GOALS, ETC.). CORRELATE PROGRESS TO PREVIOUS GOALS AND IDENTIFIED LIMITATIONS.
PC77	PLEASE SUBMIT A PLAN OF CARE DESCRIBING THE SERVICES THAT WOULD BE PROVIDED.
PC78	PLEASE DOCUMENT SPECIFIC, MEASURABLE GOALS.
PC82	THE PRIOR AUTHORIZATION (PA) SYSTEM CAN PROCESS ONLY 26 DETAILS PER PA REQUEST. PLEASE RESUBMIT YOUR REQUEST WITH NO MORE THAN 26 DETAILS.
PC83	PLEASE SUPPLY A PHYSICIANS PRESCRIPTION DATED WITHIN ONE MONTH OF REQUESTED SUBSTANCE ABUSE DAY TREATMENT.
PC84	PLEASE PROVIDE INFORMATION INDICATING THIS CLIENT IS APPROPRIATELY DETOXIFIED FROM ALCOHOL AND/OR OTHER DRUGS.
PC85	PLEASE PROVIDE INFORMATION TO INDICATE THE CLIENTS ABILITY TO ABSTAIN FROM ALCOHOL OR DRUGS WHILE IN THE SUBSTANCE ABUSE DAY TREATMENT PROGRAM.
PC86	PLEASE INDICATE IF THIS CLIENT IS WILLING TO PARTICIPATE IN AFTERCARE OR CONTINUING CARE SERVICES.

Denial Code	Long Description
PC87	PROVIDE MORE INFORMATION ON TREATMENT HISTORY; INCLUDE SERVICE PROVIDED, DATES, AND OUTCOME. PROVIDE DETAIL OF PREVIOUS TREATMENT.
PC88	PLEASE PROVIDE MORE RATIONALE FOR THE APPROPRIATENESS AND MEDICAL NECESSITY OF SUBSTANCE ABUSE DAY TREATMENT.
PC89	PROVIDE A TREATMENT PLAN THAT CONTAINS MEASURABLE GOALS AND OBJECTIVES CORRESPONDING TO THE IDENTIFIED DEFICIT.
PC91	PLEASE PROVIDE MORE INFORMATION ON FAMILY INVOLVEMENT TREATMENT.
PC92	PLEASE PROVIDE MORE HISTORY AND EXPLANATION ABOUT THE ISSUE OF ABSTINENCE FOR THIS CLIENT.
PC94	PLEASE PROVIDE THE ANTICIPATED BEGINNING DATE AND/OR THE ESTIMATED SUBSTANCE ABUSE DAY TREATMENT DISCHARGE DATE.
PC95	PLEASE SUPPLY JUSTIFICATION FOR BEGINNING CLIENT IN SERVICE PRIOR TO AUTHORIZATION BEING OBTAINED.
PC96	THE INITIAL THREE HOURS OF SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IN A CALENDAR YEAR DO NOT REQUIRE PRIOR AUTHORIZATION.
PC97	REIMBURSEMENT FOR INITIAL SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IS LIMITED TO THREE HOURS IN A CALENDAR YEAR AND DOES NOT REQUIRE PRIOR AUTHORIZATION.
PC98	THIS DRUG IS CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE BILL USING THE APPROPRIATE NATIONAL DRUG CODE (NDC) OR SUBMIT A COMPLETED DRUG ADDITION REQUEST FORM IF THE NDC IS NOT LISTED IN THE DRUG INDEX.
PC99	THIS DRUG IS NOT CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL, CURRENT ADMINISTRATIVE RULE, OR COLORADO DRUG INDEX FOR COVERAGE LIMITATIONS.
PD01	DOCUMENT THAT CLIENT HAS ACHIEVED GOOD ORAL HYGIENE, PERIODONTAL CASE TYPE 1 OR 2, AND IS MOTIVATED TO MAINTAIN SAME.
PD03	PLEASE PROVIDE AN ARTERIAL BLOOD GAS READING OR PULSE OXIMETRY RESULTS DONE ON ROOM AIR SIGNED AND DATED BY A MEDICAL DOCTOR. THIS SHOULD BE DONE WITHIN 60 DAYS OF REQUESTED SERVICE.
PD04	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 30 DAYS OF RECEIPT BY COLORADO MEDICAID.
PD07	SUBMIT A PHOTOCOPY OF A VALID PRESCRIPTION, ISSUED WITHIN THE PAST YEAR, OR COMPLETE SECTION B OF THE PRIOR AUTHORIZATION/DRUG ATTACHMENT (PA/DGA), F-11049.
PD10	BRAND MEDICALLY NECESSARY MUST BE IN THE PRESCRIBERS OWN HANDWRITING AND WRITTEN DIRECTLY ON THE PRESCRIPTION OR A SEPARATE ORDER ATTACHED TO THE ORIGINAL PRESCRIPTION.
PD12	COMPLETE DENTURES, PARTIAL DENTURES, DENTURE RELINES, AND FIXED PROSTHODONTIC SERVICES ARE NOT COVERED SERVICES FOR ADULTS FOR DATES OF SERVICE ON AND AFTER OCTOBER 1, 1995.
PD22	PLEASE COMPLETE ALL REQUIRED ELEMENTS ON THE PERSONAL CARE SCREENING TOOL (PCST), F-11133.
PD24	THIS PRIOR AUTHORIZATION REQUEST IS UNABLE TO BE PROCESSED. PLEASE RESUBMIT WITH ADDITIONAL REQUIRED FORMS, INCLUDING THE ENTIRE PERSONAL CARE SCREENING TOOL (PCST), F-11133; PERSONAL CARE ADDENDUM, F-11136; AND SUPPORTING DOCUMENTATION, AS DIRECTED.
PD25	THERE IS A PERSONAL CARE SCREENING TOOL (PCST), F-11133, COMPLETED BY ANOTHER AGENCY. CONTACT THE AGENCY TO TRANSFER SCREEN.
PD26	THERE IS A LIMITED TERM CARE FUNCTIONAL SCREEN (LTC-FS) COMPLETED BY ANOTHER AGENCY. THE PERSONAL CARE SCREENING TOOL (PCST), F-11133, INFORMATION IS IN CONFLICT WITH LTC-FS.
PD27	ONLY ONE LEVEL OF FUNCTION MAY BE SELECTED FOR ALL ELEMENTS EXCEPT TOILETING. COLORADO MEDICAID IS UNABLE TO PROCESS THE PRIOR AUTHORIZATION REQUEST.
PD28	NO UNITS MAY BE REQUESTED USING THIS PRIOR AUTHORIZATION PROCESS. PLEASE SUBMIT WITH THE APPROPRIATE ATTACHMENTS FOR REQUESTING SPECIFIC PERSONAL CARE WORKER UNITS.
PD29	CLIENT IS NOT ELIGIBLE FOR THE REQUESTED SERVICE(S) AS OF THE REQUESTED START DATE.
PD30	NO TRAVEL TIME MAY BE AUTHORIZED WHEN NO PERSONAL CARE WORKER SERVICE IS AUTHORIZED.
PD32	PROVIDER NOT CERTIFIED TO RENDER THE SERVICE(S) REQUESTED.
PD34	BASED ON THE DOCUMENTATION SUBMITTED, THIS REQUEST CAN NOT BE PRIOR AUTHORIZED. REFER TO THE PA MESSAGES FROM THE CONSULTANT FOR COMPLETE EXPLANATION.
PD98	PLEASE DOCUMENT HOW AND WHEN EACH PREVIOUSLY AUTHORIZED PRO RE NATA VISIT WAS USED.

Nursing Facility

Denial Code	Long Description
0201	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
0233	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0235	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0237	CLIENT IDENTIFICATION NUMBER DOES NOT MATCH CLIENTS FIRST NAME.
0238	THE CLIENT IDENTIFICATION NUMBER DOES NOT MATCH THE CLIENTS LAST NAME.
0242	SECONDARY DIAGNOSIS CODE IS INVALID.
0248	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0249	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0251	PROCEDURE CODE MODIFIER IN FIRST POSITION IS INVALID.
0252	THE PROCEDURE CODE MODIFIER IN SECOND POSITION IS INVALID FOR REQUESTED START DATE OR DATE OF RECEIPT.
0253	THE PROCEDURE CODE MODIFIER IN THIRD POSITION IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
0258	THE PRIMARY DIAGNOSIS CODE IS REQUIRED.
0272	THE PRIMARY DIAGNSOSIS CODE IS INVALID.
0400	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0853	HCPCS - ANNUAL UPDATE
0885	NEVER EVENTS MODIFIERS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
0886	NEVER EVENTS DIAGNOSIS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
1000	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
1002	RENDERING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1003	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1007	RENDERING PROVIDER ID IS NOT ON FILE.
1047	THE RENDERING PROVIDERS CERTIFICATION HAS BEEN CANCELLED.
1048	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1801	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
1804	A CERTIFIED SUBSTANCE ABUSE DAY TREATMENT PROVIDER MUST SUBMIT A SUBSTANCE ABUSE DAY TREATMENT PROCEDURE CODE.
1806	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
1808	THE BILLING PROVIDER DOES NOT HAVE THE REQUIRED CERTIFICATION ADDENDUM ON FILE.
1900	THE BILLING PROVIDERS TAXONOMY CODE IS INVALID.
1901	THE RENDERING PROVIDERS TAXONOMY CODE IS INVALID.
1927	A NATIONAL PROVIDER IDENTIFIER IS REQUIRED FOR THE BILLING PROVIDER.
1934	A NATIONAL PROVIDER INDENTIFIER IS REQUIRED FOR THE RENDERING PROVIDER.
1936	THE BILLING PROVIDER NUMBER IS INVALID.
1937	THE RENDERING PROVIDER NUMBER IS INVALID.
1960	INTERNAL PROCESSING IS REQUIRED.
1963	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.
1964	THE BILLING PROVIDER INDICATED IS NOT ALLOWABLE AS A BILLING PROVIDER.
1965	RENDERING PROVIDER NUMBER IS MISSING/INVALID FOR THIS PROCEDURE PROVIDER.
1974	PRESCRIBING/REFERRING/ORDERING PROVIDER INDICATED IS NOT CERTIFIED AS A PRESCRIBING/REFERRING/ORDERING PROVIDER.
1975	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
1976	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
2001	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2003	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2017	THE CLIENT IS ENROLLED IN A MEDICAID OR OTHER MANAGED CARE PROGRAM.

Denial Code	Long Description
2037	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2603	CLIENT LOCKED-IN TO A PROVIDER OR ENROLLED IN A HOSPICE. CONTACT CLIENTS HOSPICE FOR PAYMENT OF SERVICES OR RESUBMIT WITH DOCUMENTATION OF UNRELATED NATURE OF CARE.
3324	THE MODIFIER HAS BEEN DISCONTINUED BY THE CENTERS OF MEDICARE AND MEDICAID SERVICES OR THE AMERICAN MEDICAL ASSOCIATION FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
3337	THE PROCEDURE CODE HAS BEEN TERMINATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AMERICAN MEDICAL ASSOCIATION, OR AMERICAN DENTAL ASSOCIATION FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT. RESUBMIT WITH VALID A PROCEDURE CODE.
3339	THE PROCEDURE BILLED IS NOT PAYABLE ACCORDING TO DEFICIT REDUCTION ACT (DEFRA) GUIDELINES.
3351	THE PROCEDURE IS NOT COVERED FOR CLIENTS WITH A NURSING HOME AUTHORIZATION ON THE REQUESTED START DATE OR DATE OF RECEIPT.
3353	THE PROCEDURE IS NOT A COVERED SERVICE FOR HOME AND COMMUNITY-BASED WAIVER CLIENTS.
4021	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4027	THE DIAGNOSIS CODE IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
4031	THE PROCEDURE SUBMITTED IS NOT APPROPRIATE FOR CLIENTS GENDER.
4032	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4034	THE PROCEDURE CODE HAS AN AGE RESTRICTION.
4036	THE PLACE OF SERVICE CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4040	THE PRIMARY DIAGNOSIS CODE IS NOT ON FILE.
4041	THE SECONDARY DIAGNOSIS IS NOT ON FILE.
4046	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4127	INTERNAL PROCESSING IS REQUIRED.
4131	INTERNAL PROCESSING IS REQUIRED.
4141	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4149	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4150	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4236	ETIOLOGY DIAGNOSIS CODE(S) (E-CODES) ARE INVALID AS THE PRIMARY DIAGNOSIS.
4244	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4245	THE FOURTH POSITION MODIFIER IS INVALID FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT.
4256	THE PROCEDURE CODE AND MODIFIER COMBINATION IS NOT PAYABLE FOR THE CLIENTS BENEFIT PLAN.
4257	THE MODIFIERS SUBMITTED ARE EITHER INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT OR THE MODIFIERS ARE MISSING.
4311	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4315	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4316	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4371	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4372	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4711	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR CLIENTS AGE.
4714	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS AGE.
4731	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS DIAGNOSIS.
4742	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4743	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4744	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4745	DIAGNOSIS AND/OR PROCEDURE AND/OR PLACE OF SERVICE (POS) CODE IS NOT COVERED FOR EXPRESS ENROLLMENT CLIENTS.
4746	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4801	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4802	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
4821	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
4871	PLEASE REFER TO PA MESSAGES FOR RETURN INFORMATION.

Denial Code	Long Description
4963	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS GENDER.
4990	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
7500	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
7509	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
P001	THE BILLING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THE SERVICES.
P002	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P003	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P005	THE PRIOR AUTHORIZATION CAN NOT BE END DATED. THE PRIOR AUTHORIZATION STATUS IS NOT APPROVED OR APPROVED WITH REVISIONS.
P006	PLEASE FURNISH THE PROCEDURE CODE AND CORRESPONDING DESCRIPTION.
P008	THE BILLING PROVIDER NUMBER IS INVALID.
P009	THE BILLING PROVIDER NUMBER IS INVALID.
P010	THE REQUESTED END DATE IS INVALID.
P011	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P012	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P013	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P014	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P015	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P016	THE REQUESTED START DATE IS MISSING OR INVALID.
P019	THE REQUESTED START DATE IS MISSING OR INVALID.
P020	THE RENDERING PROVIDER NUMBER IS INVALID.
P021	THE RENDERING PROVIDER NUMBER IS INVALID.
P022	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P023	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P024	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P026	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P027	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P030	FIRST MODIFIER IS INVALID.
P031	FIRST MODIFIER IS INVALID.
P032	SECOND MODIFIER IS INVALID.
P033	SECOND MODIFIER IS INVALID.
P034	THIRD MODIFIER IS INVALID.
P035	THIRD MODIFIER IS INVALID.
P036	FOURTH MODIFIER IS INVALID.
P037	FOURTH MODIFIER IS INVALID.
P038	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P039	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P040	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P041	CLIENTS FIRST NAME IS MISSING.
P042	CLIENTS LAST NAME IS MISSING.
P043	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P044	BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES REQUESTED.
P045	FIRST MODIFIER IS INVALID.
P046	SECOND MODIFIER IS INVALID.
P047	THIRD MODIFIER IS INVALID.
P048	FOURTH MODIFIER IS INVALID.

Denial Code	Long Description
P052	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P053	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P054	RENDERING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES FOR THE BENEFIT PLAN.
P055	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P061	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P062	THE CLIENT ID AND/OR NAME INDICATED ON THE PA REQUEST IS INCORRECT. THE CLIENT ID AND/OR NAME HAS BEEN UPDATED. PLEASE VERIFY THE ID AND/OR NAME IS CORRECT.
P064	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
P067	THE FREQUENCY OF HOURS REQUESTED ARE NOT APPROPRIATE FOR THIS CLIENT AND HAVE BEEN MODIFIED ACCORDINGLY.
P079	BILLING PROVIDER IS ON PAYMENT SUSPENSION DUE TO CREDIBLE ALLEGATION OF FRAUD.
P120	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAS BEEN REDUCED.
P121	THE SERVICE/ PROCEDURE REQUESTED IS NOT SUPPORTED BY SUBMITTED DOCUMENTATION.
P126	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
P128	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.
P138	SERVICE(S) DO NOT MEET COLORADO MEDICAID GUIDELINES.
P167	REQUESTED DOCUMENTATION HAS NOT BEEN SUBMITTED.
P178	THE SERVICE REQUESTED IS NOT MEDICALLY NECESSARY.
P179	THE MEDICAL NECESSITY FOR THIS SERVICE IS NOT SUPPORTED BY THE SUBMITTED DOCUMENTATION.
P233	THE DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE ADDITIONAL CARE.
P257	THIS CLIENTS FUNCTIONAL ASSESSMENT SCORES PLACE THIS CLIENT OUTSIDE ELIGIBILITY FOR DAY TREATMENT.
P274	OUR RECORDS INDICATE THIS CLIENT IS INVOLVED IN EFFECTIVE AND APPROPRIATE SERVICE ELSEWHERE.
P292	INTENSIVE REHABILITATION HOURS ARE NO LONGER APPROPRIATE AS INDICATED BY HISTORY, DIAGNOSIS, AND/ OR FUNCTIONAL ASSESSMENT SCORES.
P328	THE SERVICES REQUESTED INCLUDE NON-COVERED SERVICES, AND HOURS ARE REDUCED ACCORDINGLY.
P339	THE CLIENTS PAST HISTORY INDICATES REDUCED TREATMENT HOURS ARE WARRANTED.
P342	THE REQUEST DOES NOT MEET GENERALLY ACCEPTED CONDITIONS REQUIRING FLUORIDE TREATMENTS.
P346	SERVICES EXCEED COLORADO MEDICAID LIMITATION AND DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE MEDICAL NECESSITY OF THE SERVICE.
P349	THE SERVICE REQUESTED WAS PERFORMED LESS THAN FIVE YEARS AGO.
P353	THE EXISTING APPLIANCE HAS NOT BEEN WORN FOR THREE YEARS.
P367	THE CLIENT HAS BEEN TOTALLY WITHOUT TEETH AND AN APPLIANCE FOR FIVE YEARS.
P392	THE CLIENT IS MISSING AN ANTERIOR TOOTH AND/OR HAS TWO OR MORE POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P405	THE SERVICE(S) REQUESTED COULD ADEQUATELY BE PERFORMED IN THE DENTAL OFFICE.
P406	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE OF GOOD PERIODONTAL HEALTH (AMERICAN ACADEMY OF PERIODONTOLOGY PERIODONTAL CLASSIFICATION OF TYPE I OR II).
P407	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE VISIBLE ON RADIOGRAPHS THAT AT LEAST 50 PERCENT OF THE CLINICAL CROWN IS INTACT.
P409	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING SIX OR MORE TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED, INCLUDING THIRD MOLARS.
P410	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING ONE OR MORE ANTERIOR TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED.
P411	DOCUMENTATION DOES NOT SUPPORT THE NEED FOR PERIODONTIC SERVICES. POCKETS ARE LESS THAN 4MM AND/OR GREATER THAN 6MM FOR CLIENT AND/OR THE CLIENT IS UNDER THE AGE OF 13.
P412	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA.

Denial Code	Long Description
P413	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA. THIS PA HAS BEEN GRANTED AS APPROVED NOT APPROVED WITH REVISIONS. THE DURATION REQUESTED MAY HAVE BEEN REDUCED TO REFLECT COVERAGE LIMITATIONS, PRESCRIBER ORDERS, CONFLICTI
P417	THE SERVICE(S) REQUESTED COULD BE ADEQUATELY PERFORMED WITH LOCAL ANESTHESIA.
P437	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO POOR ORAL HYGIENE.
P444	THIS LINE ITEM IS A DUPLICATE OF ANOTHER LINE ITEM ON THIS PRIOR AUTHORIZATION (PA) REQUEST. PLEASE CORRECT.
P446	THIS IS A DUPLICATE OF AN EXISTING PRIOR AUTHORIZATION (PA) REQUEST. YOU MAY CONTACT PROVIDER SERVICES IF YOU REQUIRE ASSISTANCE. DUPLICATE PA REQUEST
P448	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO DECAY HISTORY.
P449	QUESTIONABLE LONG TERM PROGNOSIS DUE TO GUM AND BONE DISEASE.
P456	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO APPARENT ROOT INFECTION.
P457	OUR RECORDS INDICATE THIS CLIENT HAS EXCEEDED ESTABLISHED PROGRAM LIMITATIONS. COLORADO MEDICAID WILL NOT AUTHORIZE NEW DENTURES.
P458	DOCUMENTATION PROVIDED INDICATES A LESS ELABORATE PROCEDURE SHOULD BE CONSIDERED.
P502	RENTAL ONLY ALLOWED; MEDICAL NEED FOR PURCHASE HAS NOT BEEN DOCUMENTED.
P503	PURCHASE ONLY ALLOWED; MEDICAL NEED FOR RENTAL HAS NOT BEEN DOCUMENTED.
P504	OCCUPATIONAL THERAPY GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P505	THE SERVICE REQUESTED IS INCLUDED IN THE NURSING HOME RATE STRUCTURE.
P511	THIS NATIONAL DRUG CODE IS ONLY BILLABLE AS PART OF A COMPOUND DRUG.
P515	THE PRESENCE OF A HANDICAPPING MALOCCLUSION OR HANDICAPPING DENTOFACIAL DEFORMITY IS NOT SUPPORTED BY THE DOCUMENTATION SUBMITTED.
P521	THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVERED BY COLORADO MEDICAID.
P522	GASTRO-INTESTINAL SURGERY FOR THE PURPOSE OF WEIGHT CONTROL IS COVERED ONLY AS A LIFE THREATENING PROCEDURE.
P523	THE TREATMENT REQUEST IS NOT CONSISTENT WITH THE CLIENT'S DIAGNOSIS.
P524	PSYCHOTHERAPY PROVIDED IN THE CLIENTS HOME IS NOT A COVERED BENEFIT OF COLORADO MEDICAID.
P525	THE INFORMATION PROVIDED IS NOT CONSISTENT WITH THE INTENSITY OF SERVICES REQUESTED.
P526	INTENSIVE MULTIPLE MODALITY TREATMENT IS NOT CONSISTENT WITH THE INFORMATION PROVIDED.
P527	MULTIPLE PROVIDERS OF TREATMENT ARE NOT INDICATED FOR THIS CLIENT.
P528	THE DURATION OF TREATMENT SESSIONS EXCEED CURRENT COLORADO MEDICAID GUIDELINES.
P534	DOCUMENTATION OF POOR PHYSICAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P535	OTHER PHYSICAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P536	THE PHYSICAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P537	USE OF PHYSICAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P538	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF A PHYSICAL THERAPIST.
P539	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS AND LIVING ARRANGEMENT.
P540	GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P541	THE PROCEDURE(S) REQUESTED ARE NOT MEDICAL IN NATURE.
P542	DOCUMENTATION OF POOR OCCUPATIONAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P543	DOCUMENTATION OF POOR SPEECH THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P544	OTHER OCCUPATIONAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P546	THE OCCUPATIONAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.

Denial Code	Long Description
P547	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF PHYSICAL THERAPY.
P548	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P549	ACTIVITIES TO PROMOTE DIVERSION OR GENERAL MOTIVATION ARE NONCOVERED COLORADO MEDICAID SERVICES.
P550	REVISIONS OF THE REQUEST IS NECESSITATED BY THE CLIENTS MINIMAL PROGRESS.
P551	RESTORATIVE NURSING INVOLVEMENT COULD BE INCREASED.
P552	CLIENTS DEMONSTRATED RESPONSE TO CURRENT THERAPY DOES NOT WARRANT THE INTENSE FREQUENCY REQUESTED.
P553	MAINTENANCE IS TWO TIMES PER WEEK OR LESS.
P554	THE SPEECH THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P555	USE OF OCCUPATIONAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P556	USE OF SPEECH THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P557	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF AN OCCUPATIONAL THERAPIST.
P558	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
P559	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P560	THE MATERIALS/ SERVICES REQUESTED ARE PRINCIPALLY COSMETIC IN NATURE.
P561	THE LENS FORMULA DOES NOT JUSTIFY REPLACEMENT.
P562	THE CHANGE IN THE LENS FORMULA DOES NOT WARRANT MULTIPLE REPLACEMENTS.
P563	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P564	LENSES ONLY ARE APPROVED; PLEASE DISPENSE A CONTRACTED FRAME. THE NON-CONTRACTED FRAME IS NOT MEDICALLY JUSTIFIED.
P565	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P566	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P567	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF OCCUPATIONAL THERAPY.
P568	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF SPEECH THERAPY.
P569	LEVEL, INTENSITY, OR EXTENT OF SERVICE(S) REQUESTED HAS BEEN MODIFIED CONSISTENT WITH MEDICAL NEED AS DEFINED IN THE PLAN OF CARE.
P570	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P571	THE SERVICE ASKED FOR IS NOT COVERED BY COLORADO MEDICAID AS THESE TASKS CAN BE DONE BY NURSES OR ACTIVITY STAFF.
P572	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P573	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.
P574	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P575	MEDICAL NEED FOR EQUIPMENT/ SUPPLY REQUESTED IS NOT SUPPORTED BY DOCUMENTATION SUBMITTED.
P576	OTHER SPEECH THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P577	DOCUMENTATION SUBMITTED IDENTIFIES THAT THE CLIENT HAS FEWER THAN TWO POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P582	LESS EXPENSIVE ALTERNATIVE SERVICES ARE AVAILABLE FOR THIS CLIENT.
P634	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P711	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING PERIODONTAL SCALING AND ROOT PLANNING.
P712	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING GINGIVECTOMY.
P754	AN APPROVED SUBSTANCE ABUSE DAY TREATMENT PROGRAM CANNOT EXCEED A SIX WEEK PERIOD.

Denial Code	Long Description
P761	THE CLIENT DOES NOT APPEAR TO BE ABLE OR WILLING TO ABSTAIN FROM ALCOHOL/DRUG USAGE WHILE IN TREATMENT. THEREFORE, SUBSTANCE ABUSE DAY TREATMENT SERVICES ARE NOT APPROVED.
P764	THIS CLIENT HAS COMPLETED INTENSIVE SUBSTANCE ABUSE TREATMENT WITHIN THE PAST 12 MONTHS. THE DOCUMENTATION PROVIDED IS NOT ADEQUATE TO JUSTIFY ADDITIONAL INTENSIVE TREATMENT AT THIS TIME.
P785	A LESS THAN SIX-WEEK HEALING PERIOD HAS BEEN SPECIFIED FOR THIS PRIOR AUTHORIZATION. THEREFORE IT IS NOT NECESSARY TO WAIT THE FULL SIX WEEKS AFTER EXTRACTIONS BEFORE TAKING DENTURE IMPRESSIONS.
P818	SIX-WEEK HEALING TIME IS REQUIRED BETWEEN EDENTULATION AND FINAL IMPRESSIONS. PAYMENT FOR DENTURES WILL BE DENIED OR RECOUPED IF HEALING PERIOD IS NOT OBSERVED.
P849	COLORADO MEDICAID HAS DETERMINED THERE WERE (ARE) SEVERAL HOME HEALTH AGENCIES WILLING TO PROVIDE MEDICALLY NECESSARY SKILLED NURSING SERVICES TO THIS CLIENT.
P864	THE DOCUMENTATION YOU HAVE SUBMITTED DOES NOT MEET THE REQUIREMENTS OF COLORADO MEDICAID.
P873	THE MEDICAL NECESSITY FOR THE HOURS REQUESTED IS NOT SUPPORTED BY THE INFORMATION SUBMITTED.
P874	THE DOCUMENTATION SUBMITTED INDICATES THE TASKS SPECIFIED CAN BE COMPLETED DURING THE VISITS APPROVED.
P878	THE DOCUMENTATION SUBMITTED DOES NOT INDICATE THAT MEDICALLY ORIENTED TASKS ARE MEDICALLY NECESSARY; THEREFORE PERSONAL CARE SERVICES HAVE BEEN APPROVED.
P880	THE QUANTITY OF SERVICES AUTHORIZED FOR THIS CLIENTS PERSONAL CARE HAS BEEN AMENDED BASED ON INFORMATION RECEIVED FROM ONE OR MORE OF THESE SOURCES: THE CLIENT, THEIR PHYSICIAN, AND/OR THE IN-HOME VISIT BY STAFF OF THE OIG (OFFICE OF INSPECTOR GENERAL).
P885	THE USE OF THIS DRUG FOR THE INTENDED PURPOSE IS NOT COVERED BY COLORADO MEDICAID, CONSISTENT WITH COLORADO ADMINISTRATIVE CODE AND FEDERAL LAW.
P924	THE MEDICAL RECORDS SUBMITTED WITH THE CURRENT REQUEST CONFLICT OR DISAGREE WITH OUR MEDICAL RECORDS ON THIS CLIENT.
P950	INDEPENDENT NURSES, PLEASE NOTE PAYABLE SERVICES MAY NOT EXCEED 12 HOURS/DAY OR 60 HOURS/WEEK.
P951	SERVICES CAN ONLY BE AUTHORIZED THROUGH ONE YEAR FROM THE PRESCRIPTION DATE.
P952	LEAD INSPECTION IS A COVERED COLORADO MEDICAID SERVICE WHEN THE CHILD HAS BEEN SHOWN TO HAVE LEAD POISONING (E.G., CHILD HAS A BLOOD LEAD LEVEL > 19 UG/DL OR TWO CONSECUTIVE BLOOD LEAD LEVELS OF 15-19 UG/DL DONE AT LEAST 90 DAYS APART). THE INSPECTION MUS
P953	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P954	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P956	THE REQUEST CAN ONLY BE BACKDATED A MAXIMUM OF 14 DAYS FROM FIRST DATE RECEIVED BY COLORADO MEDICAID.
P957	COMPLETE PERIODONTAL CHARTING AT TIME OF SERVICE, AND SUBMIT CHARTING, COPY OF OPERATIVE REPORT, TOGETHER WITH A COPY OF THE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF), F-11035, TO PA UNIT ATTENTION DENTAL CONTSULTANT.
P958	NOTE THAT CODE D4341 HAS BEEN CHANGED. REFER TO THE DECISION NOTICE FOR AUTHORIZED QUANTITY.
P960	YOUR PA HAS BEEN APPROVED FOR 90 DAYS. THE 90 DAY APPROVAL DOES NOT IMPLY THE PA REQUEST MEETS PRIOR AUTHORIZATION CRITERIA. AFTER ADDITIONAL INFORMATION IS AVAILABLE IN INTERCHANGE, COLORADO MEDICAID WILL CREATE AN AMENDMENT REQUEST TO EXTEND THE PA FOR
P961	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P962	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
PA10	THE REQUESTED END DATE IS INVALID.
PA12	PLEASE FURNISH A WRITTEN DESCRIPTION OF THE CLIENTS DIAGNOSIS.

Denial Code	Long Description
PA13	PROVIDE DIAGNOSES WITH DATES OF ONSET.
PA14	IDENTIFY PROBLEMS TO BE TREATED.
PA15	THE AUDIOLOGISTS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1), F-11020, AND PRIOR AUTHORIZATION REQUEST/HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2), F-11021.
PA16	THE PHYSICIANS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION/PHYSICIAN OTOLOGICAL REPORT (PA/POR), F-11019.
PA17	SUBMIT BRIEF HISTORY WITH REFERRAL INFORMATION, LIVING SITUATION, FUNCTIONAL STATUS, AND OTHER PERTINENT INFORMATION. WHAT CHANGE OF STATUS RESULTED IN REFERRAL AT THIS TIME?
PA18	PLEASE FURNISH THE CLIENTS HEIGHT AND WEIGHT.
PA19	PLEASE SUBMIT CLINICAL INFORMATION SUFFICIENT TO VERIFY THE NEED FOR THE REQUESTED SERVICE(S).
PA20	PLEASE RESUBMIT WITH COMPLETE PERIODONTAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PA21	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL EDUCATIONAL PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA22	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL PROGRAM PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA23	REFER TO THE DURABLE MEDICAL EQUIPMENT INDEX FOR APPROPRIATE CODE AND DESCRIPTION. DO NOT USE AN "UNLISTED" CODE.
PA24	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUALIZED FAMILY SERVICE PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA25	INFORMATION ON THE REQUEST FORM IS ILLEGIBLE, AND THE REQUEST CANNOT BE PROCESSED.
PA26	RE-EVALUATE YOUR GOALS. EMPHASIS SHOULD BE ON FUNCTIONAL SELF-CARE. GOALS MUST BE RELATED TO FUNCTIONAL OUTCOME.
PA27	PLEASE CLARIFY THE NUMBER OF HOURS PER WEEK REQUESTED.
PA28	PLEASE CLARIFY THE NUMBER OF HOURS PER DAY REQUESTED.
PA29	PLEASE CLARIFY THE NUMBER OF VISITS PER DAY REQUESTED.
PA30	ATTACH SUPPORTIVE DOCUMENTATION; HOME EXERCISE PROGRAM AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA31	THE DIAGNOSIS CODE INDICATED ON THE REQUEST DOES NOT CORRESPOND TO THE DIAGNOSIS CODE DESCRIPTION.
PA32	PLEASE SUBMIT ADDITIONAL INFORMATION SUFFICIENT TO VERIFY APPROPRIATENESS AND NEED FOR TRANSPLANT.
PA33	PLEASE SUBMIT THE INITIAL AND PROGRESSIVE OBJECTIVE FINDINGS.
PA34	ATTACH SUPPORTIVE DOCUMENTATION, FACILITY PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA35	PLEASE SUBMIT THE CLIENTS ORIGINAL COMPLAINTS AND EXAMINATION FINDINGS.
PA36	ATTACH SUPPORTIVE DOCUMENTATION, IN-HOME AUTISM PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA37	PLEASE SUBMIT YOUR TREATMENT PLAN FOR THIS CLIENT.
PA38	ATTACH SUPPORTIVE DOCUMENTATION AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA39	INITIAL EVALUATIONS MUST BE PERFORMED BY AN OCCUPATIONAL THERAPIST REGISTERED (OTR), PER AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA) STANDARDS.
PA41	IDENTIFY THE PLACE OF SERVICE AND ITS EFFECT ON SUPPORTING THE DESIRED TREATMENT OUTCOME.
PA42	PLEASE INDICATE THE HOURS OF USE OF OXYGEN PER 24-HOUR PERIOD.
PA43	PROVIDE BASELINE DOCUMENTATION FOR THIS CLIENTS LIMITATIONS USING UNITS OF MEASUREMENT THAT ARE APPLIED CONSISTENTLY WHEN REPORTING STATUS.
PA44	IDENTIFY FUNCTIONAL LIMITATIONS AS THEY ARE RELATED TO IDENTIFIED CONDITIONS.
PA46	CORRELATE PLAN OF CARE TO REQUESTED PROCEDURE CODES.
PA47	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE FREQUENCY/DURATION REQUESTED.

Denial Code	Long Description
PA48	PLEASE PROVIDE THE NAME AND CREDENTIALS OF THE RENDERING PROVIDER.
PA50	COLORADO MEDICAID RECORDS INDICATE THE CLIENT OWNS A WHEELCHAIR. DOCUMENT THE REASON AND NEED FOR REPLACEMENT AND COST TO REPAIR CURRENT WHEELCHAIR.
PA51	PLEASE DISTINGUISH PRIMARY AND SUPPORTIVE MODALITIES.
PA52	PLEASE SUBMIT A PROGRESS REPORT.
PA53	MULTIPLE FAMILY CLIENTS TREATMENT BY THE SAME PROVIDER REQUIRES FURTHER INFORMATION DOCUMENTING COORDINATION OF TREATMENT PLAN.
PA54	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE MINUTES REQUESTED.
PA55	MEDICAL NECESSITY OF TREATMENT REQUIRES ADDITIONAL DOCUMENTATION.
PA56	GIVEN AGE, DIAGNOSES, CURRENT LEVEL OF FUNCTION, PAST RESPONSE TO TREATMENT, AND LIVING SITUATION, EXPAND ON POTENTIAL FOR SIGNIFICANT FUNCTIONAL PROGRESS WITHIN THE NEXT SIX MONTHS. EMPHASIZE WHY PROGRESS IS EXPECTED WITH SERVICES AT THIS TIME.
PA57	SUBMIT THE INITIAL FINDINGS. INCLUDE A COMPREHENSIVE EVALUATION.
PA58	SUBMIT PROGRESSIVE, OBJECTIVE FINDINGS. INCLUDE A PERTINENT RE-EVALUATION.
PA59	PLEASE SUPPLY INFORMATION REGARDING THE CLIENTS MEDICATION REQUIREMENTS, IF ANY.
PA60	PLEASE SPECIFY IF THE CLIENT IS IN AN EDUCATIONAL SETTING.
PA61	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA62	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
PA63	THE SKILLS OF A THERAPIST ARE PURPOSEFUL AND SKILLED INTERVENTIONS REQUIRED TO CONTINUALLY DESIGN, IMPLEMENT, REASSESS, MODIFY/GRADE, AND/OR DISCONTINUE A PLAN OF CARE IN A TIMELY MANNER, BASED ON THE COMPLEXITY OF THE CLIENTS MEDICAL CONDITION AND/OR CO
PA64	PLEASE SUBMIT A THERAPY PLAN OF CARE, INCLUDING A CURRENT, DATED EVALUATION.
PA65	A PLAN OF CARE SIGNED AND DATED BY THE PHYSICIAN IS REQUIRED.
PA66	THE SKILLS OF A THERAPIST ARE REQUIRED WHEN ONLY THE THERAPIST CAN SAFELY AND EFFECTIVELY DELIVER THE THERAPEUTIC PROCEDURES BECAUSE OF THEIR UNIQUE KNOWLEDGE, TRAINING, AND EXPERTISE. DESCRIBE THE REASON THAT SOMEONE OTHER THAN A THERAPIST CANNOT SAFELY
PA67	PLEASE SPECIFY IF THE CLIENTS WORK SITE DEMANDS GOOD BINAURAL HEARING.
PA68	DESCRIBE THE REASON, BASED ON THE CLIENTS COGNITIVE, PHYSICAL, COMMUNICATION, OR RESOURCE STATUS, THAT A HOME PROGRAM, EQUIPMENT, OR ENVIRONMENTAL ADAPTATIONS ALONE CANNOT MEET CLIENTS NEEDS.
PA69	PLEASE SPECIFY IF THE CLIENT HAS AN ACCOMPANYING DISABILITY THAT ADDS TO THE HEARING PROBLEM.
PA70	DISTINGUISH REQUESTED PROCEDURES AND GOALS FROM OTHER SERVICES THIS CLIENT RECEIVES. THEY MAY NOT BE DUPLICATIVE.
PA71	PLEASE INDICATE THE NUMBER OF DAYS REQUESTED.
PA73	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA74	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA75	PLEASE DOCUMENT CARRYOVER OF THE THERAPY PROGRAM TO NURSING.
PA76	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA79	PROVIDE EVIDENCE OF SIGNIFICANT FUNCTIONAL PROGRESS IN LAST SIX MONTHS.
PA84	THE GRANT DATE OF THIS REQUEST CANNOT BE PRIOR TO THE SIGNATURE DATE OF THE PRESCRIBING PHYSICIAN.
PA86	PROVIDE EVIDENCE OF SKILLS GAINED IN THERAPY CARRYING OVER TO OTHER SETTINGS WITHIN SIX MONTHS.
PA87	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE NUMBER OF SESSIONS REQUESTED.
PA88	THE REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL SCOPE OF PRACTICE.
PA89	PRIOR AUTHORIZATION IS NOT REQUIRED UNTIL LIMITATION OF SERVICE HAS BEEN REACHED.
PA91	PLEASE SUBMIT REQUIRED X-RAYS.

Denial Code	Long Description
PA92	PLEASE PROVIDE AN EXPLANATION FOR THE MATERIAL SUBMITTED WITH THE REQUEST.
PA95	PLEASE DESCRIBE HOW THE PROVISION OF THIS SERVICE WOULD PREVENT INSTITUTIONALIZATION OF THE CLIENT.
PA96	COULD THE EXISTING DENTURE(S) BE RELINED OR REBASED? IF NOT, PLEASE EXPLAIN WHY NOT.
PA97	REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL STANDARDS OF PRACTICE.
PA98	PLEASE INDICATE IF THE CLIENT IS CURRENTLY BEING TUBE FED.
PB02	PLEASE PROVIDE THE REQUIRED DATED SIGNATURES ON THE ATTACHMENTS.
PB03	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING THE LOSS/DESTRUCTION/THEFT OF THE HEARING AID.
PB04	DESCRIBE THE CLIENTS ABILITY TO STAND OR AMBULATE SUFFICIENTLY TO ACCOMPLISH SELF-CARE ACTIVITIES.
PB07	PLEASE SUBMIT AN ORTHODONTIC STUDY MODEL OR DIAGNOSTIC CASTS.
PB09	PLEASE PROVIDE A PHOTOGRAPH OF THE INVOLVED AREA(S).
PB10	PLEASE PROVIDE AN ESTIMATION (IN GRAMS) OF THE TOTAL AMOUNT OF TISSUE TO BE RESECTED.
PB11	PLEASE SUBMIT THE PLAN OF CARE FOR CO-TREATMENT.
PB12	FURNISH A DETAILED DESCRIPTION FOR THE PROCEDURE CODE REQUESTED.
PB13	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB15	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB18	PLEASE COMPLETE THE ATTACHED OUT-OF-STATE PROVIDER DATA SHEET, F-11001, AND RESUBMIT.
PB20	A SIGNED AND DATED PRESCRIPTION IS REQUIRED WITHIN THREE MONTHS OF RECEIPT BY COLORADO MEDICAID FOR INITIAL REQUESTS AND WITHIN 12 MONTHS OF RECEIPT BY COLORADO MEDICAID FOR SUBSEQUENT REQUESTS.
PB21	PLEASE COMPLETE THE APPROPRIATE PRIOR AUTHORIZATION ATTACHMENT. CONTACT PROVIDER SERVICES OR THE PRIOR AUTHORIZATION UNIT FOR ASSISTANCE.
PB23	PHYSICAL THERAPY ASSISTANT NOTES AND ALL FORMS SUBMITTED MUST BE COSIGNED BY A REGISTERED PHYSICAL THERAPIST.
PB31	ARE YOU REQUESTING A COMPLETE APPLIANCE, OR REPLACEMENT PARTS?
PB32	THE PROCEDURE CODE INDICATED ON THE REQUEST DOES NOT MATCH THE DESCRIPTION OF SERVICE; PLEASE CORRECT AND RESUBMIT.
PB35	THE SERVICE REQUESTED DOES NOT REQUIRE PRIOR AUTHORIZATION.
PB41	PLEASE FURNISH A CURRENT MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT, F-11090 (DATED WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID).
PB45	THE CERTIFICATION PERIOD ON THE PLAN OF CARE (POC) DOES NOT COVER THE REQUESTED GRANT/START DATE. PLEASE RESUBMIT YOUR REQUEST WITH A NEW POC.
PB49	A CERTIFIED OCCUPATIONAL THERAPY ASSISTANTS NOTES MUST BE COSIGNED BY AN OCCUPATIONAL THERAPIST REGISTERED.
PB51	ADDITIONAL INFORMATION IS REQUIRED ON PRIOR AUTHORIZATION TO ENABLE PRICING.
PB54	REQUESTED SERVICES DO NOT MATCH SERVICES ON THE PHYSICIANS ORDERS.
PB59	PLEASE PROVIDE AN INDIVIDUAL EDUCATIONAL PLAN (IEP), WHICH HAS BEEN SIGNED BY THE PROVIDER NO EARLIER THAN NINE MONTHS PRIOR TO RECEIPT AT COLORADO MEDICAID; OTHERWISE, DOCUMENT WHY NO IEP EXISTS.
PB65	PLEASE FURNISH THE ANTICIPATED TOTAL CHARGES FOR THIS REQUEST.
PB66	A PHOTOCOPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED; THE DATE MUST BE WITHIN SIX MONTHS OF RECEIPT BY COLORADO MEDICAID.
PB67	THE PRESCRIPTION DATE MUST INCLUDE MONTH, DAY, AND YEAR.
PB68	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID.
PB73	THE SERVICES IDENTIFIED ON THE PLAN OF CARE DO NOT APPEAR APPROPRIATE FOR THE PROCEDURE CODE(S) REQUESTED ON THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018.
PB74	THE CLIENT/PROVIDER DOES NOT HAVE RETROACTIVE ENROLLMENT.
PB75	THE REQUESTED START DATE IS MORE THAN 14 DAYS BEFORE OR 62 DAYS AFTER RECEIPT.
PB82	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
PB83	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A HOME HEALTH AIDE. PLEASE RESUBMIT AS A PERSONAL CARE WORKER OR PROVIDE ADDITIONAL DOCUMENTATION.

Denial Code	Long Description
PB86	THE SERVICES REQUESTED ARE NOT BEING PROVIDED IN THE CLIENTS RESIDENCE. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL.
PB87	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A NURSE. PLEASE RESUBMIT AS A HOME HEALTH AIDE OR PROVIDE ADDITIONAL DOCUMENTATION.
PB92	PLEASE FURNISH THE CLIENTS COMPLETE ADDRESS.
PB94	IF THE CLIENT IS A RESIDENT OF A NURSING HOME, SUPPLY THE COMPLETE NAME AND ADDRESS OF THE NURSING HOME.
PB99	THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018, MUST BE SIGNED AND DATED.
PC01	PLEASE SUPPLY THE RENDERING PROVIDERS PROVIDER NUMBER.
PC03	THE DRUG ENFORCEMENT ADMINISTRATION NUMBER IS MISSING OR INVALID.
PC06	PLEASE DESCRIBE YOUR PROGRAM; INCLUDE ENTRY DATE, TERMINATION DATE, HOURS PER WEEK, AND NUMBER OF WEEKS OF PRIMARY INTENSIVE SERVICE REQUESTED.
PC07	PLEASE DESCRIBE YOUR "AFTERCARE/FOLLOW-UP" PLANS FOR THIS CLIENT.
PC08	PLEASE SUPPLY DOCUMENTATION OF PREVIOUS SUBSTANCE ABUSE SERVICES WITH DATE(S) AND OUTCOME.
PC09	PLEASE DESCRIBE IN DETAIL THE TREATMENT OBJECTIVES/GOALS FOR THIS CLIENT.
PC10	PLEASE DESCRIBE THE FAMILY SITUATION/DYNAMICS. EXPLAIN HOW THE FAMILY WILL BE INCORPORATED INTO THE CLIENTS PLAN OF CARE.
PC12	PLEASE EXPLAIN IF YOUR SERVICE ENCOURAGES THE CLIENT TO ATTEND SELF-HELP GROUPS.
PC13	PLEASE SUPPLY A SPECIFIC SCHEDULE OF ACTIVITIES, INCLUDING DAY, TIME OF DAY, LENGTH OF SESSION, AND SERVICE TO BE RENDERED DURING THAT TIME.
PC15	PLEASE FURNISH DIAGNOSTIC RATIONALE.
PC17	PLEASE DOCUMENT IF THE CLIENT EVER RECEIVED SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT.
PC19	PLEASE FURNISH MORE EXTENSIVE AND IN-DEPTH HISTORICAL AND PSYCHOSOCIAL DATA.
PC20	PLEASE SUPPLY THE DATE THE CLIENT BECAME TOTALLY ENDENTULOUS.
PC23	PLEASE SUBMIT A PHYSICIANS STATEMENT REGARDING THE MEDICAL NECESSITY OF DENTURES FOR THIS CLIENT. THE PHYSICIANS STATEMENT MUST DOCUMENT THE MEDICAL NEED FOR DENTURES.
PC24	THE SERVICE REQUESTED WAS PREVIOUSLY AUTHORIZED. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT INDICATING THIS FACT IS REQUIRED.
PC25	PLEASE SUPPLY SUFFICIENT MITIGATING CIRCUMSTANCES TO WARRANT THE CONSTRUCTION OF NEW DENTURES(S).
PC26	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
PC28	PLEASE SUBMIT A PHYSICIANS STATEMENT INDICATING DENTURES ARE NECESSARY FOR THIS NURSING HOME CLIENT.
PC29	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING LOSS OR DESTRUCTION OF DENTURE(S). INCLUDE SIGNED STATEMENT FROM CLIENT OR FACILITY DIRECTOR REGARDING HOW, WHEN AND WHERE LOST.
PC30	PLEASE PROVIDE COMPLETE INTRAORAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PC31	PLEASE DESCRIBE ANY RELATED DEFORMITIES OF THE FEET.
PC34	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD WITH REQUESTED DME ITEM(S) AND DOCUMENT IF THE CLIENT CAN USE SAFELY AND INDEPENDENTLY.
PC35	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD AND DESCRIBE THE RESULTS AND EFFECTIVENESS OF THE SERVICE REQUESTED.
PC39	PLEASE INDICATE LITER FLOW PER MINUTE, HOURS OF USE PER 24 HOUR PERIOD, AND THE EXPECTED DURATION OF NEED.
PC40	THE ITEM DOES NOT REQUIRE PRIOR AUTHORIZATION UNTIL THE LIFE EXPECTANCY HAS BEEN REACHED.
PC41	PLEASE SUPPLY INFORMATION INDICATING THE NECESSITY OF POSITIONING THE CLIENT'S BODY IN MULTIPLE POSITIONS.
PC42	PLEASE INDICATE IF THE BED HEIGHT MUST BE CHANGED TO ALLOW FOR SAFE TRANSFER OR ADEQUATE BED CARE.
PC43	SUPPLY A PHYSICIANS STATEMENT INDICATING TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR UNIT HAS REDUCED PAIN, IMPROVED/INCREASED THE CLIENTS ACTIVITY LEVEL, AND/OR REDUCED CLIENTS USE OF PAIN MEDICATION.

Denial Code	Long Description
PC44	A CURRENT AUTHORIZATION FOR THIS SERVICE IS ON FILE FOR ANOTHER PROVIDER. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT OF THAT FACT IS REQUIRED BY THE CLIENT OF FIRST PROVIDER.
PC59	DOCUMENT DECLINE OR PROGRESS IN SPECIFIC, MEASURABLE, OBJECTIVE TERMS.
PC60	DOCUMENT IF CLIENT HAS DEMONSTRATED A GOOD APPOINTMENT COMPLIANCE RECORD.
PC61	THE PHYSICIANS SIGNATURE DATE MUST NOT EXCEED 90 DAYS FROM THE DATE OF RECEIPT BY COLORADO MEDICAID.
PC62	REQUESTS FOR A CONTINUATION OF THERAPY SHOULD NOT BE SUBMITTED MORE THAN FOUR WEEKS PRIOR TO THE EXPIRATION DATE OF THE CURRENT AUTHORIZATION.
PC63	PLEASE FURNISH THE STYLE AND MANUFACTURER OF THE FRAME.
PC64	PLEASE FURNISH THE CLIENTS LENS FORMULA.
PC66	ALL REQUESTS FOR TINTS REQUIRE DOCUMENTATION OF THE VISUAL OR MEDICAL CONDITION RELATED TO PHOTOPHOBIA.
PC67	PLEASE DOCUMENT THE REASON AND JUSTIFICATION FOR REPLACEMENT BEYOND THE FIRST LENS/FRAME.
PC68	DOCUMENT IF ALL REMAINING MAXILLARY AND/OR MANDIBULAR TEETH ARE DECAY-FREE, PROPERLY RESTORED, AND PERIODONTICALLY SOUND.
PC72	SUPPLY MORE DETAIL REGARDING PROGRESS (ATTACHMENT OF GOALS, ETC.). CORRELATE PROGRESS TO PREVIOUS GOALS AND IDENTIFIED LIMITATIONS.
PC77	PLEASE SUBMIT A PLAN OF CARE DESCRIBING THE SERVICES THAT WOULD BE PROVIDED.
PC78	PLEASE DOCUMENT SPECIFIC, MEASURABLE GOALS.
PC82	THE PRIOR AUTHORIZATION (PA) SYSTEM CAN PROCESS ONLY 26 DETAILS PER PA REQUEST. PLEASE RESUBMIT YOUR REQUEST WITH NO MORE THAN 26 DETAILS.
PC83	PLEASE SUPPLY A PHYSICIANS PRESCRIPTION DATED WITHIN ONE MONTH OF REQUESTED SUBSTANCE ABUSE DAY TREATMENT.
PC84	PLEASE PROVIDE INFORMATION INDICATING THIS CLIENT IS APPROPRIATELY DETOXIFIED FROM ALCOHOL AND/OR OTHER DRUGS.
PC85	PLEASE PROVIDE INFORMATION TO INDICATE THE CLIENTS ABILITY TO ABSTAIN FROM ALCOHOL OR DRUGS WHILE IN THE SUBSTANCE ABUSE DAY TREATMENT PROGRAM.
PC86	PLEASE INDICATE IF THIS CLIENT IS WILLING TO PARTICIPATE IN AFTERCARE OR CONTINUING CARE SERVICES.
PC87	PROVIDE MORE INFORMATION ON TREATMENT HISTORY; INCLUDE SERVICE PROVIDED, DATES, AND OUTCOME. PROVIDE DETAIL OF PREVIOUS TREATMENT.
PC88	PLEASE PROVIDE MORE RATIONALE FOR THE APPROPRIATENESS AND MEDICAL NECESSITY OF SUBSTANCE ABUSE DAY TREATMENT.
PC89	PROVIDE A TREATMENT PLAN THAT CONTAINS MEASURABLE GOALS AND OBJECTIVES CORRESPONDING TO THE IDENTIFIED DEFICIT.
PC91	PLEASE PROVIDE MORE INFORMATION ON FAMILY INVOLVEMENT TREATMENT.
PC92	PLEASE PROVIDE MORE HISTORY AND EXPLANATION ABOUT THE ISSUE OF ABSTINENCE FOR THIS CLIENT.
PC94	PLEASE PROVIDE THE ANTICIPATED BEGINNING DATE AND/OR THE ESTIMATED SUBSTANCE ABUSE DAY TREATMENT DISCHARGE DATE.
PC95	PLEASE SUPPLY JUSTIFICATION FOR BEGINNING CLIENT IN SERVICE PRIOR TO AUTHORIZATION BEING OBTAINED.
PC96	THE INITIAL THREE HOURS OF SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IN A CALENDAR YEAR DO NOT REQUIRE PRIOR AUTHORIZATION.
PC97	REIMBURSEMENT FOR INITIAL SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IS LIMITED TO THREE HOURS IN A CALENDAR YEAR AND DOES NOT REQUIRE PRIOR AUTHORIZATION.
PC98	THIS DRUG IS CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE BILL USING THE APPROPRIATE NATIONAL DRUG CODE (NDC) OR SUBMIT A COMPLETED DRUG ADDITION REQUEST FORM IF THE NDC IS NOT LISTED IN THE DRUG INDEX.
PC99	THIS DRUG IS NOT CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL, CURRENT ADMINISTRATIVE RULE, OR COLORADO DRUG INDEX FOR COVERAGE LIMITATIONS.
PD01	DOCUMENT THAT CLIENT HAS ACHIEVED GOOD ORAL HYGIENE, PERIODONTAL CASE TYPE 1 OR 2, AND IS MOTIVATED TO MAINTAIN SAME.

Denial Code	Long Description
PD03	PLEASE PROVIDE AN ARTERIAL BLOOD GAS READING OR PULSE OXIMETRY RESULTS DONE ON ROOM AIR SIGNED AND DATED BY A MEDICAL DOCTOR. THIS SHOULD BE DONE WITHIN 60 DAYS OF REQUESTED SERVICE.
PD04	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 30 DAYS OF RECEIPT BY COLORADO MEDICAID.
PD07	SUBMIT A PHOTOCOPY OF A VALID PRESCRIPTION, ISSUED WITHIN THE PAST YEAR, OR COMPLETE SECTION B OF THE PRIOR AUTHORIZATION/DRUG ATTACHMENT (PA/DGA), F-11049.
PD10	BRAND MEDICALLY NECESSARY MUST BE IN THE PRESCRIBERS OWN HANDWRITING AND WRITTEN DIRECTLY ON THE PRESCRIPTION OR A SEPARATE ORDER ATTACHED TO THE ORIGINAL PRESCRIPTION.
PD12	COMPLETE DENTURES, PARTIAL DENTURES, DENTURE RELINES, AND FIXED PROSTHODONTIC SERVICES ARE NOT COVERED SERVICES FOR ADULTS FOR DATES OF SERVICE ON AND AFTER OCTOBER 1, 1995.
PD22	PLEASE COMPLETE ALL REQUIRED ELEMENTS ON THE PERSONAL CARE SCREENING TOOL (PCST), F-11133.
PD24	THIS PRIOR AUTHORIZATION REQUEST IS UNABLE TO BE PROCESSED. PLEASE RESUBMIT WITH ADDITIONAL REQUIRED FORMS, INCLUDING THE ENTIRE PERSONAL CARE SCREENING TOOL (PCST), F-11133; PERSONAL CARE ADDENDUM, F-11136; AND SUPPORTING DOCUMENTATION, AS DIRECTED.
PD25	THERE IS A PERSONAL CARE SCREENING TOOL (PCST), F-11133, COMPLETED BY ANOTHER AGENCY. CONTACT THE AGENCY TO TRANSFER SCREEN.
PD26	THERE IS A LIMITED TERM CARE FUNCTIONAL SCREEN (LTC-FS) COMPLETED BY ANOTHER AGENCY. THE PERSONAL CARE SCREENING TOOL (PCST), F-11133, INFORMATION IS IN CONFLICT WITH LTC-FS.
PD27	ONLY ONE LEVEL OF FUNCTION MAY BE SELECTED FOR ALL ELEMENTS EXCEPT TOILETING. COLORADO MEDICAID IS UNABLE TO PROCESS THE PRIOR AUTHORIZATION REQUEST.
PD28	NO UNITS MAY BE REQUESTED USING THIS PRIOR AUTHORIZATION PROCESS. PLEASE SUBMIT WITH THE APPROPRIATE ATTACHMENTS FOR REQUESTING SPECIFIC PERSONAL CARE WORKER UNITS.
PD29	CLIENT IS NOT ELIGIBLE FOR THE REQUESTED SERVICE(S) AS OF THE REQUESTED START DATE.
PD30	NO TRAVEL TIME MAY BE AUTHORIZED WHEN NO PERSONAL CARE WORKER SERVICE IS AUTHORIZED.
PD32	PROVIDER NOT CERTIFIED TO RENDER THE SERVICE(S) REQUESTED.
PD34	BASED ON THE DOCUMENTATION SUBMITTED, THIS REQUEST CAN NOT BE PRIOR AUTHORIZED. REFER TO THE PA MESSAGES FROM THE CONSULTANT FOR COMPLETE EXPLANATION.
PD98	PLEASE DOCUMENT HOW AND WHEN EACH PREVIOUSLY AUTHORIZED PRO RE NATA VISIT WAS USED.

Omnibus Reconciliation Act (OBRA)

Denial Code	Long Description
0201	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
0233	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0235	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0237	CLIENT IDENTIFICATION NUMBER DOES NOT MATCH CLIENTS FIRST NAME.
0238	THE CLIENT IDENTIFICATION NUMBER DOES NOT MATCH THE CLIENTS LAST NAME.
0242	SECONDARY DIAGNOSIS CODE IS INVALID.
0248	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0249	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0251	PROCEDURE CODE MODIFIER IN FIRST POSITION IS INVALID.
0252	THE PROCEDURE CODE MODIFIER IN SECOND POSITION IS INVALID FOR REQUESTED START DATE OR DATE OF RECEIPT.
0253	THE PROCEDURE CODE MODIFIER IN THIRD POSITION IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
0258	THE PRIMARY DIAGNOSIS CODE IS REQUIRED.
0272	THE PRIMARY DIAGNSOSIS CODE IS INVALID.
0400	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.

Denial Code	Long Description
0853	HCPCS - ANNUAL UPDATE
0885	NEVER EVENTS MODIFIERS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
0886	NEVER EVENTS DIAGNOSIS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
1000	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
1002	RENDERING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1003	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1007	RENDERING PROVIDER ID IS NOT ON FILE.
1047	THE RENDERING PROVIDERS CERTIFICATION HAS BEEN CANCELLED.
1048	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1801	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
1804	A CERTIFIED SUBSTANCE ABUSE DAY TREATMENT PROVIDER MUST SUBMIT A SUBSTANCE ABUSE DAY TREATMENT PROCEDURE CODE.
1806	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
1808	THE BILLING PROVIDER DOES NOT HAVE THE REQUIRED CERTIFICATION ADDENDUM ON FILE.
1900	THE BILLING PROVIDERS TAXONOMY CODE IS INVALID.
1901	THE RENDERING PROVIDERS TAXONOMY CODE IS INVALID.
1927	A NATIONAL PROVIDER IDENTIFIER IS REQUIRED FOR THE BILLING PROVIDER.
1934	A NATIONAL PROVIDER INDENTIFIER IS REQUIRED FOR THE RENDERING PROVIDER.
1936	THE BILLING PROVIDER NUMBER IS INVALID.
1937	THE RENDERING PROVIDER NUMBER IS INVALID.
1960	INTERNAL PROCESSING IS REQUIRED.
1963	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.
1964	THE BILLING PROVIDER INDICATED IS NOT ALLOWABLE AS A BILLING PROVIDER.
1965	RENDERING PROVIDER NUMBER IS MISSING/INVALID FOR THIS PROCEDURE PROVIDER.
1974	PRESCRIBING/REFERRING/ORDERING PROVIDER INDICATED IS NOT CERTIFIED AS A PRESCRIBING/REFERRING/ORDERING PROVIDER.
1975	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
1976	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
2001	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2003	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2017	THE CLIENT IS ENROLLED IN A MEDICAID OR OTHER MANAGED CARE PROGRAM.
2037	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2603	CLIENT LOCKED-IN TO A PROVIDER OR ENROLLED IN A HOSPICE. CONTACT CLIENTS HOSPICE FOR PAYMENT OF SERVICES OR RESUBMIT WITH DOCUMENTATION OF UNRELATED NATURE OF CARE.
3324	THE MODIFIER HAS BEEN DISCONTINUED BY THE CENTERS OF MEDICARE AND MEDICAID SERVICES OR THE AMERICAN MEDICAL ASSOCIATION FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
3337	THE PROCEDURE CODE HAS BEEN TERMINATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AMERICAN MEDICAL ASSOCIATION, OR AMERICAN DENTAL ASSOCIATION FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT. RESUBMIT WITH VALID A PROCEDURE CODE.
3339	THE PROCEDURE BILLED IS NOT PAYABLE ACCORDING TO DEFICIT REDUCTION ACT (DEFRA) GUIDELINES.
3351	THE PROCEDURE IS NOT COVERED FOR CLIENTS WITH A NURSING HOME AUTHORIZATION ON THE REQUESTED START DATE OR DATE OF RECEIPT.
3353	THE PROCEDURE IS NOT A COVERED SERVICE FOR HOME AND COMMUNITY-BASED WAIVER CLIENTS.
4021	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4027	THE DIAGNOSIS CODE IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
4031	THE PROCEDURE SUBMITTED IS NOT APPROPRIATE FOR CLIENTS GENDER.
4032	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4034	THE PROCEDURE CODE HAS AN AGE RESTRICTION.
4036	THE PLACE OF SERVICE CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4040	THE PRIMARY DIAGNOSIS CODE IS NOT ON FILE.
4041	THE SECONDARY DIAGNOSIS IS NOT ON FILE.
4046	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.

Denial Code	Long Description
4127	INTERNAL PROCESSING IS REQUIRED.
4131	INTERNAL PROCESSING IS REQUIRED.
4141	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4149	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4150	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4236	ETIOLOGY DIAGNOSIS CODE(S) (E-CODES) ARE INVALID AS THE PRIMARY DIAGNOSIS.
4244	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4245	THE FOURTH POSITION MODIFIER IS INVALID FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT.
4256	THE PROCEDURE CODE AND MODIFIER COMBINATION IS NOT PAYABLE FOR THE CLIENTS BENEFIT PLAN.
4257	THE MODIFIERS SUBMITTED ARE EITHER INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT OR THE MODIFIERS ARE MISSING.
4311	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4315	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4316	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4371	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4372	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4711	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR CLIENTS AGE.
4714	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS AGE.
4731	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS DIAGNOSIS.
4742	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4743	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4744	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4745	DIAGNOSIS AND/OR PROCEDURE AND/OR PLACE OF SERVICE (POS) CODE IS NOT COVERED FOR EXPRESS ENROLLMENT CLIENTS.
4746	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4801	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4802	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
4821	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
4871	PLEASE REFER TO PA MESSAGES FOR RETURN INFORMATION.
4963	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS GENDER.
4990	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
7500	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
7509	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
P001	THE BILLING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THE SERVICES.
P002	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P003	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P005	THE PRIOR AUTHORIZATION CAN NOT BE END DATED. THE PRIOR AUTHORIZATION STATUS IS NOT APPROVED OR APPROVED WITH REVISIONS.
P006	PLEASE FURNISH THE PROCEDURE CODE AND CORRESPONDING DESCRIPTION.
P008	THE BILLING PROVIDER NUMBER IS INVALID.
P009	THE BILLING PROVIDER NUMBER IS INVALID.
P010	THE REQUESTED END DATE IS INVALID.
P011	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P012	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P013	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P014	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.

Denial Code	Long Description
P015	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P016	THE REQUESTED START DATE IS MISSING OR INVALID.
P019	THE REQUESTED START DATE IS MISSING OR INVALID.
P020	THE RENDERING PROVIDER NUMBER IS INVALID.
P021	THE RENDERING PROVIDER NUMBER IS INVALID.
P022	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P023	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P024	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P026	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P027	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P030	FIRST MODIFIER IS INVALID.
P031	FIRST MODIFIER IS INVALID.
P032	SECOND MODIFIER IS INVALID.
P033	SECOND MODIFIER IS INVALID.
P034	THIRD MODIFIER IS INVALID.
P035	THIRD MODIFIER IS INVALID.
P036	FOURTH MODIFIER IS INVALID.
P037	FOURTH MODIFIER IS INVALID.
P038	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P039	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P040	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P041	CLIENTS FIRST NAME IS MISSING.
P042	CLIENTS LAST NAME IS MISSING.
P043	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P044	BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES REQUESTED.
P045	FIRST MODIFIER IS INVALID.
P046	SECOND MODIFIER IS INVALID.
P047	THIRD MODIFIER IS INVALID.
P048	FOURTH MODIFIER IS INVALID.
P052	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P053	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P054	RENDERING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES FOR THE BENEFIT PLAN.
P055	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P061	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P062	THE CLIENT ID AND/OR NAME INDICATED ON THE PA REQUEST IS INCORRECT. THE CLIENT ID AND/OR NAME HAS BEEN UPDATED. PLEASE VERIFY THE ID AND/OR NAME IS CORRECT.
P064	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
P067	THE FREQUENCY OF HOURS REQUESTED ARE NOT APPROPRIATE FOR THIS CLIENT AND HAVE BEEN MODIFIED ACCORDINGLY.
P079	BILLING PROVIDER IS ON PAYMENT SUSPENSION DUE TO CREDIBLE ALLEGATION OF FRAUD.
P120	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAS BEEN REDUCED.
P121	THE SERVICE/ PROCEDURE REQUESTED IS NOT SUPPORTED BY SUBMITTED DOCUMENTATION.
P126	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
P128	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.
P138	SERVICE(S) DO NOT MEET COLORADO MEDICAID GUIDELINES.
P167	REQUESTED DOCUMENTATION HAS NOT BEEN SUBMITTED.

Denial Code	Long Description
P178	THE SERVICE REQUESTED IS NOT MEDICALLY NECESSARY.
P179	THE MEDICAL NECESSITY FOR THIS SERVICE IS NOT SUPPORTED BY THE SUBMITTED DOCUMENTATION.
P233	THE DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE ADDITIONAL CARE.
P257	THIS CLIENTS FUNCTIONAL ASSESSMENT SCORES PLACE THIS CLIENT OUTSIDE ELIGIBILITY FOR DAY TREATMENT.
P274	OUR RECORDS INDICATE THIS CLIENT IS INVOLVED IN EFFECTIVE AND APPROPRIATE SERVICE ELSEWHERE.
P292	INTENSIVE REHABILITATION HOURS ARE NO LONGER APPROPRIATE AS INDICATED BY HISTORY, DIAGNOSIS, AND/ OR FUNCTIONAL ASSESSMENT SCORES.
P328	THE SERVICES REQUESTED INCLUDE NON-COVERED SERVICES, AND HOURS ARE REDUCED ACCORDINGLY.
P339	THE CLIENTS PAST HISTORY INDICATES REDUCED TREATMENT HOURS ARE WARRANTED.
P342	THE REQUEST DOES NOT MEET GENERALLY ACCEPTED CONDITIONS REQUIRING FLUORIDE TREATMENTS.
P346	SERVICES EXCEED COLORADO MEDICAID LIMITATION AND DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE MEDICAL NECESSITY OF THE SERVICE.
P349	THE SERVICE REQUESTED WAS PERFORMED LESS THAN FIVE YEARS AGO.
P353	THE EXISTING APPLIANCE HAS NOT BEEN WORN FOR THREE YEARS.
P367	THE CLIENT HAS BEEN TOTALLY WITHOUT TEETH AND AN APPLIANCE FOR FIVE YEARS.
P392	THE CLIENT IS MISSING AN ANTERIOR TOOTH AND/OR HAS TWO OR MORE POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P405	THE SERVICE(S) REQUESTED COULD ADEQUATELY BE PERFORMED IN THE DENTAL OFFICE.
P406	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE OF GOOD PERIODONTAL HEALTH (AMERICAN ACADEMY OF PERIODONTOLOGY PERIODONTAL CLASSIFICATION OF TYPE I OR II).
P407	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE VISIBLE ON RADIOGRAPHS THAT AT LEAST 50 PERCENT OF THE CLINICAL CROWN IS INTACT.
P409	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING SIX OR MORE TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED, INCLUDING THIRD MOLARS.
P410	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING ONE OR MORE ANTERIOR TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED.
P411	DOCUMENTATION DOES NOT SUPPORT THE NEED FOR PERIODONTIC SERVICES. POCKETS ARE LESS THAN 4MM AND/OR GREATER THAN 6MM FOR CLIENT AND/OR THE CLIENT IS UNDER THE AGE OF 13.
P412	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA.
P413	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA. THIS PA HAS BEEN GRANTED AS APPROVED NOT APPROVED WITH REVISIONS. THE DURATION REQUESTED MAY HAVE BEEN REDUCED TO REFLECT COVERAGE LIMITATIONS, PRESCRIBER ORDERS, CONFLICTI
P417	THE SERVICE(S) REQUESTED COULD BE ADEQUATELY PERFORMED WITH LOCAL ANESTHESIA.
P437	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO POOR ORAL HYGIENE.
P444	THIS LINE ITEM IS A DUPLICATE OF ANOTHER LINE ITEM ON THIS PRIOR AUTHORIZATION (PA) REQUEST. PLEASE CORRECT.
P446	THIS IS A DUPLICATE OF AN EXISTING PRIOR AUTHORIZATION (PA) REQUEST. YOU MAY CONTACT PROVIDER SERVICES IF YOU REQUIRE ASSISTANCE. DUPLICATE PA REQUEST
P448	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO DECAY HISTORY.
P449	QUESTIONABLE LONG TERM PROGNOSIS DUE TO GUM AND BONE DISEASE.
P456	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO APPARENT ROOT INFECTION.
P457	OUR RECORDS INDICATE THIS CLIENT HAS EXCEEDED ESTABLISHED PROGRAM LIMITATIONS. COLORADO MEDICAID WILL NOT AUTHORIZE NEW DENTURES.
P458	DOCUMENTATION PROVIDED INDICATES A LESS ELABORATE PROCEDURE SHOULD BE CONSIDERED.
P502	RENTAL ONLY ALLOWED; MEDICAL NEED FOR PURCHASE HAS NOT BEEN DOCUMENTED.
P503	PURCHASE ONLY ALLOWED; MEDICAL NEED FOR RENTAL HAS NOT BEEN DOCUMENTED.
P504	OCCUPATIONAL THERAPY GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P505	THE SERVICE REQUESTED IS INCLUDED IN THE NURSING HOME RATE STRUCTURE.
P511	THIS NATIONAL DRUG CODE IS ONLY BILLABLE AS PART OF A COMPOUND DRUG.
P515	THE PRESENCE OF A HANDICAPPING MALOCCLUSION OR HANDICAPPING DENTOFACIAL DEFORMITY IS NOT SUPPORTED BY THE DOCUMENTATION SUBMITTED.

Denial Code	Long Description
P521	THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVERED BY COLORADO MEDICAID.
P522	GASTRO-INTESTINAL SURGERY FOR THE PURPOSE OF WEIGHT CONTROL IS COVERED ONLY AS A LIFE THREATENING PROCEDURE.
P523	THE TREATMENT REQUEST IS NOT CONSISTENT WITH THE CLIENT'S DIAGNOSIS.
P524	PSYCHOTHERAPY PROVIDED IN THE CLIENTS HOME IS NOT A COVERED BENEFIT OF COLORADO MEDICAID.
P525	THE INFORMATION PROVIDED IS NOT CONSISTENT WITH THE INTENSITY OF SERVICES REQUESTED.
P526	INTENSIVE MULTIPLE MODALITY TREATMENT IS NOT CONSISTENT WITH THE INFORMATION PROVIDED.
P527	MULTIPLE PROVIDERS OF TREATMENT ARE NOT INDICATED FOR THIS CLIENT.
P528	THE DURATION OF TREATMENT SESSIONS EXCEED CURRENT COLORADO MEDICAID GUIDELINES.
P534	DOCUMENTATION OF POOR PHYSICAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P535	OTHER PHYSICAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P536	THE PHYSICAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P537	USE OF PHYSICAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P538	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF A PHYSICAL THERAPIST.
P539	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS AND LIVING ARRANGEMENT.
P540	GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P541	THE PROCEDURE(S) REQUESTED ARE NOT MEDICAL IN NATURE.
P542	DOCUMENTATION OF POOR OCCUPATIONAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P543	DOCUMENTATION OF POOR SPEECH THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P544	OTHER OCCUPATIONAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P546	THE OCCUPATIONAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P547	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF PHYSICAL THERAPY.
P548	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P549	ACTIVITIES TO PROMOTE DIVERSION OR GENERAL MOTIVATION ARE NONCOVERED COLORADO MEDICAID SERVICES.
P550	REVISIONS OF THE REQUEST IS NECESSITATED BY THE CLIENTS MINIMAL PROGRESS.
P551	RESTORATIVE NURSING INVOLVEMENT COULD BE INCREASED.
P552	CLIENTS DEMONSTRATED RESPONSE TO CURRENT THERAPY DOES NOT WARRANT THE INTENSE FREQUENCY REQUESTED.
P553	MAINTENANCE IS TWO TIMES PER WEEK OR LESS.
P554	THE SPEECH THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P555	USE OF OCCUPATIONAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P556	USE OF SPEECH THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P557	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF AN OCCUPATIONAL THERAPIST.
P558	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
P559	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P560	THE MATERIALS/ SERVICES REQUESTED ARE PRINCIPALLY COSMETIC IN NATURE.
P561	THE LENS FORMULA DOES NOT JUSTIFY REPLACEMENT.
P562	THE CHANGE IN THE LENS FORMULA DOES NOT WARRANT MULTIPLE REPLACEMENTS.
P563	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.

Denial Code	Long Description
P564	LENSES ONLY ARE APPROVED; PLEASE DISPENSE A CONTRACTED FRAME. THE NON-CONTRACTED FRAME IS NOT MEDICALLY JUSTIFIED.
P565	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P566	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P567	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF OCCUPATIONAL THERAPY.
P568	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF SPEECH THERAPY.
P569	LEVEL, INTENSITY, OR EXTENT OF SERVICE(S) REQUESTED HAS BEEN MODIFIED CONSISTENT WITH MEDICAL NEED AS DEFINED IN THE PLAN OF CARE.
P570	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P571	THE SERVICE ASKED FOR IS NOT COVERED BY COLORADO MEDICAID AS THESE TASKS CAN BE DONE BY NURSES OR ACTIVITY STAFF.
P572	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P573	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.
P574	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P575	MEDICAL NEED FOR EQUIPMENT/ SUPPLY REQUESTED IS NOT SUPPORTED BY DOCUMENTATION SUBMITTED.
P576	OTHER SPEECH THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P577	DOCUMENTATION SUBMITTED IDENTIFIES THAT THE CLIENT HAS FEWER THAN TWO POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P582	LESS EXPENSIVE ALTERNATIVE SERVICES ARE AVAILABLE FOR THIS CLIENT.
P634	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P711	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING PERIODONTAL SCALING AND ROOT PLANNING.
P712	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING GINGIVECTOMY.
P754	AN APPROVED SUBSTANCE ABUSE DAY TREATMENT PROGRAM CANNOT EXCEED A SIX WEEK PERIOD.
P761	THE CLIENT DOES NOT APPEAR TO BE ABLE OR WILLING TO ABSTAIN FROM ALCOHOL/DRUG USAGE WHILE IN TREATMENT. THEREFORE, SUBSTANCE ABUSE DAY TREATMENT SERVICES ARE NOT APPROVED.
P764	THIS CLIENT HAS COMPLETED INTENSIVE SUBSTANCE ABUSE TREATMENT WITHIN THE PAST 12 MONTHS. THE DOCUMENTATION PROVIDED IS NOT ADEQUATE TO JUSTIFY ADDITIONAL INTENSIVE TREATMENT AT THIS TIME.
P785	A LESS THAN SIX-WEEK HEALING PERIOD HAS BEEN SPECIFIED FOR THIS PRIOR AUTHORIZATION. THEREFORE IT IS NOT NECESSARY TO WAIT THE FULL SIX WEEKS AFTER EXTRACTIONS BEFORE TAKING DENTURE IMPRESSIONS.
P818	SIX-WEEK HEALING TIME IS REQUIRED BETWEEN EDENTULATION AND FINAL IMPRESSIONS. PAYMENT FOR DENTURES WILL BE DENIED OR RECOUPED IF HEALING PERIOD IS NOT OBSERVED.
P849	COLORADO MEDICAID HAS DETERMINED THERE WERE (ARE) SEVERAL HOME HEALTH AGENCIES WILLING TO PROVIDE MEDICALLY NECESSARY SKILLED NURSING SERVICES TO THIS CLIENT.
P864	THE DOCUMENTATION YOU HAVE SUBMITTED DOES NOT MEET THE REQUIREMENTS OF COLORADO MEDICAID.
P873	THE MEDICAL NECESSITY FOR THE HOURS REQUESTED IS NOT SUPPORTED BY THE INFORMATION SUBMITTED.
P874	THE DOCUMENTATION SUBMITTED INDICATES THE TASKS SPECIFIED CAN BE COMPLETED DURING THE VISITS APPROVED.
P878	THE DOCUMENTATION SUBMITTED DOES NOT INDICATE THAT MEDICALLY ORIENTED TASKS ARE MEDICALLY NECESSARY; THEREFORE PERSONAL CARE SERVICES HAVE BEEN APPROVED.
P880	THE QUANTITY OF SERVICES AUTHORIZED FOR THIS CLIENTS PERSONAL CARE HAS BEEN AMENDED BASED ON INFORMATION RECEIVED FROM ONE OR MORE OF THESE SOURCES: THE CLIENT, THEIR PHYSICIAN, AND/OR THE IN-HOME VISIT BY STAFF OF THE OIG (OFFICE OF INSPECTOR GENERAL).

Denial Code	Long Description
P885	THE USE OF THIS DRUG FOR THE INTENDED PURPOSE IS NOT COVERED BY COLORADO MEDICAID, CONSISTENT WITH COLORADO ADMINISTRATIVE CODE AND FEDERAL LAW.
P924	THE MEDICAL RECORDS SUBMITTED WITH THE CURRENT REQUEST CONFLICT OR DISAGREE WITH OUR MEDICAL RECORDS ON THIS CLIENT.
P950	INDEPENDENT NURSES, PLEASE NOTE PAYABLE SERVICES MAY NOT EXCEED 12 HOURS/DAY OR 60 HOURS/WEEK.
P951	SERVICES CAN ONLY BE AUTHORIZED THROUGH ONE YEAR FROM THE PRESCRIPTION DATE.
P952	LEAD INSPECTION IS A COVERED COLORADO MEDICAID SERVICE WHEN THE CHILD HAS BEEN SHOWN TO HAVE LEAD POISONING (E.G., CHILD HAS A BLOOD LEAD LEVEL > 19 UG/DL OR TWO CONSECUTIVE BLOOD LEAD LEVELS OF 15-19 UG/DL DONE AT LEAST 90 DAYS APART). THE INSPECTION MUS
P953	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P954	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P956	THE REQUEST CAN ONLY BE BACKDATED A MAXIMUM OF 14 DAYS FROM FIRST DATE RECEIVED BY COLORADO MEDICAID.
P957	COMPLETE PERIODONTAL CHARTING AT TIME OF SERVICE, AND SUBMIT CHARTING, COPY OF OPERATIVE REPORT, TOGETHER WITH A COPY OF THE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF), F-11035, TO PA UNIT ATTENTION DENTAL CONTSULTANT.
P958	NOTE THAT CODE D4341 HAS BEEN CHANGED. REFER TO THE DECISION NOTICE FOR AUTHORIZED QUANTITY.
P960	YOUR PA HAS BEEN APPROVED FOR 90 DAYS. THE 90 DAY APPROVAL DOES NOT IMPLY THE PA REQUEST MEETS PRIOR AUTHORIZATION CRITERIA. AFTER ADDITIONAL INFORMATION IS AVAILABLE IN INTERCHANGE, COLORADO MEDICAID WILL CREATE AN AMENDMENT REQUEST TO EXTEND THE PA FOR
P961	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P962	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
PA10	THE REQUESTED END DATE IS INVALID.
PA12	PLEASE FURNISH A WRITTEN DESCRIPTION OF THE CLIENTS DIAGNOSIS.
PA13	PROVIDE DIAGNOSES WITH DATES OF ONSET.
PA14	IDENTIFY PROBLEMS TO BE TREATED.
PA15	THE AUDIOLOGISTS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1), F-11020, AND PRIOR AUTHORIZATION REQUEST/HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2), F-11021.
PA16	THE PHYSICIANS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION/PHYSICIAN OTOLOGICAL REPORT (PA/POR), F-11019.
PA17	SUBMIT BRIEF HISTORY WITH REFERRAL INFORMATION, LIVING SITUATION, FUNCTIONAL STATUS, AND OTHER PERTINENT INFORMATION. WHAT CHANGE OF STATUS RESULTED IN REFERRAL AT THIS TIME?
PA18	PLEASE FURNISH THE CLIENTS HEIGHT AND WEIGHT.
PA19	PLEASE SUBMIT CLINICAL INFORMATION SUFFICIENT TO VERIFY THE NEED FOR THE REQUESTED SERVICE(S).
PA20	PLEASE RESUBMIT WITH COMPLETE PERIODONTAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PA21	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL EDUCATIONAL PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA22	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL PROGRAM PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA23	REFER TO THE DURABLE MEDICAL EQUIPMENT INDEX FOR APPROPRIATE CODE AND DESCRIPTION. DO NOT USE AN "UNLISTED" CODE.
PA24	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUALIZED FAMILY SERVICE PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA25	INFORMATION ON THE REQUEST FORM IS ILLEGIBLE, AND THE REQUEST CANNOT BE PROCESSED.

Denial Code	Long Description
PA26	RE-EVALUATE YOUR GOALS. EMPHASIS SHOULD BE ON FUNCTIONAL SELF-CARE. GOALS MUST BE RELATED TO FUNCTIONAL OUTCOME.
PA27	PLEASE CLARIFY THE NUMBER OF HOURS PER WEEK REQUESTED.
PA28	PLEASE CLARIFY THE NUMBER OF HOURS PER DAY REQUESTED.
PA29	PLEASE CLARIFY THE NUMBER OF VISITS PER DAY REQUESTED.
PA30	ATTACH SUPPORTIVE DOCUMENTATION; HOME EXERCISE PROGRAM AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA31	THE DIAGNOSIS CODE INDICATED ON THE REQUEST DOES NOT CORRESPOND TO THE DIAGNOSIS CODE DESCRIPTION.
PA32	PLEASE SUBMIT ADDITIONAL INFORMATION SUFFICIENT TO VERIFY APPROPRIATENESS AND NEED FOR TRANSPLANT.
PA33	PLEASE SUBMIT THE INITIAL AND PROGRESSIVE OBJECTIVE FINDINGS.
PA34	ATTACH SUPPORTIVE DOCUMENTATION, FACILITY PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA35	PLEASE SUBMIT THE CLIENTS ORIGINAL COMPLAINTS AND EXAMINATION FINDINGS.
PA36	ATTACH SUPPORTIVE DOCUMENTATION, IN-HOME AUTISM PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA37	PLEASE SUBMIT YOUR TREATMENT PLAN FOR THIS CLIENT.
PA38	ATTACH SUPPORTIVE DOCUMENTATION AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA39	INITIAL EVALUATIONS MUST BE PERFORMED BY AN OCCUPATIONAL THERAPIST REGISTERED (OTR), PER AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA) STANDARDS.
PA41	IDENTIFY THE PLACE OF SERVICE AND ITS EFFECT ON SUPPORTING THE DESIRED TREATMENT OUTCOME.
PA42	PLEASE INDICATE THE HOURS OF USE OF OXYGEN PER 24-HOUR PERIOD.
PA43	PROVIDE BASELINE DOCUMENTATION FOR THIS CLIENTS LIMITATIONS USING UNITS OF MEASUREMENT THAT ARE APPLIED CONSISTENTLY WHEN REPORTING STATUS.
PA44	IDENTIFY FUNCTIONAL LIMITATIONS AS THEY ARE RELATED TO IDENTIFIED CONDITIONS.
PA46	CORRELATE PLAN OF CARE TO REQUESTED PROCEDURE CODES.
PA47	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE FREQUENCY/DURATION REQUESTED.
PA48	PLEASE PROVIDE THE NAME AND CREDENTIALS OF THE RENDERING PROVIDER.
PA50	COLORADO MEDICAID RECORDS INDICATE THE CLIENT OWNS A WHEELCHAIR. DOCUMENT THE REASON AND NEED FOR REPLACEMENT AND COST TO REPAIR CURRENT WHEELCHAIR.
PA51	PLEASE DISTINGUISH PRIMARY AND SUPPORTIVE MODALITIES.
PA52	PLEASE SUBMIT A PROGRESS REPORT.
PA53	MULTIPLE FAMILY CLIENTS TREATMENT BY THE SAME PROVIDER REQUIRES FURTHER INFORMATION DOCUMENTING COORDINATION OF TREATMENT PLAN.
PA54	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE MINUTES REQUESTED.
PA55	MEDICAL NECESSITY OF TREATMENT REQUIRES ADDITIONAL DOCUMENTATION.
PA56	GIVEN AGE, DIAGNOSES, CURRENT LEVEL OF FUNCTION, PAST RESPONSE TO TREATMENT, AND LIVING SITUATION, EXPAND ON POTENTIAL FOR SIGNIFICANT FUNCTIONAL PROGRESS WITHIN THE NEXT SIX MONTHS. EMPHASIZE WHY PROGRESS IS EXPECTED WITH SERVICES AT THIS TIME.
PA57	SUBMIT THE INITIAL FINDINGS. INCLUDE A COMPREHENSIVE EVALUATION.
PA58	SUBMIT PROGRESSIVE, OBJECTIVE FINDINGS. INCLUDE A PERTINENT RE-EVALUATION.
PA59	PLEASE SUPPLY INFORMATION REGARDING THE CLIENTS MEDICATION REQUIREMENTS, IF ANY.
PA60	PLEASE SPECIFY IF THE CLIENT IS IN AN EDUCATIONAL SETTING.
PA61	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA62	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
PA63	THE SKILLS OF A THERAPIST ARE PURPOSEFUL AND SKILLED INTERVENTIONS REQUIRED TO CONTINUALLY DESIGN, IMPLEMENT, REASSESS, MODIFY/GRADE, AND/OR DISCONTINUE A PLAN OF CARE IN A TIMELY MANNER, BASED ON THE COMPLEXITY OF THE CLIENTS MEDICAL CONDITION AND/OR CO

Denial Code	Long Description
PA64	PLEASE SUBMIT A THERAPY PLAN OF CARE, INCLUDING A CURRENT, DATED EVALUATION.
PA65	A PLAN OF CARE SIGNED AND DATED BY THE PHYSICIAN IS REQUIRED.
PA66	THE SKILLS OF A THERAPIST ARE REQUIRED WHEN ONLY THE THERAPIST CAN SAFELY AND EFFECTIVELY DELIVER THE THERAPEUTIC PROCEDURES BECAUSE OF THEIR UNIQUE KNOWLEDGE, TRAINING, AND EXPERTISE. DESCRIBE THE REASON THAT SOMEONE OTHER THAN A THERAPIST CANNOT SAFELY
PA67	PLEASE SPECIFY IF THE CLIENTS WORK SITE DEMANDS GOOD BINAURAL HEARING.
PA68	DESCRIBE THE REASON, BASED ON THE CLIENTS COGNITIVE, PHYSICAL, COMMUNICATION, OR RESOURCE STATUS, THAT A HOME PROGRAM, EQUIPMENT, OR ENVIRONMENTAL ADAPTATIONS ALONE CANNOT MEET CLIENTS NEEDS.
PA69	PLEASE SPECIFY IF THE CLIENT HAS AN ACCOMPANYING DISABILITY THAT ADDS TO THE HEARING PROBLEM.
PA70	DISTINGUISH REQUESTED PROCEDURES AND GOALS FROM OTHER SERVICES THIS CLIENT RECEIVES. THEY MAY NOT BE DUPLICATIVE.
PA71	PLEASE INDICATE THE NUMBER OF DAYS REQUESTED.
PA73	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA74	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA75	PLEASE DOCUMENT CARRYOVER OF THE THERAPY PROGRAM TO NURSING.
PA76	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA79	PROVIDE EVIDENCE OF SIGNIFICANT FUNCTIONAL PROGRESS IN LAST SIX MONTHS.
PA84	THE GRANT DATE OF THIS REQUEST CANNOT BE PRIOR TO THE SIGNATURE DATE OF THE PRESCRIBING PHYSICIAN.
PA86	PROVIDE EVIDENCE OF SKILLS GAINED IN THERAPY CARRYING OVER TO OTHER SETTINGS WITHIN SIX MONTHS.
PA87	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE NUMBER OF SESSIONS REQUESTED.
PA88	THE REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL SCOPE OF PRACTICE.
PA89	PRIOR AUTHORIZATION IS NOT REQUIRED UNTIL LIMITATION OF SERVICE HAS BEEN REACHED.
PA91	PLEASE SUBMIT REQUIRED X-RAYS.
PA92	PLEASE PROVIDE AN EXPLANATION FOR THE MATERIAL SUBMITTED WITH THE REQUEST.
PA95	PLEASE DESCRIBE HOW THE PROVISION OF THIS SERVICE WOULD PREVENT INSTITUTIONALIZATION OF THE CLIENT.
PA96	COULD THE EXISTING DENTURE(S) BE RELINED OR REBASED? IF NOT, PLEASE EXPLAIN WHY NOT.
PA97	REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL STANDARDS OF PRACTICE.
PA98	PLEASE INDICATE IF THE CLIENT IS CURRENTLY BEING TUBE FED.
PB02	PLEASE PROVIDE THE REQUIRED DATED SIGNATURES ON THE ATTACHMENTS.
PB03	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING THE LOSS/DESTRUCTION/THEFT OF THE HEARING AID.
PB04	DESCRIBE THE CLIENTS ABILITY TO STAND OR AMBULATE SUFFICIENTLY TO ACCOMPLISH SELF-CARE ACTIVITIES.
PB07	PLEASE SUBMIT AN ORTHODONTIC STUDY MODEL OR DIAGNOSTIC CASTS.
PB09	PLEASE PROVIDE A PHOTOGRAPH OF THE INVOLVED AREA(S).
PB10	PLEASE PROVIDE AN ESTIMATION (IN GRAMS) OF THE TOTAL AMOUNT OF TISSUE TO BE RESECTED.
PB11	PLEASE SUBMIT THE PLAN OF CARE FOR CO-TREATMENT.
PB12	FURNISH A DETAILED DESCRIPTION FOR THE PROCEDURE CODE REQUESTED.
PB13	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB15	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB18	PLEASE COMPLETE THE ATTACHED OUT-OF-STATE PROVIDER DATA SHEET, F-11001, AND RESUBMIT.
PB20	A SIGNED AND DATED PRESCRIPTION IS REQUIRED WITHIN THREE MONTHS OF RECEIPT BY COLORADO MEDICAID FOR INITIAL REQUESTS AND WITHIN 12 MONTHS OF RECEIPT BY COLORADO MEDICAID FOR SUBSEQUENT REQUESTS.
PB21	PLEASE COMPLETE THE APPROPRIATE PRIOR AUTHORIZATION ATTACHMENT. CONTACT PROVIDER SERVICES OR THE PRIOR AUTHORIZATION UNIT FOR ASSISTANCE.

Denial Code	Long Description
PB23	PHYSICAL THERAPY ASSISTANT NOTES AND ALL FORMS SUBMITTED MUST BE COSIGNED BY A REGISTERED PHYSICAL THERAPIST.
PB31	ARE YOU REQUESTING A COMPLETE APPLIANCE, OR REPLACEMENT PARTS?
PB32	THE PROCEDURE CODE INDICATED ON THE REQUEST DOES NOT MATCH THE DESCRIPTION OF SERVICE; PLEASE CORRECT AND RESUBMIT.
PB35	THE SERVICE REQUESTED DOES NOT REQUIRE PRIOR AUTHORIZATION.
PB41	PLEASE FURNISH A CURRENT MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT, F-11090 (DATED WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID).
PB45	THE CERTIFICATION PERIOD ON THE PLAN OF CARE (POC) DOES NOT COVER THE REQUESTED GRANT/START DATE. PLEASE RESUBMIT YOUR REQUEST WITH A NEW POC.
PB49	A CERTIFIED OCCUPATIONAL THERAPY ASSISTANTS NOTES MUST BE COSIGNED BY AN OCCUPATIONAL THERAPIST REGISTERED.
PB51	ADDITIONAL INFORMATION IS REQUIRED ON PRIOR AUTHORIZATION TO ENABLE PRICING.
PB54	REQUESTED SERVICES DO NOT MATCH SERVICES ON THE PHYSICIANS ORDERS.
PB59	PLEASE PROVIDE AN INDIVIDUAL EDUCATIONAL PLAN (IEP), WHICH HAS BEEN SIGNED BY THE PROVIDER NO EARLIER THAN NINE MONTHS PRIOR TO RECEIPT AT COLORADO MEDICAID; OTHERWISE, DOCUMENT WHY NO IEP EXISTS.
PB65	PLEASE FURNISH THE ANTICIPATED TOTAL CHARGES FOR THIS REQUEST.
PB66	A PHOTOCOPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED; THE DATE MUST BE WITHIN SIX MONTHS OF RECEIPT BY COLORADO MEDICAID.
PB67	THE PRESCRIPTION DATE MUST INCLUDE MONTH, DAY, AND YEAR.
PB68	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID.
PB73	THE SERVICES IDENTIFIED ON THE PLAN OF CARE DO NOT APPEAR APPROPRIATE FOR THE PROCEDURE CODE(S) REQUESTED ON THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018.
PB74	THE CLIENT/PROVIDER DOES NOT HAVE RETROACTIVE ENROLLMENT.
PB75	THE REQUESTED START DATE IS MORE THAN 14 DAYS BEFORE OR 62 DAYS AFTER RECEIPT.
PB82	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
PB83	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A HOME HEALTH AIDE. PLEASE RESUBMIT AS A PERSONAL CARE WORKER OR PROVIDE ADDITIONAL DOCUMENTATION.
PB86	THE SERVICES REQUESTED ARE NOT BEING PROVIDED IN THE CLIENTS RESIDENCE. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL.
PB87	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A NURSE. PLEASE RESUBMIT AS A HOME HEALTH AIDE OR PROVIDE ADDITIONAL DOCUMENTATION.
PB92	PLEASE FURNISH THE CLIENTS COMPLETE ADDRESS.
PB94	IF THE CLIENT IS A RESIDENT OF A NURSING HOME, SUPPLY THE COMPLETE NAME AND ADDRESS OF THE NURSING HOME.
PB99	THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018, MUST BE SIGNED AND DATED.
PC01	PLEASE SUPPLY THE RENDERING PROVIDERS PROVIDER NUMBER.
PC03	THE DRUG ENFORCEMENT ADMINISTRATION NUMBER IS MISSING OR INVALID.
PC06	PLEASE DESCRIBE YOUR PROGRAM; INCLUDE ENTRY DATE, TERMINATION DATE, HOURS PER WEEK, AND NUMBER OF WEEKS OF PRIMARY INTENSIVE SERVICE REQUESTED.
PC07	PLEASE DESCRIBE YOUR "AFTERCARE/FOLLOW-UP" PLANS FOR THIS CLIENT.
PC08	PLEASE SUPPLY DOCUMENTATION OF PREVIOUS SUBSTANCE ABUSE SERVICES WITH DATE(S) AND OUTCOME.
PC09	PLEASE DESCRIBE IN DETAIL THE TREATMENT OBJECTIVES/GOALS FOR THIS CLIENT.
PC10	PLEASE DESCRIBE THE FAMILY SITUATION/DYNAMICS. EXPLAIN HOW THE FAMILY WILL BE INCORPORATED INTO THE CLIENTS PLAN OF CARE.
PC12	PLEASE EXPLAIN IF YOUR SERVICE ENCOURAGES THE CLIENT TO ATTEND SELF-HELP GROUPS.
PC13	PLEASE SUPPLY A SPECIFIC SCHEDULE OF ACTIVITIES, INCLUDING DAY, TIME OF DAY, LENGTH OF SESSION, AND SERVICE TO BE RENDERED DURING THAT TIME.
PC15	PLEASE FURNISH DIAGNOSTIC RATIONALE.
PC17	PLEASE DOCUMENT IF THE CLIENT EVER RECEIVED SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT.
PC19	PLEASE FURNISH MORE EXTENSIVE AND IN-DEPTH HISTORICAL AND PSYCHOSOCIAL DATA.

Denial Code	Long Description
PC20	PLEASE SUPPLY THE DATE THE CLIENT BECAME TOTALLY ENDENTULOUS.
PC23	PLEASE SUBMIT A PHYSICIANS STATEMENT REGARDING THE MEDICAL NECESSITY OF DENTURES FOR THIS CLIENT. THE PHYSICIANS STATEMENT MUST DOCUMENT THE MEDICAL NEED FOR DENTURES.
PC24	THE SERVICE REQUESTED WAS PREVIOUSLY AUTHORIZED. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT INDICATING THIS FACT IS REQUIRED.
PC25	PLEASE SUPPLY SUFFICIENT MITIGATING CIRCUMSTANCES TO WARRANT THE CONSTRUCTION OF NEW DENTURES(S).
PC26	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
PC28	PLEASE SUBMIT A PHYSICIANS STATEMENT INDICATING DENTURES ARE NECESSARY FOR THIS NURSING HOME CLIENT.
PC29	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING LOSS OR DESTRUCTION OF DENTURE(S). INCLUDE SIGNED STATEMENT FROM CLIENT OR FACILITY DIRECTOR REGARDING HOW, WHEN AND WHERE LOST.
PC30	PLEASE PROVIDE COMPLETE INTRAORAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PC31	PLEASE DESCRIBE ANY RELATED DEFORMITIES OF THE FEET.
PC34	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD WITH REQUESTED DME ITEM(S) AND DOCUMENT IF THE CLIENT CAN USE SAFELY AND INDEPENDENTLY.
PC35	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD AND DESCRIBE THE RESULTS AND EFFECTIVENESS OF THE SERVICE REQUESTED.
PC39	PLEASE INDICATE LITER FLOW PER MINUTE, HOURS OF USE PER 24 HOUR PERIOD, AND THE EXPECTED DURATION OF NEED.
PC40	THE ITEM DOES NOT REQUIRE PRIOR AUTHORIZATION UNTIL THE LIFE EXPECTANCY HAS BEEN REACHED.
PC41	PLEASE SUPPLY INFORMATION INDICATING THE NECESSITY OF POSITIONING THE CLIENT'S BODY IN MULTIPLE POSITIONS.
PC42	PLEASE INDICATE IF THE BED HEIGHT MUST BE CHANGED TO ALLOW FOR SAFE TRANSFER OR ADEQUATE BED CARE.
PC43	SUPPLY A PHYSICIANS STATEMENT INDICATING TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR UNIT HAS REDUCED PAIN, IMPROVED/INCREASED THE CLIENTS ACTIVITY LEVEL, AND/OR REDUCED CLIENTS USE OF PAIN MEDICATION.
PC44	A CURRENT AUTHORIZATION FOR THIS SERVICE IS ON FILE FOR ANOTHER PROVIDER. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT OF THAT FACT IS REQUIRED BY THE CLIENT OF FIRST PROVIDER.
PC59	DOCUMENT DECLINE OR PROGRESS IN SPECIFIC, MEASURABLE, OBJECTIVE TERMS.
PC60	DOCUMENT IF CLIENT HAS DEMONSTRATED A GOOD APPOINTMENT COMPLIANCE RECORD.
PC61	THE PHYSICIANS SIGNATURE DATE MUST NOT EXCEED 90 DAYS FROM THE DATE OF RECEIPT BY COLORADO MEDICAID.
PC62	REQUESTS FOR A CONTINUATION OF THERAPY SHOULD NOT BE SUBMITTED MORE THAN FOUR WEEKS PRIOR TO THE EXPIRATION DATE OF THE CURRENT AUTHORIZATION.
PC63	PLEASE FURNISH THE STYLE AND MANUFACTURER OF THE FRAME.
PC64	PLEASE FURNISH THE CLIENTS LENS FORMULA.
PC66	ALL REQUESTS FOR TINTS REQUIRE DOCUMENTATION OF THE VISUAL OR MEDICAL CONDITION RELATED TO PHOTOPHOBIA.
PC67	PLEASE DOCUMENT THE REASON AND JUSTIFICATION FOR REPLACEMENT BEYOND THE FIRST LENS/FRAME.
PC68	DOCUMENT IF ALL REMAINING MAXILLARY AND/OR MANDIBULAR TEETH ARE DECAY-FREE, PROPERLY RESTORED, AND PERIODONTICALLY SOUND.
PC72	SUPPLY MORE DETAIL REGARDING PROGRESS (ATTACHMENT OF GOALS, ETC.). CORRELATE PROGRESS TO PREVIOUS GOALS AND IDENTIFIED LIMITATIONS.
PC77	PLEASE SUBMIT A PLAN OF CARE DESCRIBING THE SERVICES THAT WOULD BE PROVIDED.
PC78	PLEASE DOCUMENT SPECIFIC, MEASURABLE GOALS.
PC82	THE PRIOR AUTHORIZATION (PA) SYSTEM CAN PROCESS ONLY 26 DETAILS PER PA REQUEST. PLEASE RESUBMIT YOUR REQUEST WITH NO MORE THAN 26 DETAILS.
PC83	PLEASE SUPPLY A PHYSICIANS PRESCRIPTION DATED WITHIN ONE MONTH OF REQUESTED SUBSTANCE ABUSE DAY TREATMENT.

Denial Code	Long Description
PC84	PLEASE PROVIDE INFORMATION INDICATING THIS CLIENT IS APPROPRIATELY DETOXIFIED FROM ALCOHOL AND/OR OTHER DRUGS.
PC85	PLEASE PROVIDE INFORMATION TO INDICATE THE CLIENTS ABILITY TO ABSTAIN FROM ALCOHOL OR DRUGS WHILE IN THE SUBSTANCE ABUSE DAY TREATMENT PROGRAM.
PC86	PLEASE INDICATE IF THIS CLIENT IS WILLING TO PARTICIPATE IN AFTERCARE OR CONTINUING CARE SERVICES.
PC87	PROVIDE MORE INFORMATION ON TREATMENT HISTORY; INCLUDE SERVICE PROVIDED, DATES, AND OUTCOME. PROVIDE DETAIL OF PREVIOUS TREATMENT.
PC88	PLEASE PROVIDE MORE RATIONALE FOR THE APPROPRIATENESS AND MEDICAL NECESSITY OF SUBSTANCE ABUSE DAY TREATMENT.
PC89	PROVIDE A TREATMENT PLAN THAT CONTAINS MEASURABLE GOALS AND OBJECTIVES CORRESPONDING TO THE IDENTIFIED DEFICIT.
PC91	PLEASE PROVIDE MORE INFORMATION ON FAMILY INVOLVEMENT TREATMENT.
PC92	PLEASE PROVIDE MORE HISTORY AND EXPLANATION ABOUT THE ISSUE OF ABSTINENCE FOR THIS CLIENT.
PC94	PLEASE PROVIDE THE ANTICIPATED BEGINNING DATE AND/OR THE ESTIMATED SUBSTANCE ABUSE DAY TREATMENT DISCHARGE DATE.
PC95	PLEASE SUPPLY JUSTIFICATION FOR BEGINNING CLIENT IN SERVICE PRIOR TO AUTHORIZATION BEING OBTAINED.
PC96	THE INITIAL THREE HOURS OF SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IN A CALENDAR YEAR DO NOT REQUIRE PRIOR AUTHORIZATION.
PC97	REIMBURSEMENT FOR INITIAL SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IS LIMITED TO THREE HOURS IN A CALENDAR YEAR AND DOES NOT REQUIRE PRIOR AUTHORIZATION.
PC98	THIS DRUG IS CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE BILL USING THE APPROPRIATE NATIONAL DRUG CODE (NDC) OR SUBMIT A COMPLETED DRUG ADDITION REQUEST FORM IF THE NDC IS NOT LISTED IN THE DRUG INDEX.
PC99	THIS DRUG IS NOT CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL, CURRENT ADMINISTRATIVE RULE, OR COLORADO DRUG INDEX FOR COVERAGE LIMITATIONS.
PD01	DOCUMENT THAT CLIENT HAS ACHIEVED GOOD ORAL HYGIENE, PERIODONTAL CASE TYPE 1 OR 2, AND IS MOTIVATED TO MAINTAIN SAME.
PD03	PLEASE PROVIDE AN ARTERIAL BLOOD GAS READING OR PULSE OXIMETRY RESULTS DONE ON ROOM AIR SIGNED AND DATED BY A MEDICAL DOCTOR. THIS SHOULD BE DONE WITHIN 60 DAYS OF REQUESTED SERVICE.
PD04	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 30 DAYS OF RECEIPT BY COLORADO MEDICAID.
PD07	SUBMIT A PHOTOCOPY OF A VALID PRESCRIPTION, ISSUED WITHIN THE PAST YEAR, OR COMPLETE SECTION B OF THE PRIOR AUTHORIZATION/DRUG ATTACHMENT (PA/DGA), F-11049.
PD10	BRAND MEDICALLY NECESSARY MUST BE IN THE PRESCRIBERS OWN HANDWRITING AND WRITTEN DIRECTLY ON THE PRESCRIPTION OR A SEPARATE ORDER ATTACHED TO THE ORIGINAL PRESCRIPTION.
PD12	COMPLETE DENTURES, PARTIAL DENTURES, DENTURE RELINES, AND FIXED PROSTHODONTIC SERVICES ARE NOT COVERED SERVICES FOR ADULTS FOR DATES OF SERVICE ON AND AFTER OCTOBER 1, 1995.
PD22	PLEASE COMPLETE ALL REQUIRED ELEMENTS ON THE PERSONAL CARE SCREENING TOOL (PCST), F-11133.
PD24	THIS PRIOR AUTHORIZATION REQUEST IS UNABLE TO BE PROCESSED. PLEASE RESUBMIT WITH ADDITIONAL REQUIRED FORMS, INCLUDING THE ENTIRE PERSONAL CARE SCREENING TOOL (PCST), F-11133; PERSONAL CARE ADDENDUM, F-11136; AND SUPPORTING DOCUMENTATION, AS DIRECTED.
PD25	THERE IS A PERSONAL CARE SCREENING TOOL (PCST), F-11133, COMPLETED BY ANOTHER AGENCY. CONTACT THE AGENCY TO TRANSFER SCREEN.
PD26	THERE IS A LIMITED TERM CARE FUNCTIONAL SCREEN (LTC-FS) COMPLETED BY ANOTHER AGENCY. THE PERSONAL CARE SCREENING TOOL (PCST), F-11133, INFORMATION IS IN CONFLICT WITH LTC-FS.
PD27	ONLY ONE LEVEL OF FUNCTION MAY BE SELECTED FOR ALL ELEMENTS EXCEPT TOILETING. COLORADO MEDICAID IS UNABLE TO PROCESS THE PRIOR AUTHORIZATION REQUEST.
PD28	NO UNITS MAY BE REQUESTED USING THIS PRIOR AUTHORIZATION PROCESS. PLEASE SUBMIT WITH THE APPROPRIATE ATTACHMENTS FOR REQUESTING SPECIFIC PERSONAL CARE WORKER UNITS.

Denial Code	Long Description
PD29	CLIENT IS NOT ELIGIBLE FOR THE REQUESTED SERVICE(S) AS OF THE REQUESTED START DATE.
PD30	NO TRAVEL TIME MAY BE AUTHORIZED WHEN NO PERSONAL CARE WORKER SERVICE IS AUTHORIZED.
PD32	PROVIDER NOT CERTIFIED TO RENDER THE SERVICE(S) REQUESTED.
PD34	BASED ON THE DOCUMENTATION SUBMITTED, THIS REQUEST CAN NOT BE PRIOR AUTHORIZED. REFER TO THE PA MESSAGES FROM THE CONSULTANT FOR COMPLETE EXPLANATION.
PD98	PLEASE DOCUMENT HOW AND WHEN EACH PREVIOUSLY AUTHORIZED PRO RE NATA VISIT WAS USED.

Out-of-State (OOS) Inpatient

DENIAL CODE	LONG DESCRIPTION
0201	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
0233	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0235	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0237	CLIENT IDENTIFICATION NUMBER DOES NOT MATCH CLIENTS FIRST NAME.
0238	THE CLIENT IDENTIFICATION NUMBER DOES NOT MATCH THE CLIENTS LAST NAME.
0242	SECONDARY DIAGNOSIS CODE IS INVALID.
0248	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0249	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0251	PROCEDURE CODE MODIFIER IN FIRST POSITION IS INVALID.
0252	THE PROCEDURE CODE MODIFIER IN SECOND POSITION IS INVALID FOR REQUESTED START DATE OR DATE OF RECEIPT.
0253	THE PROCEDURE CODE MODIFIER IN THIRD POSITION IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
0258	THE PRIMARY DIAGNOSIS CODE IS REQUIRED.
0272	THE PRIMARY DIAGNSOSIS CODE IS INVALID.
0400	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0853	HCPCS - ANNUAL UPDATE
0885	NEVER EVENTS MODIFIERS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
0886	NEVER EVENTS DIAGNOSIS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
1000	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
1002	RENDERING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1003	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1007	RENDERING PROVIDER ID IS NOT ON FILE.
1047	THE RENDERING PROVIDERS CERTIFICATION HAS BEEN CANCELLED.
1048	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1801	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
1804	A CERTIFIED SUBSTANCE ABUSE DAY TREATMENT PROVIDER MUST SUBMIT A SUBSTANCE ABUSE DAY TREATMENT PROCEDURE CODE.
1806	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
1808	THE BILLING PROVIDER DOES NOT HAVE THE REQUIRED CERTIFICATION ADDENDUM ON FILE.
1900	THE BILLING PROVIDERS TAXONOMY CODE IS INVALID.
1901	THE RENDERING PROVIDERS TAXONOMY CODE IS INVALID.
1927	A NATIONAL PROVIDER IDENTIFIER IS REQUIRED FOR THE BILLING PROVIDER.
1934	A NATIONAL PROVIDER INDENTIFIER IS REQUIRED FOR THE RENDERING PROVIDER.
1936	THE BILLING PROVIDER NUMBER IS INVALID.
1937	THE RENDERING PROVIDER NUMBER IS INVALID.
1960	INTERNAL PROCESSING IS REQUIRED.
1963	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.

DENIAL CODE	LONG DESCRIPTION
1964	THE BILLING PROVIDER INDICATED IS NOT ALLOWABLE AS A BILLING PROVIDER.
1965	RENDERING PROVIDER NUMBER IS MISSING/INVALID FOR THIS PROCEDURE PROVIDER.
1974	PRESCRIBING/REFERRING/ORDERING PROVIDER INDICATED IS NOT CERTIFIED AS A PRESCRIBING/REFERRING/ORDERING PROVIDER.
1975	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
1976	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
2001	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2003	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2017	THE CLIENT IS ENROLLED IN A MEDICAID OR OTHER MANAGED CARE PROGRAM.
2037	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2603	CLIENT LOCKED-IN TO A PROVIDER OR ENROLLED IN A HOSPICE. CONTACT CLIENTS HOSPICE FOR PAYMENT OF SERVICES OR RESUBMIT WITH DOCUMENTATION OF UNRELATED NATURE OF CARE.
3324	THE MODIFIER HAS BEEN DISCONTINUED BY THE CENTERS OF MEDICARE AND MEDICAID SERVICES OR THE AMERICAN MEDICAL ASSOCIATION FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
3337	THE PROCEDURE CODE HAS BEEN TERMINATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AMERICAN MEDICAL ASSOCIATION, OR AMERICAN DENTAL ASSOCIATION FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT. RESUBMIT WITH VALID A PROCEDURE CODE.
3339	THE PROCEDURE BILLED IS NOT PAYABLE ACCORDING TO DEFICIT REDUCTION ACT (DEFRA) GUIDELINES.
3351	THE PROCEDURE IS NOT COVERED FOR CLIENTS WITH A NURSING HOME AUTHORIZATION ON THE REQUESTED START DATE OR DATE OF RECEIPT.
3353	THE PROCEDURE IS NOT A COVERED SERVICE FOR HOME AND COMMUNITY-BASED WAIVER CLIENTS.
4021	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4027	THE DIAGNOSIS CODE IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
4031	THE PROCEDURE SUBMITTED IS NOT APPROPRIATE FOR CLIENTS GENDER.
4032	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4034	THE PROCEDURE CODE HAS AN AGE RESTRICTION.
4036	THE PLACE OF SERVICE CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4040	THE PRIMARY DIAGNOSIS CODE IS NOT ON FILE.
4041	THE SECONDARY DIAGNOSIS IS NOT ON FILE.
4046	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4127	INTERNAL PROCESSING IS REQUIRED.
4131	INTERNAL PROCESSING IS REQUIRED.
4141	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4149	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4150	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4236	ETIOLOGY DIAGNOSIS CODE(S) (E-CODES) ARE INVALID AS THE PRIMARY DIAGNOSIS.
4244	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4245	THE FOURTH POSITION MODIFIER IS INVALID FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT.
4256	THE PROCEDURE CODE AND MODIFIER COMBINATION IS NOT PAYABLE FOR THE CLIENTS BENEFIT PLAN.
4257	THE MODIFIERS SUBMITTED ARE EITHER INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT OR THE MODIFIERS ARE MISSING.
4311	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4315	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4316	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4371	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4372	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4711	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR CLIENTS AGE.
4714	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS AGE.
4731	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS DIAGNOSIS.
4742	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4743	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.

DENIAL CODE	LONG DESCRIPTION
4744	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4745	DIAGNOSIS AND/OR PROCEDURE AND/OR PLACE OF SERVICE (POS) CODE IS NOT COVERED FOR EXPRESS ENROLLMENT CLIENTS.
4746	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4801	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4802	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
4821	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
4871	PLEASE REFER TO PA MESSAGES FOR RETURN INFORMATION.
4963	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS GENDER.
4990	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
7500	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
7509	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
C001	THIS PRIOR AUTHORIZATION WAS DENIED BECAUSE THE PRIOR AUTHORIZATION FORM WAS NOT COMPLETED OR THE NECESSARY ATTACHMENT WAS NOT INCLUDED.
C002	THIS PRIOR AUTHORIZATION WAS DENIED BECAUSE THE CLIENT DOES NOT MEET THE CRITERIA TO RECEIVE A NON-PREFERRED PRODUCT ON THE COLORADO MEDICAID PREFERRED DRUG LIST.
C003	THIS PRIOR AUTHORIZATION WAS DENIED BECAUSE OF A NON-APPROVED DIAGNOSIS. SEE PRIOR AUTHORIZATION CRITERIA (APPENDIX P) FOR APPROVED DIAGNOSES FOR THIS DRUG AT HTTP://WWW.COLORADO.GOV/CS/SATELLITE/HCPF/HCPF/1201542571132.
C004	THIS PRIOR AUTHORIZATION WAS DENIED BECAUSE THE QUANTITY LIMITS HAVE BEEN EXCEEDED. SEE DRUG LIMITS FOR THE ALLOWABLE QUANTITIES FOR THIS MEDICATION AT HTTP://WWW.COLORADO.GOV/CS/SATELLITE/HCPF/HCPF/1201542571132.
C005	THIS PRIOR AUTHORIZATION WAS DENIED BECAUSE OF THE DOSING SCHEDULE. SEE PRIOR AUTHORIZATION CRITERIA (APPENDIX P) FOR THE APPROVED DOSING SCHEDULE FOR THIS DRUG AT HTTP://WWW.COLORADO.GOV/CS/SATELLITE/HCPF/HCPF/1201542571132.
C006	THIS PRIOR AUTHORIZATION WAS DENIED BECAUSE MEDICATIONS ADMINISTERED IN A HOSPITAL, PHYSICIAN OFFICE OR DIALYSIS UNIT SHOULD BE BILLED DIRECTLY BY THOSE FACILITIES AS A MEDICAL ITEM. THESE MEDICATIONS ARE NOT A PHARMACY BENEFIT UNDER COLORADO MEDICAID.
C007	THIS PRIOR AUTHORIZATION WAS DENIED BECAUSE DESI DRUGS (MEDICATIONS DETERMINED NOT TO BE SAFE AND EFFECTIVE BY THE FDA) AND NON-REBATE ABLE DRUGS (MEDICATIONS THAT HAVE NOT SIGNED A REBATE AGREEMENT WITH THE CENTERS FOR MEDICARE AND MEDICAID SERVICES) ARE NOT A BENEFIT OF COLORADO MEDICAID.
C008	THIS PRIOR AUTHORIZATION (PA) WAS DENIED BECAUSE A PAIN EVALUATION WAS NOT SUBMITTED TO THE PRIOR AUTHORIZATION HELPDESK WITH THE PA FORM. PLEASE FAX A PAIN EVALUATION TO THE PA HELPDESK FOR RECONSIDERATION.
C009	THIS PRIOR AUTHORIZATION WAS DENIED BECAUSE THE CLIENT HAS EXCEEDED THE 90 DAY LIFETIME BENEFIT FOR SMOKING CESSATION PRODUCTS
C010	THIS PRIOR AUTHORIZATION WAS DENIED BECAUSE DURABLE MEDICAL EQUIPMENT (DME) AND SUPPLIES ARE A MEDICAL BENEFIT OF COLORADO MEDICAID AND NEED TO BE BILLED AS A MEDICAL CL DME ARE NOT A PHARMACY BENEFIT.
C011	THIS PRIOR AUTHORIZATION WAS DENIED BECAUSE THE CLIENT DOES NOT MEET THE CRITERIA FOR APPROVAL. SEE PRIOR AUTHORIZATION CRITERIA (APPENDIX P) AT HTTP://WWW.COLORADO.GOV/CS/SATELLITE/HCPF/HCPF/1201542571132.
C01Z	THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. THE REQUIRED CLIENT STATE ID NUMBER IS MISSING OR INVALID. PLEASE RESUBMIT PAR REQUEST WITH THE CORRECTED INFORMATION TO CFMC VIA FAX AT: 303-790-4643.
C02Z	*INACTIVE* THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. THE REQUIRED CLIENT STATE ID NUMBER DOES NOT MATCH THE CLIENT NAME. PLEASE RESUBMIT PAR REQUEST WITH THE CORRECTED INFORMATION TO CFMC VIA FAX AT: 303-790-4643.

DENIAL CODE	LONG DESCRIPTION
C03Z	*INACTIVE* THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. THE REQUIRED CLIENT DATE OF BIRTH IS MISSING OR INVALID. PLEASE RESUBMIT PAR REQUEST WITH THE CORRECTED INFORMATION TO CFMC VIA FAX AT: 303-790-4643.
C04Z	*INACTIVE* THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. THE REQUIRED REQUESTING PROVIDER NUMBER IS MISSING OR INVALID. PLEASE RESUBMIT PAR REQUEST WITH THE CORRECTED INFORMATION TO CFMC VIA FAX AT: 303-790-4643.
C05Z	*INACTIVE* THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. THE REQUIRED BILLING PROVIDER NUMBER IS MISSING OR INVALID. PLEASE RESUBMIT PAR REQUEST WITH THE CORRECTED INFORMATION TO CFMC VIA FAX AT: 303-790-4643.
C100	THE ITEM OR SERVICE REQUESTED IS NOT A MEDICAID BENEFIT.
C101	*INACTIVE* DENIAL 1 THE PROCEDURE IS NOT A BENEFIT OF THE COLORADO MEDICAID PROGRAM.
C102	*INACTIVE* DENIAL 2 THE PROCEDURE IS NOT A BENEFIT FOR CHILDREN, RECIPIENTS AGE BIRTH THROUGH AGE 20.
C103	*INACTIVE* DENIAL 3 THE PROCEDURE IS NOT A BENEFIT FOR ADULTS, RECIPIENTS AGE 21 AND OLDER.
C104	*INACTIVE* DENIAL 4 A REPORT OF THE DENTAL CONDITION WHICH SUPPORTS THE NEED FOR SERVICE WAS NOT SUBMITTED. ELECTRONIC PAR: 1. YOU CAN RE-SUBMIT THIS PAR. 2. CLICK ON THE PROVIDER TAB DURING ELECTRONIC DENTAL PRIOR AUTHORIZATION. 3. DESCRIBE THE DENTAL CONDITION THAT SUPPORTS THE NEED FOR SERVICE. PAPER PAR: 1. YOU CAN RE-SUBMIT THIS PAR. 2. ON THE ADA CLAIM IN AREA 32 "REMARKS FOR UNUSUAL SERVICES" 3. DESCRIBE THE DENTAL CONDITION THAT SUPPORTS THE NEED FOR SERVICE.
C105	*INACTIVE* DENIAL 5 REPORT OF DENTAL CONDITION/CONCURRENT MED CONDITION WHICH SUPPORTS NEED NOT SUBMITTED. ELECTRONIC PAR 1. RE-SUBMIT PAR. 2. CLICK PROVIDER TAB DURING ELECTRONIC DENTAL PAR, 3. DESCRIBE DENTAL CONDITION SUPPORTING NEED FOR SERVICE. 4. DESCRIBE CONCURRENT MEDICAL CONDITION SUPPORTING NEED FOR SERVICE. PAPER PAR 1. YOU CAN RE-SUBMIT THIS PAR. 2. ON THE ADA CLAIM IN AREA 32 "REMARKS FOR UNUSUAL SERVICES" 3. DESCRIBE DENTAL CONDITION SUPPORTING NEED FOR SERVICE. 4. DESCRIBE CONCURRENT MEDICAL CONDITION SUPPORTING NEED FOR SERVICE.
C106	*INACTIVE* DENIAL 6 THE PROCEDURE CODE IS NOT VALID FOR THE DESCRIBED PROCEDURE. ELECTRONIC AND PAPER PAR 1. YOU CAN RE-SUBMIT THIS PAR. 2. PLEASE REFER TO THE DECEMBER 1998 MEDICAID BULLETIN 3. SEE CURRENT CODES AND THEIR DESCRIPTIONS. 4. YOU MAY SUBMIT ADA OR MEDICAID CODES.
C107	*INACTIVE* DENIAL 07 THE PROCEDURE CODE IS NOT A BENEFIT FOR THIS TOOTH NUMBER. ELECTRONIC AND PAPER 1. YOU CAN RE-SUBMIT THIS PAR. 2. PLEASE REFER TO THE DECEMBER 1998 MEDICAID BULLETIN 3. SEE PROCEDURE CODE TOOTH NUMBER LIMITATIONS.
C108	*INACTIVE* DENIAL 8 THE TOOTH SURFACE DESIGNATION SUBMITTED IS NOT VALID FOR THIS TOOTH NUMBER.
C109	*INACTIVE* DENIAL 9 THE PROCEDURE IS A DUPLICATE SERVICE.
C110	*INACTIVE* DENIAL 10 INFO REQUIRED FOR PAR REVIEW NOT SUBMITTED. ELECTRONIC PAR 1. RE-SUBMIT THIS PAR. 2. CLICK ON PROVIDER TAB DURING ELECTRONIC DENTAL PAR, 3. SEE THE DECEMBER 1998 MEDICAID BULLETIN FOR THIS PROCEDURE CODE. 4. BRIEFLY DESCRIBE THE INFORMATION REQUIRED AS LISTED IN THE LAST COLUMN. PAPER PAR 1. YOU CAN RESUBMIT THIS PAR. 2. ON THE ADA CLAIM IN AREA 32 " REMARKS FOR UNUSUAL SERVICES" 3. SEE THE DECEMBER 1998 MEDICAID BULLETIN FOR THE PROCEDURE CODE. 4. BRIEFLY DESCRIBE THE INFORMATION REQUIRED AS LISTED IN THE LAST COLUMN.
C111	*INACTIVE* DENIAL 11 PERIODONTAL DIAG AND CLASS NOT SUBMITTED. ELECTRONIC PAR 1. RE-SUBMIT THIS PAR. 2. CLICK ON PROVIDER TAB DURING ELECTRONIC DENTAL PAR, 3. BRIEFLY DESCRIBE PERIODONTAL DIAGNOSIS SUPPORTING NEED FOR SERVICE. 4. WRITE THE PERIODONTAL CLASSIFICATION SUPPORTING NEED FOR SERVICE. PAPER PAR 1. RE-SUBMIT THIS PAR. 2. ON THE ADA CLAIM IN ARE 32 "REMARKS FOR UNUSUAL SERVICES" 3. BRIEFLY DESCRIBE PERIODONTAL DIAGNOSIS SUPPORTING NEED FOR SERVICE. 4. WRITE THE PERIODONTAL CLASSIFICATION SUPPORTING NEED FOR SERVICE.

DENIAL CODE	LONG DESCRIPTION
C112	*INACTIVE* DENIAL 12 THE ORTHODONTIC DIAGNOSIS WHICH SUPPORTS THE NEED FOR THE PROCEDURE WAS NOT SUBMITTED. ELECTRONIC PAR 1. YOU CAN RE-SUBMIT THIS PAR. 2. CLICK ON THE PROVIDER TAB DURING ELECTRONIC DENTAL PRIOR AUTHORIZATION. 3. DESCRIBE THE ORTHODONTIC DIAGNOSIS SUPPORTING NEED FOR SERVICE. PAPER PAR 1. YOU CAN RE-SUBMIT THIS PAR. 2. ON THE ADA CLAIM IN AREA 32 "REMARKS FOR UNUSUAL SERVICES" 3. DESCRIBE THE ORTHODONTIC DIAGNOSIS SUPPORTING NEED FOR SERVICE.
C113	*INACTIVE* DENIAL 13 THE INFO SUBMITTED DOES NOT SUPPORT NEED FOR PROCEDURE. ELECTRONIC PAR 1. RE-SUBMIT THIS PAR. 2. CLICK ON PROVIDER TAB DURING ELECTRONIC DENTAL PAR. 3. DESCRIBE IN MORE DETAIL DENTAL CONDITION SUPPORTING NEED FOR SERVICE. 4. DESCRIBE IN MORE DETAIL CONCURRENT MEDICAL CONDITION SUPPORTING NEED FOR SERVICE. PAPER PAR 1. RE-SUBMIT PAR. 2. ON ADA CLAIM IN 32 "REMARKS FOR UNUSUAL SERVICES" 3. DESCRIBE IN MORE DETAIL DENTAL CONDITION NEED FOR SERVICE. 4. DESCRIBE IN MORE DETAIL CONCURRENT MEDICAL CONDITION NEED FOR SERVICE.
C114	*INACTIVE* DENIAL 14 SUBMITTED INFORMATION DOES NOT SUPPORT A FAVORABLE PROGNOSIS.
C115	*INACTIVE* DENIAL 15 THE "TMJ PRE-SURGICAL EVALUATION FORM" FOR PRIMARY SURGEON WAS NOT SUBMITTED. PAPER PAR 1. YOU CAN RE-SUBMIT THIS PAR. 2. THIS PRIOR AUTHORIZATION MUST BE SUBMITTED ON PAPER. 3. WE NEED THE ADA CLAIM FORM AND TMJ PRE-SURGICAL EVALUATION FORM. 4. CONTACT ACS AT 534-0109, EXT 724 REQUEST A COPY OF THE TMJ PRE-SURGICAL EVALUATION FORM. 5. THIS IS THE ONLY ATTACHMENT IN ADDITION TO THE ADA CLAIM FORM WHICH IS REQUIRED FOR REVIEW.
C116	*INACTIVE* 16 PAR CANNOT BE APPROVED AFTER THE SERVICE HAS BEEN STARTED.
C117	CLIENT ID IS MISSING OR INVALID. PLEASE RESUBMIT WITH A CORRECT CLIENT ID.
C120	*INACTIVE* THE PAR THAT YOU SENT DIRECTLY TO ACS IS BEING DENIED. PLEASE SEND THIS PAR TO THE AUTHORIZING AGENT: CFMC, P.O. BOX 17300, DENVER, CO 80217. UPON APPROVAL, CFMC WILL FORWARD THE PAR TO ACS FOR PAR ENTRY.
C121	*INACTIVE* THE ITEM OR SERVICE REQUESTED IS NOT A MEDICAID HOME HEALTH BENEFIT.
C122	*INACTIVE* THE ITEM OR SERVICE REQUESTED IS AVAILABLE UNDER OTHER COLORADO MEDICAID BENEFITS FOR WHICH THE CLIENT IS ELIGIBLE. (EG. PRIVATE DUTY NURSING, HCBS PERSONAL CARE, SCHOOL HEALTH AND RELATED SERVICES, OUT PATIENT THERAPY)
C123	*INACTIVE* THE INFORMATION SUBMITTED DOES NOT SUPPORT THE NEED FOR THE SERVICES REQUESTED, YOU MAY RE-SUBMIT THE PAR DESCRIBING IN MORE DETAIL CURRENT MEDICAL CONDITIONS SUPPORTING THE NEED FOR SERVICES.
C124	*INACTIVE* THE REQUESTED INFORMATION HAS NOT BEEN SUBMITTED. YOU MAY SUBMIT A NEW PAR WITH THE REQUESTED INFORMATION-HOME HEALTH PLAN OF CARE AND/OR THERAPY ASSESSMENTS, CURRENT CLINICAL SUMMARY.
C125	*INACTIVE* THE REQUESTED INFORMATION HAS NOT BEEN SUBMITTED. YOU MAY SUBMIT A NEW PAR WITH THE REQUESTED INFORMATION-WRITTEN DOCUMENTATION OF THE RESULTS OF THE EPSDT MEDICAL SCREENING, OR OTHER EQUIVALENT EXAMINATION RESULTS PROVIDED BY THE CLIENTS THIRD-PARTY INSURANCE.
C126	*INACTIVE* THIS SERVICE DOES NOT REQUIRE PRIOR AUTHORIZATION. SUBMIT CHARGES ON THE APPROPRIATE CLAIM FORM.
C127	*INACTIVE* THE REVENUE CODE IS ALREADY AUTHORIZED FOR THIS CLIENT, THIS PROVIDER, THIS DATE SPAN. PLEASE BILL USING THE INFORMATION ON THE ORIGINAL PAR, OR SUBMIT A NEW PAR FOR REVISION TO INCREASE SERVICES.
C128	*INACTIVE* THE CLINICAL INFORMATION DOES NOT SUBSTANTIATE MEDICAL NECESSITY.
C129	*INACTIVE* THE INFORMATION SUBMITTED IS INSUFFICIENT. COMPLETION OF THE PRIOR AUTHORIZATION REQUEST INFORMATION IS REQUIRED TO REVIEW THIS PRIOR AUTHORIZATION.
C130	*INACTIVE* THE AGENCY IS NOT A MEDICAID PROVIDER.
C131	*INACTIVE* NO SERVICES SHALL BE APPROVED FOR DATES OF SERVICE PRIOR TO THE DATE OF RECEIPT OF THE COMPLETE PRIOR AUTHORIZATION REQUEST BY THE STATE OR ITS AGENT.
C132	*INACTIVE* EXTENDED HOME HEALTH AIDE VISITS REQUESTED WITHOUT SUBMITTING SUFFICIENT INFORMATION ABOUT SERVICES ON EACH VISIT.
C133	*INACTIVE* THERAPY SERVICES REQUESTED ARE NOT INCLUDED IN THE PLAN OF CARE, WHICH DOES NOT LIST THE SPECIFIC PROCEDURES AND MODALITIES TO BE USED NOR THE AMOUNT, DURATION, AND FREQUENCY.

DENIAL CODE	LONG DESCRIPTION
C134	*INACTIVE* DETAILED INFORMATION ON EACH PLANNED HOME HEALTH VISIT, INCLUDING THE TIMES IN AND OUT, ALL TASKS TO BE PERFORMED ON EACH VISIT, AND THE PLACE OF SERVICE FOR EACH SERVICE IS NOT INCLUDED ON THE PRIOR AUTHORIZATION REQUEST.
C135	NURSING VISITS SOLELY FOR PSYCHIATRIC COUNSELING ARE NOT REIMBURSABLE.
C136	*INACTIVE* ANY VISIT MADE SOLELY FOR SUPERVISION OF THE HOME HEALTH AIDE SHALL NOT BE REIMBURSED.
C151	*INACTIVE* THIS ITEM OR SERVICE REQUESTED IS NOT A HOME AND COMMUNITY BASED SERVICES-BRAIN INJURY PROGRAM/ MEDICAID BENEFIT.
C152	*INACTIVE* THE REQUESTED CLINICAL INFORMATION DOES NOT SUBSTANTIATE HOW THE DEVICE OR SERVICE WILL RESULT IN ENHANCEMENT OF THE CLIENTS ABILITY TO PERFORM ACTIVITIES OF DAILY LIVING, OR TO PERCEIVE, CONTROL OR COMMUNICATE WITH THE ENVIRONMENT IN WHICH THEY LIVE.
C153	ITEM IS NOT OF DIRECT MEDICAL OR REMEDIAL BENEFIT TO THE CLIENT.
C154	THIS ITEM IS PRIMARILY FOR A VOCATIONAL OR EDUCATION APPLICATION. FUNDING MUST FIRST BE PURSUED THROUGH THE DIVISION OF VOCATIONAL REHABILITATION/DEPT. OF EDUCATION.
C155	HOME MODIFICATION REQUEST/ENVIRONMENTAL MODIFICATION DOES NOT CONTAIN SUPPORTING DOCUMENTATION, WHICH SUBSTANTIATES THE NECESSITY OF THE MODIFICATION.
C156	*INACTIVE* THE REQUESTED MODIFICATION IS NOT A DIRECT MEDICAL OR REMEDIAL BENEFIT TO THE CLIENT.
C157	*INACTIVE* THE PRIOR AUTHORIZATION REQUEST DOES NOT CONTAIN THE REQUIRED DOCUMENTATION OF AN OCCUPATIONAL THERAPIST OR PHYSICAL THERAPIST IN HOME ASSESSMENT.
C158	HOME MODIFICATION REQUEST IS NOT REASONABLE IN COST WHEN COMPARED TO USUAL AND CUSTOMARY CHARGES.
C159	*INACTIVE* NON-MEDICAL TRANSPORTATION REQUEST DOES NOT PROVIDE TRANSPORTATION FOR SERVICES, WHICH PREVENT INSTITUTIONALIZATION.
C160	TRANSITIONAL LIVING PRIOR AUTHORIZATION WAS REQUESTED FOR A CLIENT WHO DOES NOT MEET THE DEFINITION OF "IN NEED" ACCORDING TO 10 C.C.R. 2505-10, SEC. 8.516.30.B.2-3.
C161	PRIOR AUTHORIZATION PERIOD EXCEEDS BENEFIT DEFINED IN 10 C.C.R. 2505-10, SEC.8.516.30.C.5.
C162	PRIOR AUTHORIZATION PERIOD EXCEEDS BENEFIT DEFINED IN 10 C.C.R. 2505-10, SEC.8.516.30.C.5.
C163	THE PRIOR AUTHORIZATION REQUEST MUST INCLUDE: A MEDICAL PRESCRIPTION, THE NAME AND MEDICAID IDENTIFICATION NUMBER OF THE CLIENT, THE CLINIC NAME, BUSINESS ADDRESS, PHONE NUMBER, AND MEDICAID PROVIDER NUMBER, THE REFERRING PHYSICIAN NAME, BUSINESS ADDRESS, PHONE NUMBER, THE RENDERING THERAPIST NAME, PROVIDER NUMBER, BUSINESS ADDRESS, AND PHONE NUMBER, BILLING PROVIDER INFORMATION, A SERVICE PLAN FOR THE CLIENT, PHYSICAL THERAPY HISTORY (INCLUDING HOME HEALTH PROGRAM INVOLVEMENT). MEDICAID BULLETIN B0200140.
C164	THE PRIOR AUTHORIZATION REQUEST IS NOT NEEDED. THE ORIGINAL PRIOR AUTHORIZATION IS STILL IN EFFECT. MEDICAID BULLETIN B0200139.
C165	THE SERVICE REQUESTED FOR THIS CLIENT IS COVERED UNDER ANOTHER PROGRAM (I.E., HOME HEALTH OR HOSPITAL SERVICES, DME, ETC.).
C166	THERAPY SERVICES FOR THIS CLIENT HAVE BEEN AUTHORIZED TO A DIFFERENT PROVIDER. MEDICAID BULLETIN B0200139.
C167	*INACTIVE* CATEGORY OF HANDICAPPING MALOCCLUSION NOT CHECKED.
C168	PROCEDURE DOES NOT REQUIRE PRIOR AUTHORIZATION APPROVAL FOR THIS CLIENT.
C169	OUTPATIENT INDIVIDUAL AND INDIVIDUAL BRIEF COUNSELING VISITS ARE LIMITED TO 35 VISITS PER STATE FISCAL YEAR.
C170	DOCUMENTATION SUPPORTING MEDICAL NECESSITY IS NOT SUFFICIENT.
C171	THE PRIOR AUTHORIZATION REQUEST SHALL INCLUDE: * A MEDICAL PRESCRIPTION, * CLIENT NAME AND MEDICAID IDENTIFICATION * CLINIC NAME, BUSINESS ADDRESS, PHONE NUMBER AND MEDICAID PROVIDER NUMBER, * THE RENDERING THERAPIST NAME, PROVIDER NUMBER, BUSINESS ADDRESS AND PHONE NUMBER, * BILLING PROVIDER INFORMATION, * A SERVICE PLAN FOR THE CLIENT, * MENTAL HEALTH HISTORY (INCLUDING THE MENTAL HEALTH CAPITATION PROGRAM (MHASA) OR HOME HEALTH PROGRAM INVOLVEMENT).
C172	SERVICE REQUESTED FOR THIS CLIENT IS COVERED UNDER ANOTHER PROGRAM (I.E. 10 C.C.R. 2505-10, SECTION 8.212 MENTAL HEALTH CAPITATION PROGRAM).

DENIAL CODE	LONG DESCRIPTION
C173	MENTAL HEALTH VISITS FOR THIS CLIENT HAVE BEEN AUTHORIZED TO A DIFFERENT PROVIDER.
C174	THIS CLIENT IS EXEMPTED FROM PREFABRICATED CROWN SERVICES IF THE CLIENT WAS SCHEDULED FOR HOSPITALIZATION FOR DENTAL SERVICES BEFORE MAY 13, 2004.
C175	PROCEDURE DOES NOT REQUIRE A PRIOR AUTHORIZATION.
C176	*INACTIVE* THE PAR THAT YOU SENT DIRECTLY TO ACS IS BEING DENIED. PLEASE SEND THIS PAR TO THE AUTHORIZING AGENT: CFMC, ATTENTION MEDICAID/DME PARS, 23 INVERNESS WAY EAST, SUITE 100, ENGLEWOOD, CO 80112-5708.
C177	*INACTIVE* THE PAR THAT YOU SENT DIRECTLY TO ACS IS BEING DENIED. PLEASE SEND THIS PAR TO THE AUTHORIZING AGENT: CFMC, ATTENTION MEDICAID/DME PARS, TO THE FAX SERVER NUMBER AT 303 695-3377.
C190	ITEM OR SERVICE REQUESTED IS NOT A BENEFIT OF THE HOME AND COMMUNITY BASED SERVICES PERSONS WITH BRAIN INJURY WAIVER.
C191	ALTERNATIVE FUNDING FOR MODIFICATION HAS NOT BEEN CONSIDERED.
C192	MODIFICATION DID NOT INCLUDE TWO BIDS.
C193	COST OF MODIFICATION EXCEEDS LIFETIME CAP.
C194	REQUESTED CLINICAL INFORMATION DOES NOT SUBSTANTIATE HOW THE DEVICE OR SERVICE WILL RESULT IN ENHANCEMENT OF THE CLIENTS ABILITY TO PERFORM ACTIVITIES OF DAILY LIVING, OR TO PERCEIVE, CONTROL OR COMMUNICATE WITHIN THE CLIENTS ENVIRONMENT.
C195	MODIFICATION IS NOT A DIRECT MEDICAL OR REMEDIAL BENEFIT TO THE CLIENT.
C196	DOCUMENTATION WAS NOT PROVIDED FROM AN OCCUPATIONAL THERAPIST OR PHYSICAL THERAPIST.
C197	REQUEST FOR NON-MEDICAL TRANSPORTATION REQUEST IS NOT REQUIRED BY CARE PLAN TO PREVENT INSTITUTIONALIZATION.
C200	THE DIAGNOSIS/CLINICAL INFORMATION DOES NOT SUBSTANTIATE MEDICAL NECESSITY.
C201	*INACTIVE* CLIENT HAS NOT UTILIZED THE EQUIPMENT IN THE MANNER FOR WHICH IT WAS INTENDED. REPAIRS AND/OR REPLACEMENT OF EQUIPMENT WILL NOT BE ALLOWED IN CASES OF REPEATED MISUSE.
C202	*INACTIVE* THIS PRODUCT CANNOT BE APPROVED AS ITS PRIMARY PURPOSE IS TO EITHER ENHANCE THE PERSONAL COMFORT OF THE CLIENT OR PROVIDE CONVENIENCE FOR THE CLIENT CAREGIVER.
C203	*INACTIVE* THE INFORMATION SUBMITTED DOES NOT MEET THE COLORADO MEDICAID PROGRAM GUIDELINES FOR MEDICAL NECESSITY.
C204	*INACTIVE* THIS PRODUCT HAS BEEN PROVIDED IN THE RECENT PAST. PLEASE SUBMIT ADDITIONAL INFORMATION DOCUMENTING THE REASON FOR ITS BEING REQUESTED ONCE AGAIN.
C205	*INACTIVE* THIS REQUEST IS FOR A WHEELCHAIR. THE COLORADO MEDICAID PROGRAM HAS PROVIDED A SIMILAR PRODUCT WITHIN THE LAST FEW YEARS. IT IS MEDICAID POLICY THAT THE ORIGINAL WHEELCHAIR SHOULD BE UTILIZED FOR A MINIMUM OF 5 YEARS. PLEASE SUBMIT ADDITIONAL INFORMATION DOCUMENTING THE NEED FOR A NEW WHEELCHAIR AT THIS POINT IN TIME.
C206	*INACTIVE* IT IS THE RESPONSIBILITY OF THE PROVIDER TO SERVICE, REPAIR AND SUPPLY NECESSARY PARTS FOR ANY DURABLE MEDICAL EQUIPMENT PRODUCT COVERED BY A WARRANTY DURING THE WARRANTY PERIOD. NO REPLACEMENT PARTS OR REPAIRS WILL BE REIMBURSED BY COLORADO MEDICAID DURING THE WARRANTY PERIOD.
C207	*INACTIVE* THIS PRODUCT WOULD MORE APPROPRIATELY BE PROVIDED ON A RENTAL BASIS.
C208	*INACTIVE* THIS PRODUCT INTENDED USAGE IS FOR EXERCISE. COLORADO MEDICAID DOES NOT COVER PRODUCTS THAT ARE PRESCRIBED PRIMARILY FOR EXERCISE.
C209	*INACTIVE* THIS PRODUCT HAS BEEN REQUESTED FOR A CLIENT WHO IS CURRENTLY RESIDING IN A NURSING FACILITY OR HOSPITAL SETTING. THEREFORE, IT WILL NOT BE REIMBURSED THROUGH THE DURABLE MEDICAL EQUIPMENT PROGRAM OF COLORADO MEDICAID. IT IS THE RESPONSIBILITY OF THE FACILITY TO PROVIDE THIS PRODUCT.
C210	*INACTIVE* PLEASE RESUBMIT ON PAPER. PRIOR AUTHORIZATION REQUESTS (PARS) MUST BE SUBMITTED ON PAPER FOR THE FOLLOWING ITEMS: ELECTRIC WHEELCHAIRS, SCOOTERS, ORTHOTICS AND PROSTHETICS, AUGMENTATIVE COMMUNICATION DEVICES. MEDICAID BULLETIN B9900014, MAY 1999, FRONT PAGE SEND PAPER PARS FOR THESE ITEMS DIRECTLY TO: CFMC, ATTENTION: MEDICAID/DME PARS, PO BOX 17300, DENVER, COLORADO 80217 - 0300
C211	*INACTIVE* THIS PRODUCT IS NOT A BENEFIT OF THE DURABLE MEDICAL EQUIPMENT PROGRAM. HOWEVER, IT MAY BE COVERED UNDER ONE OF THE DEPARTMENT WAIVER PROGRAMS

DENIAL CODE	LONG DESCRIPTION
C212	*INACTIVE* THE INFORMATION SUBMITTED DOES NOT SUPPORT THE NEED FOR THE EQUIPMENT REQUESTED. YOU MAY RE-SUBMIT THE PRIOR AUTHORIZATION REQUEST DESCRIBING IN MORE DETAIL THE CURRENT MEDICAL CONDITIONS THAT SUPPORT THE NEED FOR THE EQUIPMENT.
C213	*INACTIVE* THE INFORMATION SUBMITTED DOES NOT SUPPORT THE NEED FOR THE MEDICAL SUPPLIES REQUESTED. YOU MAY RE-SUBMIT THE PRIOR AUTHORIZATION REQUEST DESCRIBING IN MORE DETAIL THE CURRENT MEDICAL CONDITIONS THAT SUPPORT THE NEED FOR THE SUPPLIES.
C214	*INACTIVE* THE REQUESTED INFORMATION HAS NOT BEEN SUBMITTED.
C215	*INACTIVE* THE REQUESTED ADDITIONAL INFORMATION IS INSUFFICIENT. COMPLETION OF THE REQUESTED INFORMATION IS REQUIRED TO REVIEW THIS PRIOR AUTHORIZATION REQUEST.
C216	*INACTIVE* THIS PRODUCT DOES NOT REQUIRE PRIOR AUTHORIZATION. SUBMIT CHARGES ON THE APPROPRIATE CLAIM FORM.
C217	*INACTIVE* SERIAL NUMBER IS REQUIRED FOR ALL REPAIRS. PLEASE RESUBMIT PRIOR AUTHORIZATION REQUEST WITH THE SERIAL NUMBER. MEDICAID BULLETIN B0100089, JANUARY 2001, PAGE 3
C218	*INACTIVE* PLEASE SEND INVOICED ACQUISITION COST FOR THIS ITEM.
C219	*INACTIVE* FOLLOWING INFO NEEDED TO REVIEW REQUEST FOR SPECIALIZED BED. 1. HOURS A DAY CLIENT IN BED? 2. WHAT BED DOES CLIENT HAVE NOW? 3. WHY DOES CURRENT BED NOT MEET NEEDS? 3. OTHER ALTERNATIVES TRIED? 4. CAN CLIENT WORK CONTROLS, CHANGE POSITIONS INDEPENDENTLY? 5. DOES CLIENT HAVE CAREGIVER ASSISTANT? 6. MEDICAL NECESSITY SEMI-ELECTRIC OR TOTAL ELECTRIC BED WILL MEET? 7. EXPLAIN WHY MANUAL HOSPITAL BED WILL NOT MEET NEEDS. SUBMIT LETTER WITH INFO REQUESTED AND RETURN TO ACS, PARS UNIT, P.O. BOX 30, DENVER, COLORADO 80201-0030.
C220	*INACTIVE* WHEELCHAIR PURCHASES MUST HAVE THE MANUFACTURER, BRAND NAME, MODEL NAME AND SERIAL NUMBER. MEDICAID BULLETIN B0100089, JANUARY 2001, PAGE 3. PLEASE SUBMIT THIS LETTER WITH THE INFORMATION REQUESTED AND RETURN TO ACS, PARS UNIT, P.O. BOX 30, DENVER, COLORADO 80201-0030.
C221	*INACTIVE* FOLLOWING INFO NEEDED TO REVIEW REQUEST FOR SEAT LIFT. 1. DOES CLIENT HAVE SEVERE HIP ARTHRITIS/KNEE OR SEVERE NEUROMUSCULAR DISEASE? 2. IS SEAT LIFT MECHANISM PART OF PHYSICIAN COURSE OF TREATMENT AND PRESCRIBED TO EFFECT IMPROVEMENT OR ARREST OR RETARD DETERIORATION IN PATIENT CONDITION? 3. IS CLIENT COMPLETELY INCAPABLE OF STANDING FROM ANY CHAIR IN HOME? 4. ONCE STANDING, CAN CLIENT AMBULATE INDEPENDENTLY? SUBMIT THIS LETTER WITH INFO REQUESTED AND RETURN TO ACS, PARS UNIT, P.O. BOX 30, DENVER, COLORADO 80201-0030.
C222	*INACTIVE* INFO NEEDED TO REVIEW REQUEST FOR PATIENT LIFT. 1. DOES TRANSFER BETWEEN BED, CHAIR, WHEELCHAIR OR COMMODE REQUIRE ASSISTANCE OF MORE THAN ONE PERSON? 2. WITHOUT USE OF LIFT WILL CLIENT BE CONFINED TO BED? 3. OTHER ALTERNATIVES TRIED? 4. HOW LONG WILL CLIENT REQUIRE USE OF LIFT? 5. PROVIDE INFO ABOUT PHYSICAL DIMENSIONS OF HOME ENVIRONMENT THAT SHOULD BE TAKEN INTO CONSIDERATION. 10 C.C.R. 2505-10, SEC. 8.593.02 (A) - (G). SUBMIT THIS LETTER WITH INFO REQUESTED AND RETURN TO ACS, PARS UNIT, P.O. BOX 30, DENVER, COLORADO 80201-0030
C223	*INACTIVE* INFO NEEDED TO REVIEW REQUEST FOR ELECTRIC/POWER LIFT. 1. IDENTIFY SPASTICITY OF PATIENT. 2. HOW LIFT ALLOW APPROP POSITION OF PATIENT WITH ONE CAREGIVER? 3. CAREGIVER NEED FOR PROXIMITY OR PHYSICAL CONTACT DURING TRANSFER FOR SAFETY REASONS. 4. DESC HOW LIFT WILL PROVIDE SAFE METHOD OF TRANSFER FOR CAREGIVERS WITH RESTRICTIONS/DYSFUNCTIONS. 5. INFO ABOUT PHYSICAL DIMENSIONS OF HOME ENVIRON. 10 C.C.R. 2505-10, SEC. 8.593.02 (A) - (G). SUBMIT LETTER WITH INFO REQUESTED TO ACS, PARS UNIT, P.O. BOX 30, DENVER, COLORADO 80201-0030.
C224	*INACTIVE* THE FOLLOWING INFORMATION IS NEEDED TO REVIEW THIS REQUEST FOR THE MATTRESS. 1. DOES THE CLIENT HAVE A HISTORY OF SKIN BREAKDOWN OR CURRENTLY HAVE SKIN BREAKDOWN? PLEASE EXPLAIN? 2. WHAT OTHER ALTERNATIVES HAVE BEEN TRIED? 3. WHAT IS THE LENGTH OF NECESSITY OF THE MATTRESS? 10 C.C.R. 2505-10, SEC. 8.593.02 (A) - (G). PLEASE SUBMIT THIS LETTER WITH THE INFORMATION REQUESTED AND RETURN TO ACS, PARS UNIT, P.O. BOX 30, DENVER, COLORADO 80201-0030.

DENIAL CODE	LONG DESCRIPTION
C225	*INACTIVE* THE FOLLOWING INFORMATION IS NEEDED TO REVIEW THIS REQUEST FOR THE BLOOD PRESSURE MONITOR. 1. PLEASE SEND THE LATEST THREE BLOOD PRESSURE READINGS, THE DATES OF THE READINGS, MEDICATION AND HOW FREQUENTLY THE BLOOD PRESSURE NEEDS TO BE MONITORED. 2. IF ORDERING AN AUTOMATIC MONITOR, PLEASE EXPLAIN WHY A MANUAL MONITOR WILL NOT MEET THE CLIENT NEEDS. 10 C.C.R. 2505-10, SEC. 8.593.02 (A) - (G). PLEASE SUBMIT THIS LETTER WITH THE INFORMATION REQUESTED AND RETURN TO ACS, PARS UNIT, P.O. BOX 30, DENVER, COLORADO 80201-0030.
C226	*INACTIVE* THE FOLLOWING INFORMATION IS NEEDED TO REVIEW THIS REQUEST FOR THE FORMULA. PLEASE PROVIDE THE BRAND NAME BEING REQUESTED AND THE NUMBER OF CALORIES REQUIRED PER DAY FROM THE FORMULA. SPECIALTY PROVIDER MANUAL, SUPPLY/DME, PAGE 2. PLEASE SUBMIT THIS LETTER WITH THE INFORMATION REQUESTED AND RETURN TO ACS, PARS UNIT, P.O. BOX 30, DENVER, COLORADO 80201-0030.
C227	*INACTIVE* PRIOR AUTHORIZATION DOES NOT INDICATE A PHYSICIAN SIGNATURE. A PHYSICIAN SIGNATURE IS REQUIRED.
C228	*INACTIVE* INFO IS NEEDED: 1. DURING TRIAL PERIOD, DID TENS: A. PRODUCE NO RELIEF? B. PRODUCE GREATER DISCOMFORT? C. ALLEVIATE PAIN? 2. LIST PAIN MED/DOSAGE PRIOR TO TREATMENT? 3. WAS PAIN MED/DOSAGE REDUCED AFTER APPLICATION? 4. DEGREE OF MOBILITY PRIOR TO TREATMENT? 5. DID DEGREE OF MOBILITY IMPROVE? 6. DID PATIENT DERIVE SIGNIFICANT THERAPEUTIC BENEFIT? 7. DOES PATIENT OWN TENS UNIT OR OWNED/USED TENS UNIT IN PAST? 8. ALTERNATIVE TREATMENTS AND/OR CLINICAL RESULTS. A. TRACTION B. TRIGGER POINT INJECTIONS C. SURGERY D. DRUGS.
C229	*INACTIVE* PRIOR AUTHORIZATION REQUESTS MUST BE SUBMITTED ON PAPER FOR THE FOLLOWING ITEMS: ELECTRIC WHEELCHAIRS, SCOOTERS, ORTHOTICS AND PROSTHETICS, AUGMENTATIVE COMMUNICATION DEVICES. PLEASE SEND THE PRIOR AUTHORIZATION REQUEST FOR THESE ITEMS DIRECTLY TO CFMC, ATTENTION MEDICAID/DME PARS, 23 INVERNESS WAY EAST, SUITE 100, ENGLEWOOD, CO 80112-5708.
C230	*INACTIVE* THIS PRODUCT IS NOT A BENEFIT OF THE DURABLE MEDICAL EQUIPMENT PROGRAM.
C231	*INACTIVE* THE INFORMATION SUBMITTED DOES NOT SUPPORT THE NEED FOR THE EQUIPMENT REQUESTED. YOU MAY RE-SUBMIT THE PRIOR AUTHORIZATION REQUEST DESCRIBING IN MORE DETAIL THE CURRENT MEDICAL CONDITIONS THAT SUPPORT THE NEED FOR THE EQUIPMENT.
C232	*INACTIVE* THE INFORMATION SUBMITTED DOES NOT SUPPORT THE NEED FOR THE MEDICAL SUPPLIES OR EQUIPMENT REQUESTED. YOU MAY RESUBMIT THE PRIOR AUTHORIZATION REQUEST DESCRIBING IN MORE DETAIL THE CURRENT MEDICAL CONDITIONS THAT SUPPORT THE NEED FOR THE SUPPLIES.
C233	*INACTIVE* THIS PRODUCT DOES NOT REQUIRE PRIOR AUTHORIZATION. SUBMIT CHARGES ON THE APPROPRIATE CLAIM FORM.
C234	*INACTIVE* SERIAL NUMBER IS REQUIRED FOR ALL REPAIRS. PLEASE RESUBMIT PRIOR AUTHORIZATION REQUEST WITH THE SERIAL NUMBER. MEDICAID BULLETIN B0100089, JANUARY 2001, PAGE 3.
C235	*INACTIVE* HOSPITAL BED QUESTIONNAIRE #1 IS NEEDED TO REVIEW THIS REQUEST. PLEASE SUBMIT THIS LETTER WITH THE INFORMATION REQUESTED.
C236	*INACTIVE* WHEELCHAIR PURCHASES MUST HAVE THE MANUFACTURER, BRAND NAME AND MODEL NAME. PLEASE SUBMIT THIS LETTER WITH THE INFORMATION REQUESTED.
C237	*INACTIVE* SEAT LIFT QUESTIONNAIRE #4 IS NEEDED TO REVIEW THIS REQUEST. PLEASE SUBMIT THIS LETTER WITH THE INFORMATION REQUESTED.
C238	*INACTIVE* PATIENT LIFT QUESTIONNAIRE #3 IS NEEDED TO REVIEW THIS REQUEST. PLEASE SUBMIT THIS LETTER WITH THE INFORMATION REQUESTED.
C239	*INACTIVE* ELECTRIC/POWER LIFT QUESTIONNAIRE #3 IS NEEDED TO REVIEW THIS REQUEST. PLEASE SUBMIT THIS LETTER WITH THE INFORMATION REQUESTED.
C240	*INACTIVE* PRESSURE RELIEF MATTRESS QUESTIONNAIRE #2 IS NEEDED TO REVIEW THIS REQUEST. PLEASE SUBMIT THIS LETTER WITH THE INFORMATION REQUESTED.
C241	*INACTIVE* BLOOD PRESSURE UNIT/MONITOR QUESTIONNAIRE #5 IS NEEDED TO REVIEW THIS REQUEST. PLEASE SUBMIT THIS LETTER WITH THE INFORMATION REQUESTED.
C242	*INACTIVE* ORAL AND ENTERAL NUTRITION FORMULA QUESTIONNAIRE #10 (WITH PARTICULAR ATTENTION TO THE NUMBER OF CALORIES PER DAY) IS NEEDED TO REVIEW THIS REQUEST. PLEASE SUBMIT THIS LETTER WITH THE INFORMATION REQUESTED.

DENIAL CODE	LONG DESCRIPTION
C243	*INACTIVE* THE PRIOR AUTHORIZATION REQUEST DOES NOT INDICATE A PHYSICIAN SIGNATURE. A PHYSICIAN SIGNATURE IS REQUIRED.
C244	*INACTIVE* TENS OR NMES QUESTIONNAIRE #9 IS NEEDED TO REVIEW THIS REQUEST. PLEASE SUBMIT THIS LETTER WITH THE INFORMATION REQUESTED.
C245	*INACTIVE* SERVICE PREVIOUSLY AUTHORIZED TO THIS PROVIDER OR ANOTHER PROVIDER. THE PROCEDURE CODE IS ALREADY AUTHORIZED FOR THIS CLIENT, THIS DATE SPAN.
C246	*INACTIVE* SERVICE PREVIOUSLY AUTHORIZED TO THIS PROVIDER. THE PROCEDURE CODE IS ALREADY AUTHORIZED FOR THIS CLIENT, THIS PROVIDER, AND THIS DATE SPAN. PLEASE BILL USING THE INFORMATION ON THE ORIGINAL PAR.
C247	*INACTIVE* SERVICES AUTHORIZED TO ANOTHER PROVIDER.
C248	*INACTIVE* PLEASE SEND PRODUCT INFORMATION ON THIS ITEM.
C249	*INACTIVE* A SERIAL NUMBER IS REQUIRED FOR ALL REPAIRS. PLEASE RESUBMIT PAR WITH THE SERIAL NUMBER.
C250	*INACTIVE* THE DATES ENTERED EITHER ON THE HEADER OR DETAIL LINES ARE INVALID. PLEASE REVIEW THE DATES AND SUBMIT A NEW PRIOR AUTHORIZATION REQUEST WITH VALID DATES, INCLUDING CORRECT DATES.
C251	THIS INDIVIDUAL IS NOT A MEDICAID-ELIGIBLE INDIVIDUAL UNDER AGE 21.
C252	THE ITEM OR SERVICE REQUESTED IS NOT A MEDICAID BENEFIT.
C253	THE REQUESTED INFORMATION HAS NOT BEEN SUBMITTED. YOU MAY SUBMIT A NEW PRIOR AUTHORIZATION REQUEST WITH THE REQUESTED INFORMATION-EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT SCREEN AND ADDITIONAL DOCUMENTATION INDICATING MEDICAL NECESSITY.
C254	THE INFORMATION SUBMITTED DOES NOT SUPPORT THE MEDICAL NEED FOR THE SERVICES REQUESTED, YOU MAY RE-SUBMIT THE PRIOR AUTHORIZATION REQUEST DESCRIBING IN MORE DETAIL CURRENT MEDICAL NECESSITY SUPPORTING THE NEED FOR SERVICES.
C255	THE CLINICAL INFORMATION DOES NOT SUBSTANTIATE MEDICAL NECESSITY.
C256	*INACTIVE* THIS AGENCY/INDIVIDUAL IS NOT A MEDICAID PROVIDER.
C257	*INACTIVE* THIS AUDIOLOGICAL SERVICE IS NOT A BENEFIT OF THE HEALTH CARE PROGRAM FOR CHILDREN WITH SPECIAL NEEDS.
C258	*INACTIVE* THIS AUDIOLOGICAL SERVICE IS NOT A BENEFIT OF THE HEALTH CARE PROGRAM FOR CHILDREN WITH SPECIAL NEEDS.
C259	THIS VISION SERVICE WAS NOT PROVIDED BY AN OPHTHALMOLOGIST, OPTOMETRIST OR OPTICIAN.
C260	THESE EYEGLASSES WERE NOT ORDERED BY AN OPHTHALMOLOGIST OR AN OPTOMETRIST.
C261	THESE EYEGLASSES WERE NOT DISPENSED BY AN OPTICIAN.
C262	THERE IS NO PRIOR AUTHORIZATION FOR THESE ORTHOPTIC VISION TREATMENT SERVICES.
C263	THERE IS NO PRIOR AUTHORIZATION FOR THESE CONTACT LENSES.
C264	SERVICE PREVIOUSLY AUTHORIZED TO THIS PROVIDER. THE PROCEDURE CODE IS ALREADY AUTHORIZED FOR THIS CLIENT, THIS PROVIDER, AND THIS DATE SPAN. PLEASE BILL USING THE INFORMATION ON THE ORIGINAL PAR.
C265	SERVICES AUTHORIZED TO ANOTHER PROVIDER.
C266	THE DATES ENTERED EITHER ON THE HEADER OR DETAIL LINES ARE INVALID. PLEASE REVIEW THE DATES AND SUBMIT A NEW PRIOR AUTHORIZATION REQUEST WITH VALID DATES.
C271	CLIENT IS NOT ELIGIBLE FOR ALL OR PART OF THE DATES COVERED IN THIS PRIOR AUTHORIZATION. VERIFY ELIGIBILITY PRIOR TO PERFORMING SERVICES.
C290	MODIFICATION DID NOT INCLUDE TWO BIDS.
C291	REQUEST FOR NON-MEDICAL TRANSPORTATION IS NOT REQUIRED BY CARE PLAN TO PREVENT INSTITUTIONALIZATION.
C292	ITEM OR SERVICE REQUESTED IS NOT A BENEFIT OF THE HOME AND COMMUNITY BASED SERVICES FOR THE ELDERLY, BLIND, AND DISABLED WAIVER.

DENIAL CODE	LONG DESCRIPTION
C315	*INACTIVE* INFO NEEDED TO COMPLETE PAR REVIEW: 1. DURING TRIAL PERIOD DID TENS: A. PRODUCE NO RELIEF? B. PRODUCE GREATER DISCOMFORT? C. SIGNIFICANTLY ALLEVIATE PAIN? 2. WAS PATIENT ON PAIN MED BEFORE TREATMENT? LIST MED/DOSAGE. 3. WAS MED/DOSAGE REDUCED? 4. DEGREE OF MOBILITY PRIOR TO TREATMENT? 5. DID MOBILITY IMPROVE? 6. DO THERAPEUTIC BENEFITS WARRANT CONTINUED USE? 7. DOES PATIENT OWN OR OWNED/USED TENS UNIT? 8. APPROPRIATENESS OF ALTERNATIVE TREATMENTS AND/OR THE CLINICAL RESULTS. A. TRACTION B. TRIGGER POINT INJECTIONS C. SURGERY D. DRUGS
C316	*INACTIVE* THE PROCEDURE CODE REQUESTED HAS BEEN CHANGED. PLEASE NOTE THE NEW PROCEDURE CODE.
C317	*INACTIVE* PLEASE REVIEW THE DATES AND SUBMIT A NEW PAR WITH VALID DATES, INCLUDING CORRECT YEAR. THE DATES ENTERED EITHER ON THE HEADER OR DETAIL LINES ARE INVALID.
C318	*INACTIVE* PLEASE PROVIDE THE MEDICAID PROVIDER ID NUMBER OF THE PHARMACY OR DME SUPPLY COMPANY SUPPLYING THE REQUESTED ITEMS
C351	*INACTIVE* THE ITEM OR SERVICE REQUESTED IS NOT A MEDICAID HOME HEALTH BENEFIT.
C352	THE INFORMATION SUBMITTED DOES NOT SUPPORT THE NEED FOR THE SERVICES REQUESTED, YOU MAY RE-SUBMIT THE PAR DESCRIBING IN MORE DETAIL CURRENT MEDICAL CONDITIONS SUPPORTING THE NEED FOR SERVICES.
C353	*INACTIVE* THE REQUESTED INFORMATION HAS NOT BEEN SUBMITTED. YOU MAY SUBMIT A NEW PAR WITH THE REQUESTED INFORMATION-HOME HEALTH PLAN OF CARE AND/OR THERAPY ASSESSMENTS, CURRENT CLINICAL SUMMARY.
C354	*INACTIVE* THIS SERVICE DOES NOT REQUIRE PRIOR AUTHORIZATION. SUBMIT CHARGES ON THE APPROPRIATE CLAIM FORM (ACUTE HOME HEALTH OR LONG TERM HOME HEALTH WITH ACUTE EPISODE).
C355	*INACTIVE* THE REVENUE CODE IS ALREADY AUTHORIZED FOR THIS CLIENT, THIS PROVIDER, THIS DATE SPAN. PLEASE BILL USING THE INFORMATION ON THE ORIGINAL PAR, OR SUBMIT A NEW PAR FOR REVISION TO INCREASE SERVICES.
C356	*INACTIVE* THE PAR THAT YOU SENT DIRECTLY TO ACS IS BEING DENIED. PLEASE SEND THIS PAR TO THE AUTHORIZING AGENT: SINGLE ENTRY POINT AGENCY IN COUNTY OF CLIENT RESIDENCE.
C357	*INACTIVE* THE CLINICAL INFORMATION DOES NOT SUBSTANTIATE MEDICAL NECESSITY.
C358	*INACTIVE* THE REQUESTED ADDITIONAL INFORMATION IS INSUFFICIENT. COMPLETION OF THE REQUESTED INFORMATION IS REQUIRED TO REVIEW THIS PRIOR AUTHORIZATION.
C359	*INACTIVE* THE AGENCY IS NOT A MEDICAID PROVIDER.
C360	*INACTIVE* NURSING VISITS SOLELY FOR THE PURPOSE OF ASSESS AND TEACH ARE NOT BILLABLE IN THIS CASE.
C361	NURSING VISITS ARE UNREASONABLE IN AMOUNT, FREQUENCY, OR DURATION.
C362	*INACTIVE* HOME HEALTH AIDE UNITS ARE REQUESTED, NO SKILLED TASKS ARE IDENTIFIED.
C363	*INACTIVE* HEALTH AIDE VISITS ARE NOT MEDICALLY NECESSARY.
C364	*INACTIVE* HOME HEALTH SERVICES SHALL BE PROVIDED AT THE CLIENT PLACE OF RESIDENCE EXCEPT FOR EPSDT EXTRAORDINARY HH WHICH IS PRIOR AUTHORIZED USING A DIFFERENT PROCESS AND FORM.
C365	*INACTIVE* THE CLIENT IS 18 YEARS OLD OR OVER AND SKILLED THERAPIES ARE NOT A BENEFIT UNDER LONG TERM HOME HEALTH.
C366	*INACTIVE* EXTENDED HOME HEALTH AIDE VISITS REQUESTED WITHOUT SUBMITTING SUFFICIENT INFORMATION ABOUT SERVICES ON EACH VISIT.
C367	*INACTIVE* DOCUMENTATION TO SUPPORT PRN VISITS HAS NOT BEEN SUBMITTED.
C368	*INACTIVE* WRITTEN INSTRUCTIONS FROM THE THERAPIST OR OTHER MEDICAL PROFESSIONAL ARE REQUIRED TO SUPPORT THE NEED FOR ROM WHEN IT IS THE ONLY SKILLED SERVICE PERFORMED BY A HOME HEALTH AIDE.
C369	*INACTIVE* MEDICATION SET-UP BY A NURSE IS THE ONLY REASON FOR VISITS AND DOCUMENTATION THAT THE PHARMACY WAS CONTACTED IS MISSING.
C370	*INACTIVE* DOCUMENTATION DOES NOT SUPPORT THE NEED FOR TWO HOME HEALTH AIDES AT THE SAME TIME FOR A TWO-PERSON TRANSFER.
C371	*INACTIVE* CLIENT PAR IS SENT TO THE WRONG AUTHORIZING AGENT, EPSDT HH, PDN, AND OUTPATIENT THERAPY SHOULD BE SUBMITTED TO CFMC AT PO BOX 17300, DENVER, CO, 80217.

DENIAL CODE	LONG DESCRIPTION
C372	*INACTIVE* BASED ON THE NEEDS OF THE CLIENT, AUTHORIZATION IS BEING GIVEN FOR A LESSER AMOUNT OF SERVICES THAN REQUESTED.
C373	*INACTIVE* PAR FORM HAS BEEN SUBMITTED LATER THAN 10 DAYS FROM THE HCFA-485 "FROM" DATE. PAR DATES HAVE BEEN ADJUSTED.
C374	*INACTIVE* REVISIONS FOR INCREASES IN SERVICES SHALL BE SUBMITTED AND PROCESSED ACCORDING TO THE SAME REQUIREMENTS AS FOR NEW PARS, WITH A CURRENT WRITTEN ASSESSMENT/PHYSICIAN ORDERS PERTAINING TO THE INCREASE.
C377	*INACTIVE* NURSING VISITS SOLELY FOR FOOT CARE SHALL BE REIMBURSED ONLY IF THE CLIENT HAS A DOCUMENTED DIAGNOSIS THAT SUPPORTS THE NEED FOR A NURSE, AND THE CLIENT OR FAMILY CAREGIVER IS NOT ABLE OR WILLING TO PROVIDE THE FOOT CARE.
C378	TO BE ELIGIBLE FOR LONG TERM HOME HEALTH SERVICES, AS SET FORTH AT SECTION 8.523.11K, MEDICAID CLIENTS 18 YEARS AND OVER SHALL MEET THE LEVEL OF CARE SCREENING GUIDELINES FOR LONG TERM CARE SERVICES AT SECTION 10CCR 2505-10/8.401; 10CCR 2505-10/8.522.10.
C379	*INACTIVE* THE PAR THAT YOU SENT DIRECTLY TO THE SEP IS BEING DENIED. PLEASE SEND THIS PAR TO THE AUTHORIZING AGENT: ACS.
C380	*INACTIVE* CLIENT PAR IS SENT TO THE WRONG AUTHORIZING AGENT, EPSDT HH, OR OUTPATIENT THERAPY SHOULD BE SUBMITTED TO CFMC.
C381	*INACTIVE* BASED ON THE NEEDS OF THE CLIENT, AUTHORIZATION IS BEING GIVEN FOR A LESSER AMOUNT OF SERVICES THAN REQUESTED.
C382	*INACTIVE* ANY VISIT MADE SOLELY FOR SUPERVISION OF THE HOME HEALTH AIDE SHALL NOT BE REIMBURSED.
C383	*INACTIVE* THE REQUESTED INFORMATION HAS NOT BEEN SUBMITTED. YOU MAY SUBMIT A NEW PAR WITH THE REQUESTED INFORMATION-HOME HEALTH PLAN OF CARE AND/OR THERAPY ASSESSMENTS, CURRENT CLINICAL SUMMARY.
C384	*INACTIVE* CLIENT PAR IS SENT TO THE WRONG AUTHORIZING AGENT, PRIVATE DUTY NURSING PARS AND APPLICATION PAPERWORK SHOULD BE SUBMITTED DO DDM ASCEND VIA FAX TO 877-431-9568.
C385	*INACTIVE* IMPROPER BILLING MAY RESULT FROM VISITS THAT ARE UNREASONABLE IN AMOUNT, FREQUENCY AND DURATION OR VISITS PERFORMED WHEN SKILLED TASKS PERFORMED ARE NOT MEDICALLY NECESSARY.
C386	*INACTIVE* SERVICE PREVIOUSLY AUTHORIZED TO THIS PROVIDER. THE PROCEDURE CODE IS ALREADY AUTHORIZED FOR THIS CLIENT, THIS PROVIDER, AND THIS DATE SPAN. PLEASE BILL USING THE INFORMATION ON THE ORIGINAL PAR.
C387	*INACTIVE* SERVICES AUTHORIZED TO ANOTHER PROVIDER.
C390	*INACTIVE* EXTENDED HOME HEALTH AIDE VISITS REQUESTED WITHOUT SUBMITTING SUFFICIENT INFORMATION ABOUT SERVICES ON EACH VISIT.
C391	*INACTIVE* CLIENT PAR IS SENT TO THE WRONG AUTHORIZING AGENT, EPSDT HH, AND OUTPATIENT THERAPY SHOULD BE SUBMITTED TO CFMC.
C392	*INACTIVE* BASED ON THE NEEDS OF THE CLIENT, AUTHORIZATION IS BEING GIVEN FOR A LESSER AMOUNT OF SERVICES THAN REQUESTED.
C393	*INACTIVE* PAR FORM HAS BEEN SUBMITTED LATER THAN 10 DAYS FROM THE PAR START DATE. PAR UNITS HAVE BEEN ADJUSTED.
C394	*INACTIVE* THE REQUESTED INFORMATION HAS NOT BEEN SUBMITTED. YOU MAY SUBMIT A NEW PAR WITH THE REQUESTED INFORMATION-HOME HEALTH PLAN OF CARE AND/OR THERAPY ASSESSMENTS, CURRENT CLINICAL SUMMARY.
C395	*INACTIVE* THE PAR THAT YOU SENT DIRECTLY TO ACS IS BEING DENIED. PLEASE SEND THIS PAR TO THE AUTHORIZING AGENT: SINGLE ENTRY POINT AGENCY IN COUNTY OF CLIENT RESIDENCE.
C396	*INACTIVE* SERVICE PREVIOUSLY AUTHORIZED TO THIS PROVIDER. THE PROCEDURE CODE IS ALREADY AUTHORIZED FOR THIS CLIENT, THIS PROVIDER, AND THIS DATE SPAN. PLEASE BILL USING THE INFORMATION ON THE ORIGINAL PAR.
C397	THE DATES ENTERED EITHER ON THE HEADER OR DETAIL LINES ARE INVALID. PLEASE REVIEW THE DATES AND SUBMIT A NEW PRIOR AUTHORIZATION REQUEST WITH VALID DATES.
C400	THE REQUESTED INFORMATION HAS NOT BEEN SUBMITTED. YOU MAY SUBMIT A NEW PAR WITH THE REQUESTED INFORMATION.

DENIAL CODE	LONG DESCRIPTION
C401	*INACTIVE* THE SERVICE IS NOT A BENEFIT OF THE COLORADO MEDICAID MEDICAL TRANSPORTATION PROGRAM. 10 C.C.R. 2505-10, SEC. 8.680-8.691 OTHER HEALTH SERVICES - TRANSPORTATION (AS OF FEBRUARY 1, 2002, THE CITATIONS WILL BE: 10 C.C.R. 2505-10, SEC. 8.680-8.688 NON-EMERGENT MEDICAL TRANSPORTATION
C402	TRANSPORTATION TO MEDICAL TREATMENT LOCATED ON OR AT MILITARY FACILITIES IS EXCLUDED FROM THE COLORADO MEDICAID MEDICAL TRANSPORTATION PROGRAM. (AS OF FEBRUARY 1, 2002, THE CITATION WILL BE: 10 C.C.R. 2505-10, SEC. 8.682 BENEFITS/EXCLUSIONS.)
C403	TRANSPORTATION TO MEDICAL TREATMENT TO PROVIDERS NOT ENROLLED IN THE MEDICAID PROGRAM WHEN MEDICAID IS THE PRIMARY PAYER IS EXCLUDED FROM THE COLORADO MEDICAID MEDICAL TRANSPORTATION PROGRAM. (AS OF FEBRUARY 1, 2002, THE CITATION WILL BE: 10 C.C.R. 2505-10, SEC. 8.682 BENEFITS/EXCLUSIONS.)
C404	TRANSPORTATION TO MEDICAL TREATMENT TO PROVIDERS NOT ENROLLED IN THE MEDICAID PROGRAM WHEN MEDICAID IS THE PRIMARY PAYER IS EXCLUDED FROM THE COLORADO MEDICAID MEDICAL TRANSPORTATION PROGRAM. (AS OF FEBRUARY 1, 2002, THE CITATION WILL BE: 10 C.C.R. 2505-10, SEC. 8.682 BENEFITS/EXCLUSIONS.)
C405	TRANSPORTATION TO PICK UP OR DELIVER PRESCRIPTIONS, MEDICAL SUPPLIES, OR DURABLE MEDICAL EQUIPMENT IS EXCLUDED FROM THE COLORADO MEDICAID MEDICAL TRANSPORTATION PROGRAM. (AS OF FEBRUARY 1, 2002, THE CITATION WILL BE: 10 C.C.R. 2505-10, SEC. 8.682 BENEFITS/EXCLUSIONS.)
C406	TRANSPORTATION FOR NURSING FACILITY OR GROUP HOME RESIDENTS TO ANY MEDICAL OR REHABILITATIVE SERVICES REQUIRED TO BE PART OF THE FACILITY PROGRAM BY FEDERAL OR STATE LAW IS EXCLUDED FROM THE COLORADO MEDICAID MEDICAL TRANSPORTATION PROGRAM. (AS OF FEBRUARY 1, 2002, THE CITATION WILL BE: 10 C.C.R. 2505-10, SEC. 8.682 BENEFITS/EXCLUSIONS.)
C407	CHARGES WHEN THE CLIENT IS NOT IN THE VEHICLE IS EXCLUDED FROM THE COLORADO MEDICAID MEDICAL TRANSPORTATION PROGRAM. (AS OF FEBRUARY 1, 2002, THE CITATION WILL BE: 10 C.C.R. 2505-10, SEC. 8.682 BENEFITS/EXCLUSIONS.)
C408	TRANSPORTATION TO COURT-ORDERED MEDICAL SERVICES THAT ARE NOT A BENEFIT OF MEDICAID IS EXCLUDED FROM THE COLORADO MEDICAID MEDICAL TRANSPORTATION PROGRAM. (AS OF FEBRUARY 1, 2002, THE CITATION WILL BE: 10 C.C.R. 2505-10, SEC. 8.682 BENEFITS/EXCLUSIONS.)
C409	MEALS AND LODGING EXPENSES WHEN TRAVEL TO AND FROM A NON-EMERGENT MEDICALLY NECESSARY COVERED SERVICE CAN REASONABLY BE COMPLETED IN ONE CALENDAR DAY IS EXCLUDED FROM THE COLORADO MEDICAID MEDICAL TRANSPORTATION PROGRAM. (AS OF FEBRUARY 1, 2002, THE CITATION WILL BE: 10 C.C.R. 2505-10, SEC. 8.682 BENEFITS/EXCLUSIONS.)
C410	REIMBURSEMENT FOR TRAVEL EXPENSES OF AN ESCORT WHEN THE TRAVEL IS NOT EXPECTED TO EXTEND BEYOND ONE CALENDAR DAY IS EXCLUDED FROM THE COLORADO MEDICAID MEDICAL TRANSPORTATION PROGRAM. (AS OF FEBRUARY 1, 2002, THE CITATION WILL BE: 10 C.C.R. 2505-10, SEC. 8.682 BENEFITS/EXCLUSIONS.)
C411	THE REQUIRED DOCUMENTATION WAS NOT SUBMITTED FOR AUTHORIZATION OF OUT-OF-STATE MEDICAL TRANSPORTATION. (AS OF FEBRUARY 1, 2002, THE CITATION WILL BE: 10 C.C.R. 2505-10, SEC. 8.686 OUT-OF-STATE TRANSPORTATION AUTHORIZATIONS.)
C412	THE REQUIRED DOCUMENTATION WAS NOT SUBMITTED FOR AUTHORIZATION OF COMMERCIAL AIRLINE OR TRAIN TRANSPORTATION. (AS OF FEBRUARY 1, 2002, THE CITATION WILL BE: 10 C.C.R. 2505-10, SEC. 8.685.07 PRIOR AUTHORIZATION REQUIREMENTS/PROCEDURES, COMMERCIAL AIRLINE OR TRAIN.)
C413	THE REQUIRED DOCUMENTATION WAS NOT SUBMITTED FOR AUTHORIZATION OF AMBULANCE AND AIR AMBULANCE TRANSPORTATION. (AS OF FEBRUARY 1, 2002, THE CITATION WILL BE: 10 C.C.R. 2505-10, SEC. 8.685.08 PRIOR AUTHORIZATION REQUIREMENTS/PROCEDURES, AMBULANCE AND AIR AMBULANCE.)
C414	THE REQUIRED DOCUMENTATION WAS NOT SUBMITTED FOR AUTHORIZATION OF ANCILLARY SERVICES RELATED TO MEDICAL TRANSPORTATION. (AS OF FEBRUARY 1, 2002, THE CITATION WILL BE: 10 C.C.R. 2505-10, SEC. 8.685.09 PRIOR AUTHORIZATION REQUIREMENTS/PROCEDURES, ANCILLARY SERVICES.)
C415	SERVICES AUTHORIZED TO ANOTHER PROVIDER.
C420	REQUEST FOR NON-MEDICAL TRANSPORTATION IS NOT REQUIRED BY CARE PLAN TO PREVENT INSTITUTIONALIZATION.
C421	ITEM OR SERVICE REQUESTED IS NOT A BENEFIT OF THE HOME AND COMMUNITY BASED SERVICES FOR PERSONS LIVING WITH AIDS WAIVER.
C430	MODIFICATION IS NOT TO PREVENT INSTITUTIONALIZATION OF THE CLIENT.

DENIAL CODE	LONG DESCRIPTION
C431	ALTERNATIVE FUNDING FOR MODIFICATION HAS NOT BEEN CONSIDERED.
C432	MODIFICATION DID NOT INCLUDE TWO BIDS.
C433	AMOUNT OF MODIFICATION EXCEEDS COST CONTAINMENT.
C434	COST OF MODIFICATION EXCEEDS LIFETIME CAP.
C435	REQUEST FOR NON-MEDICAL TRANSPORTATION IS NOT REQUIRED BY CARE PLAN TO PREVENT INSTITUTIONALIZATION.
C436	ITEM OR SERVICE REQUESTED IS NOT A BENEFIT OF THE HOME AND COMMUNITY BASED SERVICES FOR PERSONS WITH MENTAL ILLNESS WAIVER.
C437	MODIFICATION DOES NOT GIVE CLIENT GREATER INDEPENDENCE.
C438	MODIFICATION DOES NOT ENSURE THE HEALTH SAFETY AND WELFARE OF THE CLIENT.
C439	MODIFICATION IS NOT A DIRECT MEDICAL OR REMEDIAL BENEFIT TO THE CLIENT.
C440	MODIFICATION DUPLICATES AN EXISTING ADAPTATION.
C441	MODIFICATION IS PART OF NEW CONSTRUCTION.
C442	DOCUMENTATION WAS NOT PROVIDED FROM AN OCCUPATIONAL THERAPIST OR PHYSICAL THERAPIST.
C443	MODIFICATION INCLUDES PURCHASE COST OF DURABLE MEDICAL EQUIPMENT.
C444	MODIFICATION REQUESTED IS NOT THE MOST COST EFFECTIVE SOLUTION.
C445	THE DATES ENTERED EITHER ON THE HEADER OR DETAIL LINES ARE INVALID. PLEASE REVIEW THE DATES AND SUBMIT A NEW PRIOR AUTHORIZATION REQUEST WITH VALID DATES.
C451	PROVIDER IS NOT ACTIVE FOR ALL OR PART OF THE DATES ON THIS PRIOR AUTHORIZATION REQUEST. PLEASE VERIFY PROVIDER NUMBER.
C452	THE INFORMATION SUBMITTED DOES NOT SUPPORT THE NEED FOR THE SERVICES REQUESTED, YOU MAY RE-SUBMIT THE PAR DESCRIBING IN MORE DETAIL CURRENT MEDICAL CONDITIONS SUPPORTING THE NEED FOR SERVICES.
C453	THE REQUESTED INFORMATION HAS NOT BEEN SUBMITTED. YOU MAY SUBMIT A NEW PAR WITH THE REQUESTED INFORMATION-NURSING ASSESSMENT, PLAN OF CARE AND/OR THERAPY ASSESSMENTS, CURRENT CLINICAL SUMMARY.
C454	THE REVENUE CODE IS ALREADY AUTHORIZED FOR THIS CLIENT, THIS PROVIDER, AND THIS DATE SPAN. PLEASE BILL USING THE INFORMATION ON THE ORIGINAL PAR, OR SUBMIT A NEW PAR FOR REVISION TO INCREASE OR DECREASE SERVICES.
C455	THE CLINICAL INFORMATION DOES NOT SUBSTANTIATE MEDICAL NECESSITY.
C456	THE REQUESTED ADDITIONAL INFORMATION IS INSUFFICIENT. COMPLETION OF THE REQUESTED INFORMATION IS REQUIRED TO REVIEW THIS PRIOR AUTHORIZATION.
C457	THE AGENCY IS NOT A MEDICAID PROVIDER.
C458	PDN PARS SHALL INCLUDE ONLY PRIVATE DUTY NURSING RN OR LPN SERVICES. OTHER SERVICES ARE INCLUDED ON THIS PAR.
C459	BASED ON THE NEEDS OF THE CLIENT, AUTHORIZATION IS BEING GIVEN FOR A LESSER AMOUNT OF SERVICES THAN REQUESTED.
C460	REVISIONS FOR INCREASES IN SERVICES SHALL BE SUBMITTED AND PROCESSED ACCORDING TO THE SAME REQUIREMENTS AS FOR NEW PARS, WITH A CURRENT WRITTEN ASSESSMENT/PHYSICIAN ORDERS PERTAINING TO THE INCREASE.
C461	SERVICES TOTAL MORE THAN TWENTY-FOUR (24) HOURS PER DAY.
C462	NO SERVICES SHALL BE APPROVED FOR DATES OF SERVICE BEFORE THE DATE THAT THE COMPLETED PAR IS RECEIVED.
C463	SERVICES REQUESTED ARE DUPLICATIVE OF CARE THAT IS BEING REIMBURSED UNDER ANOTHER BENEFIT OR FUNDING SOURCE, INCLUDING BUT NOT LIMITED TO HOME HEALTH, OTHER INSURANCE, OR MEDICAL FOSTER CARE.
C464	*INACTIVE* SERVICES REQUESTED ARE BEYOND THE 20 HOUR PER DAY BENEFIT LIMITATION AS A RESULT OF AN EPSDT MEDICAL SCREENING HOWEVER THE CORRECT DOCUMENTATION HAS NOT BEEN RECEIVED. (THE EPSDT CLAIM FORM DOES NOT MEET THIS REQUIREMENT.)
C465	*INACTIVE* A PAR SHALL COVER A PERIOD OF NO LONGER THAN SIX (6) MONTHS.
C466	THE PLAN OF CARE YOU SUBMITTED WITH YOUR PDN PAR DOES NOT INDICATE THE FREQUENCY AND THE TIMES OF DAY THAT ALL TECHNOLOGY-RELATED CARE WILL BE ADMINISTERED.
C467	THE APPLICATION YOU SUBMITTED FOR PDN IS INCOMPLETE, PLEASE SEND THE REQUIRED INFORMATION.

DENIAL CODE	LONG DESCRIPTION
C468	THIS CLIENT IS INELIGIBLE FOR MEDICAID IN THE NON-INSTITUTIONAL SETTING.
C469	THIS CLIENT IS INELIGIBLE FOR PDN.
C470	THE HOURS REQUESTED ON THE PAR ARE GREATER THAN THE PLAN OF CARE ORDERS.
C471	NURSING VISITS ARE UNREASONABLE IN AMOUNT, FREQUENCY, OR DURATION.
C472	INFORMATION SUBMITTED DOES NOT SUPPORT THE NEED FOR THE SERVICES REQUESTED, YOU MAY RE-SUBMIT THE PAR DESCRIBING IN MORE DETAIL CURRENT MEDICAL CONDITIONS SUPPORTING THE NEED FOR SERVICES.
C473	*INACTIVE* CLIENT PAR IS SENT TO THE WRONG AUTHORIZING AGENT, EPSDT HH, OR OUTPATIENT THERAPY SHOULD BE SUBMITTED TO CFMC.
C474	NURSING VISITS SOLELY FOR PSYCHIATRIC COUNSELING ARE NOT REIMBURSABLE.
C475	THE REQUESTED ADDITIONAL INFORMATION IS INSUFFICIENT. COMPLETION OF THE REQUESTED INFORMATION IS REQUIRED TO REVIEW THIS PRIOR AUTHORIZATION.
C476	SERVICE PREVIOUSLY AUTHORIZED TO THIS PROVIDER. THE PROCEDURE CODE IS ALREADY AUTHORIZED FOR THIS CLIENT, THIS PROVIDER, THIS DATE SPAN. PLEASE BILL USING THE INFORMATION ON THE ORIGINAL PAR.
C477	SERVICES AUTHORIZED TO ANOTHER PROVIDER.
C478	SERVICES REQUESTED ARE BEYOND THE 16 HOUR PER DAY BENEFIT LIMITATION AS A RESULT OF AN EPSDT MEDICAL SCREENING HOWEVER THE CORRECT DOCUMENTATION HAS NOT BEEN RECEIVED. (THE EPSDT CLAIM FORM DOES NOT MEET THIS REQUIREMENT.)
C479	THE PAR SHALL COVER A PERIOD OF NO LONGER THAN SIX (6) MONTHS.
C50A	*INACTIVE* THE PAR THAT YOU SENT DIRECTLY TO ACS IS BEING DENIED. PLEASE SEND THIS PAR TO THE AUTHORIZING AGENT: CFMC, ATTENTION MEDICAID/DME PARS, TO THE FAX SERVER NUMBER AT 303-790-4643.
C518	*INACTIVE* INSTRUCTIONS FROM THE THERAPIST OR OTHER MEDICAL PROFESSIONAL ARE REQUIRED TO SUPPORT THE NEED FOR ROM WHEN IT IS THE ONLY SKILLED SERVICE PERFORMED BY A HOME HEALTH AIDE.
C51A	*INACTIVE* THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. THE REQUIRED CLIENT STATE ID NUMBER IS MISSING OR INVALID. PLEASE RESUBMIT THE 5615 AND ULTC 100.2 CERTIFICATION PAGE WITH THE CORRECT INFORMATION TO DDM ASCEND VIA FAX AT: 877-431-9568.
C52A	*INACTIVE* THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. THE CLIENT STATE ID NUMBER DOES NOT MATCH THE CLIENT NAME. PLEASE RESUBMIT THE 5615 AND ULTC 100.2 CERTIFICATION PAGE WITH THE CORRECT INFORMATION TO DDM ASCEND VIA FAX AT: 877-431-9568.
C53A	*INACTIVE* THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. THE REQUIRED CLIENT DATE OF BIRTH IS MISSING OR INVALID. PLEASE RESUBMIT THE 5615 AND ULTC 100.2 CERTIFICATION PAGE WITH THE CORRECT INFORMATION TO DDM ASCEND VIA FAX AT: 877-431-9568.
C55A	*INACTIVE* THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. THE REQUIRED BILLING PROVIDER NUMBER IS MISSING OR INVALID. PLEASE RESUBMIT THE 5615 AND ULTC 100.2 CERTIFICATION PAGE WITH THE CORRECT INFORMATION TO DDM ASCEND VIA FAX AT: 877-431-9568.
C600	SERVICE DOES NOT REQUIRE PRIOR AUTHORIZATION. SUBMIT CHARGES ON THE APPROPRIATE CLAIM FORM.
C643	COST CONTAINMENT INFORMATION IS MISSING. PLEASE RESUBMIT WITH REQUIRED INFORMATION.
C700	THIS VISION SERVICE WAS NOT PROVIDED BY AN OPHTHALMOLOGIST, OPTOMETRIST OR OPTICIAN.
C800	*INACTIVE* SERVICE PREVIOUSLY AUTHORIZED TO THIS PROVIDER. THE PROCEDURE CODE IS ALREADY AUTHORIZED FOR THIS CLIENT, THIS PROVIDER, THIS DATE SPAN. PLEASE BILL USING THE INFORMATION ON THE ORIGINAL PAR.
C850	*INACTIVE* SERVICES AUTHORIZED TO ANOTHER PROVIDER.
C851	SERVICES AUTHORIZED TO ANOTHER PROVIDER.
C852	DUPLICATE REQUESTS CANNOT BE PROCESSED. THIS PRIOR AUTHORIZATION REQUEST (PAR) IS A DUPLICATE OF ANOTHER PAR THAT IS CURRENTLY IN THE SYSTEM.
C899	THE PRIOR AUTHORIZATION DID NOT INCLUDE THE APPROPRIATE PROCEDURE CODING AND/OR MODIFIER(S) FOR THE EFFECTIVE DATES SUBMITTED. BOTH THE SERVICE AND THE ADMINISTRATION FEE MUST BE INCLUDED WITH THE SAME EFFECTIVE DATES. PLEASE RESUBMIT WITH CORRECTED CODING.
C900	MODIFICATION IS NOT TO PREVENT INSTITUTIONALIZATION OF THE CLIENT.

DENIAL CODE	LONG DESCRIPTION
C901	MODIFICATION DOES NOT GIVE CLIENT GREATER INDEPENDENCE.
C902	MODIFICATION DOES NOT ENSURE THE HEALTH SAFETY AND WELFARE OF THE CLIENT.
C903	MODIFICATION IS NOT A DIRECT MEDICAL OR REMEDIAL BENEFIT TO THE CLIENT.
C904	MODIFICATION DUPLICATES AN EXISTING ADAPTATION.
C905	DUPLICATES AN EXISTING ADAPTATION.
C906	DOCUMENTATION WAS NOT PROVIDED FROM AN OCCUPATIONAL THERAPIST OR PHYSICAL THERAPIST.
C907	MODIFICATION INCLUDES PURCHASE COST OF DURABLE MEDICAL EQUIPMENT.
C908	MODIFICATION REQUESTED IS NOT THE MOST COST EFFECTIVE SOLUTION.
C909	ALTERNATIVE FUNDING HAS NOT BEEN CONSIDERED.
C910	MODIFICATION DID NOT INCLUDE TWO BIDS.
C911	*INACTIVE* AMOUNT OF MODIFICATION EXCEEDS COST CONTAINMENT.
C912	*INACTIVE* THE ITEM OR SERVICE REQUESTED IS NOT A MEDICAID HOME HEALTH BENEFIT.
C913	THE ITEM OR SERVICE REQUESTED IS NOT A MEDICAID PRIVATE DUTY NURSING (PDN) BENEFIT.
C914	THE PROCEDURE IS NOT A BENEFIT OF THE COLORADO MEDICAID PROGRAM.
C915	THE PROCEDURE IS NOT A BENEFIT FOR A CHILD MEDICAID CLIENT, AGE BIRTH THROUGH AGE 20.
C916	THE PROCEDURE IS NOT A BENEFIT FOR AN ADULT MEDICAID CLIENT, AGE 21 AND OLDER.
C917	A REPORT OF THE DENTAL CONDITION THAT SUPPORTS THE NEED FOR SERVICE WAS NOT SUBMITTED FOR THIS CHILD CLIENT.
C918	A REPORT OF DENTAL CONDITION AND CONCURRENT MEDICAL CONDITION THAT SUPPORTS THE NEED FOR SERVICE NOT SUBMITTED FOR THIS ADULT CLIENT.
C919	THE PROCEDURE CODE IS NOT VALID FOR THE DESCRIBED PROCEDURE.
C920	THE PROCEDURE CODE IS NOT A BENEFIT FOR THIS TOOTH NUMBER.
C921	THE TOOTH SURFACE DESIGNATION SUBMITTED IS NOT VALID FOR THIS TOOTH NUMBER.
C922	THE PROCEDURE IS A DUPLICATE SERVICE.
C923	INFORMATION REQUIRED FOR PRIOR AUTHORIZATION REVIEW WAS NOT SUBMITTED.
C924	PERIODONTAL DIAGNOSIS AND CLASSIFICATION WERE NOT SUBMITTED.
C925	THE INFORMATION SUBMITTED DOES NOT SUPPORT THE NEED FOR THE PROCEDURE.
C926	SUBMITTED INFORMATION DOES NOT SUPPORT A FAVORABLE PROGNOSIS.
C927	*INACTIVE* TMJ PAR INFORMATION FROM THE PRIMARY SURGEON WAS INCOMPLETE OR NOT D14 X COCT669 2004-01-1320.36.06
C928	PAR IS NOT REQUIRED FOR THE ASSISTANT SURGEON.
C929	PRIOR AUTHORIZATION REQUEST CANNOT BE APPROVED AFTER THE SERVICE HAS BEEN STARTED.
C930	*INACTIVE* CONDITION DOES NOT QUALIFY AS A HANDICAPPING MALOCCLUSION.
C931	*INACTIVE* NO CERTIFICATION THAT ORTHODONTICS IS NOT IN PREPARATION FOR CORRECTIVE JAW SURGERY.
C933	ORTHODONTIC TREATMENT IS NOT A BENEFIT TO TREAT DENTAL CONDITIONS WHICH ARE PRIMARILY COSMETIC IN NATURE.
C934	ORTHODONTIC TREATMENT IS NOT A BENEFIT WHEN THERE IS NO SEVERE HANDICAPPING MALOCCLUSION, AND SELF ESTEEM IS THE PRIMARY REASON FOR TREATMENT.
C935	PHASE ONE ORTHODONTIC TREATMENT IS NOT A BENEFIT FOR THE REPORTED CONDITION/S.
C936	ORTHODONTIC PRIOR AUTHORIZATION CANNOT BE APPROVED WHEN THE REQUESTING PROVIDER IS NOT ENROLLED AS A MEDICAID ORTHODONTIC PROVIDER.
CA01	*INACTIVE* THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. THE REQUIRED CLIENT STATE ID NUMBER IS MISSING OR INVALID. PLEASE RESUBMIT PAR REQUEST WITH THE CORRECTED INFORMATION TO: ACS, P.O. BOX 30, DENVER, CO 80201-0030.
CA02	*INACTIVE* THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. THE REQUIRED CLIENT STATE ID NUMBER DOES NOT MATCH THE CLIENT NAME. PLEASE RESUBMIT PAR REQUEST WITH THE CORRECTED INFORMATION TO: ACS, P.O. BOX 30, DENVER, CO 80201-0030.
CA03	*INACTIVE* THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. THE REQUIRED CLIENT DATE OF BIRTH IS MISSING OR INVALID. PLEASE RESUBMIT PAR REQUEST WITH THE CORRECTED INFORMATION TO: ACS, P.O. BOX 30, DENVER, CO 80201-0030.

DENIAL CODE	LONG DESCRIPTION
CA04	*INACTIVE* THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. THE REQUIRED REQUESTING PROVIDER NUMBER IS MISSING OR INVALID. PLEASE RESUBMIT PAR REQUEST WITH THE CORRECTED INFORMATION TO: ACS, P.O. BOX 30, DENVER, CO 80201-0030.
CA05	*INACTIVE* THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. THE REQUIRED BILLING PROVIDER NUMBER IS MISSING OR INVALID. PLEASE RESUBMIT PAR REQUEST WITH THE CORRECTED INFORMATION TO: ACS, P.O. BOX 30, DENVER, CO 80201-0030.
CA06	THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. THE REQUIRED CLIENT STATE ID NUMBER IS MISSING OR INVALID. PLEASE RESUBMIT PAR REQUEST WITH THE CORRECTED INFORMATION TO THE AUTHORIZING AGENCY LISTED IN APPENDIX D.
CA07	THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. THE REQUIRED CLIENT STATE ID NUMBER DOES NOT MATCH THE CLIENT NAME. PLEASE RESUBMIT PAR REQUEST WITH THE CORRECTED INFORMATION TO THE AUTHORIZING AGENCY LISTED IN APPENDIX D.
CA08	THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. THE REQUIRED CLIENT DATE OF BIRTH IS MISSING OR INVALID. PLEASE RESUBMIT PAR REQUEST WITH THE CORRECTED INFORMATION TO THE AUTHORIZING AGENCY LISTED IN APPENDIX D.
CA09	THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. THE REQUIRED REQUESTING PROVIDER NUMBER IS MISSING OR INVALID. PLEASE RESUBMIT PAR REQUEST WITH THE CORRECTED INFORMATION TO THE AUTHORIZING AGENCY LISTED IN APPENDIX D.
CA10	THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. THE REQUIRED BILLING PROVIDER NUMBER IS MISSING OR INVALID. PLEASE RESUBMIT PAR REQUEST WITH THE CORRECTED INFORMATION TO THE AUTHORIZING AGENCY LISTED IN APPENDIX D.
CA11	THE PAR THAT YOU SENT DIRECTLY TO ACS IS BEING DENIED. PLEASE SEND THIS PAR TO THE AUTHORIZING AGENCY LISTED IN APPENDIX D.
CA12	*INACTIVE* THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. THE REQUIRED CLIENT STATE ID NUMBER IS MISSING OR INVALID. PLEASE RESUBMIT PAR REQUEST WITH THE CORRECTED INFORMATION TO THE AUTHORIZING AGENCY LISTED IN APPENDIX D.
CA13	*INACTIVE* THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. THE REQUIRED CLIENT STATE ID NUMBER DOES NOT MATCH THE CLIENT NAME. PLEASE RESUBMIT PAR REQUEST WITH THE CORRECTED INFORMATION TO THE AUTHORIZING AGENCY LISTED IN APPENDIX D.
CA14	*INACTIVE* THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. THE REQUIRED CLIENT DATE OF BIRTH IS MISSING OR INVALID. PLEASE RESUBMIT PAR REQUEST WITH THE CORRECTED INFORMATION TO THE AUTHORIZING AGENCY LISTED IN APPENDIX D.
CA15	*INACTIVE* THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. THE REQUIRED REQUESTING PROVIDER NUMBER IS MISSING OR INVALID. PLEASE RESUBMIT PAR REQUEST WITH THE CORRECTED INFORMATION TO THE AUTHORIZING AGENCY LISTED IN APPENDIX D.
CA16	*INACTIVE* THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. THE REQUIRED BILLING PROVIDER NUMBER IS MISSING OR INVALID. PLEASE RESUBMIT PAR REQUEST WITH THE CORRECTED INFORMATION TO THE AUTHORIZING AGENCY LISTED IN APPENDIX D.
CA17	PROVIDER MUST BE AN ENROLLED IN THE COLORADO MEDICAL ASSISTANCE PROGRAM.
CA18	THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. THE REQUIRED CLIENT STATE ID NUMBER IS MISSING OR INVALID. PLEASE RESUBMIT THE 5615 AND ULTC 100.2 CERTIFICATION PAGE WITH THE CORRECT INFORMATION TO THE AUTHORIZING AGENCY LISTED IN APPENDIX D.
CA19	THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. THE CLIENT STATE ID NUMBER DOES NOT MATCH THE CLIENT NAME. PLEASE RESUBMIT THE 5615 AND ULTC 100.2 CERTIFICATION PAGE WITH THE CORRECT INFORMATION TO THE AUTHORIZING AGENCY LISTED IN APPENDIX D.
CA20	THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. THE REQUIRED CLIENT DATE OF BIRTH IS MISSING OR INVALID. PLEASE RESUBMIT THE 5615 AND ULTC 100.2 CERTIFICATION PAGE WITH THE CORRECT INFORMATION TO THE AUTHORIZING AGENCY LISTED IN APPENDIX D.
CA21	THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. THE REQUIRED BILLING PROVIDER NUMBER IS MISSING OR INVALID. PLEASE RESUBMIT THE 5615 AND ULTC 100.2 CERTIFICATION PAGE WITH THE CORRECT INFORMATION TO THE AUTHORIZING AGENCY LISTED IN APPENDIX D.

DENIAL CODE	LONG DESCRIPTION
CC01	CONSUMER DIRECTED ATTENDANT SUPPORT (CDAS) SERVICES MUST BE SUBMITTED ON THE SAME PRIOR AUTHORIZATION REQUEST (PAR) AS THE ADMINISTRATION FEE. PLEASE RESUBMIT THE PAR WITH BOTH THE ADMINISTRATION FEE/MODIFIER AND THE SERVICE PROCEDURE CODE.
CD01	*INACTIVE* CLIENT HAS NOT UTILIZED THE EQUIPMENT IN THE MANNER FOR WHICH IT WAS INTENDED. REPAIRS AND/OR REPLACEMENT OF EQUIPMENT WILL NOT BE ALLOWED IN CASES OF REPEATED MISUSE.
CD02	*INACTIVE* THIS PRODUCT CANNOT BE APPROVED AS ITS PRIMARY PURPOSE IS TO EITHER ENHANCE THE PERSONAL COMFORT OF THE CLIENT OR PROVIDE CONVENIENCE FOR THE CLIENT CAREGIVER.
CD03	THE INFORMATION SUBMITTED DOES NOT MEET THE COLORADO MEDICAID PROGRAM GUIDELINES FOR MEDICAL NECESSITY.
CD04	SERVICE PREVIOUSLY AUTHORIZED TO THIS PROVIDER OR ANOTHER PROVIDER. THE PROCEDURE CODE IS ALREADY AUTHORIZED FOR THIS CLIENT, THIS DATE SPAN.
CD05	THIS REQUEST IS FOR A WHEELCHAIR. THE COLORADO MEDICAID PROGRAM HAS PROVIDED A SIMILAR PRODUCT WITHIN THE LAST FEW YEARS. IT IS MEDICAID POLICY THAT THE ORIGINAL WHEELCHAIR SHOULD BE UTILIZED FOR A MINIMUM OF 5 YEARS. PLEASE SUBMIT ADDITIONAL INFORMATION DOCUMENTING THE NEED FOR A NEW WHEELCHAIR AT THIS POINT IN TIME.
CD06	IT IS THE RESPONSIBILITY OF THE PROVIDER TO SERVICE, REPAIR AND SUPPLY NECESSARY PARTS FOR ANY DURABLE MEDICAL EQUIPMENT PRODUCT COVERED BY A WARRANTY DURING THE WARRANTY PERIOD. NO REPLACEMENT PARTS OR REPAIRS WILL BE REIMBURSED BY COLORADO MEDICAID DURING THE WARRANTY PERIOD.
CD07	THIS PRODUCT WOULD MORE APPROPRIATELY BE PROVIDED ON A RENTAL BASIS.
CD08	THIS PRODUCT INTENDED USAGE IS FOR EXERCISE. COLORADO MEDICAID DOES NOT COVER PRODUCTS THAT ARE PRESCRIBED PRIMARILY FOR EXERCISE.
CD09	THIS PRODUCT HAS BEEN REQUESTED FOR A CLIENT WHO IS CURRENTLY RESIDING IN A NURSING FACILITY OR HOSPITAL SETTING. THEREFORE, IT WILL NOT BE REIMBURSED THROUGH THE DURABLE MEDICAL EQUIPMENT PROGRAM OF COLORADO MEDICAID. IT IS THE RESPONSIBILITY OF THE FACILITY TO PROVIDE THIS PRODUCT.
CD10	*INACTIVE* PRIOR AUTHORIZATION REQUESTS MUST BE FAXED TO CFMC FOR THE FOLLOWING ITEMS: ELECTRIC WHEELCHAIRS, SCOOTERS, ORTHOTICS AND PROSTHETICS, AUGMENTATIVE COMMUNICATION DEVICES. PLEASE SEND THE PRIOR AUTHORIZATION REQUEST FOR THESE ITEMS DIRECTLY TO CFMC, ATTENTION MEDICAID/DME PARS, TO THE FAX SERVER LINE AT 303-790-4643.
CD11	THIS PRODUCT IS NOT A BENEFIT OF THE DURABLE MEDICAL EQUIPMENT PROGRAM.
CD14	THE REQUESTED INFORMATION HAS NOT BEEN SUBMITTED.
CD16	THIS PRODUCT DOES NOT REQUIRE PRIOR AUTHORIZATION. SUBMIT CHARGES ON THE APPROPRIATE CLAIM FORM.
CD21	PRIOR AUTHORIZATIONS REQUESTS MUST BE SUBMITTED IN A TIMELY FASHION. RETROACTIVE REQUESTS BEYOND THREE MONTHS SHALL ONLY BE CONSIDERED IN CASES OF CLIENT RETROACTIVE PROGRAM ELIGIBILITY.
CD23	EFFECTIVE AUGUST 1, 2007 PULSE OXIMETERS WILL HAVE A MAXIMUM ALLOWABLE RENTAL CAP OF $750.00 PER YEAR. ONCE THE TOTAL RENTAL PAYMENT REACHES $750.00 THE EQUIPMENT WILL CONVERT TO A PURCHASE. THIS CHANGE IS IN ACCORDANCE WITH THE FOLLOWING RULE: 8.590.2.R. RENTAL POLICY.
CD30	THIS PRODUCT WOULD BE MORE APPROPRIATELY PROVIDED AS A PURCHASE.
CD31	AS PER MEDICAID BULLETIN MARCH 2003, 1 UNIT EQUALS 100. YOUR REQUESTED QUANTITY HAS BEEN DIVIDED BY 100.
CD32	THE AMOUNT REQUESTED EXCEEDS THE ALLOWED QUANTITY AND HAS BEEN REDUCED ACCORDINGLY. PLEASE REFER TO THE CURRENT MEDICAID SUPPLY BULLETIN AND 10 C.C.R. 2505-10, SEC. 8.590.2. NP.
CD33	THE AMOUNT REQUESTED IS EXCESSIVE FOR THE DIAGNOSIS AND HAS BEEN REDUCED ACCORDINGLY. PLEASE REFER TO THE CURRENT MEDICAID SUPPLY BULLETIN AND 10 C.C.R. 2505-10, SEC. 8. 590.2.NP.
CD35	PER MEDICAID SUPPLY BULLETIN, A9900 IS LIMITED TO SPECIALIZED, DETAILED OR COMPLEX WORK IN THE INITIAL PREPARATION OF A PRODUCT.
CD59	PRIOR AUTHORIZATION IS NOT REQUIRED FOR MEDICARE CROSSOVER CLAIMS. (8.590.3.B) PROVIDERS ARE REQUIRED TO BILL MEDICARE FIRST BEFORE BILLING MEDICAID FOR THIS SERVICE. (SEC. 8.590.7.K)
CD60	*INACTIVE* SERVICE PREVIOUSLY AUTHORIZED TO THIS PROVIDER. THE PROCEDURE CODE IS ALREADY AUTHORIZED FOR THIS CLIENT, THIS PROVIDER, THIS DATE SPAN. PLEASE BILL USING THE INFORMATION ON THE ORIGINAL PAR.

DENIAL CODE	LONG DESCRIPTION
CD61	*INACTIVE* SERVICES AUTHORIZED TO ANOTHER PROVIDER.
CD63	THIS ITEM IS INCLUDED IN THE RENTAL/PURCHASE OF THE EQUIPMENT OR SERVICE THAT HAS BEEN APPROVED. PLEASE REFER TO THE CURRENT MEDICAID SUPPLY BULLETIN.
CDA1	*INACTIVE* THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. THE DATE(S) ENTERED EITHER ON THE HEADER OR DETAIL LINES ARE INVALID. PLEASE REVIEW THE DATES AND SUBMIT A NEW PAR WITH VALID DATES TO: ACS, P.O. BOX 30, DENVER, CO 80201-0030.
CDA2	*INACTIVE* THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. THE INFORMATION SUBMITTED DOES NOT SUPPORT THE NEED FOR THE MEDICAL SUPPLIES OR EQUIPMENT REQUESTED. PLEASE RESUBMIT THE PAR DESCRIBING IN MORE DETAIL THE CURRENT MEDICAL CONDITIONS THAT SUPPORT THE NEED FOR THE SUPPLIES TO: ACS, P.O. BOX 30, DENVER, CO 80201-0030.
CDA3	*INACTIVE* THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. THE ADDITIONAL INFORMATION SUBMITTED IS INSUFFICIENT. COMPLETION OF THE REQUESTED INFORMATION IS REQUIRED FOR REVIEW. PLEASE RESUBMIT PAR WITH THE REQUESTED INFORMATION TO: ACS, P.O. BOX 30, DENVER, CO 80201-0030.
CDA4	*INACTIVE* THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. SERIAL NUMBER IS REQUIRED FOR ALL REPAIRS. PLEASE RESUBMIT PAR WITH THE SERIAL NUMBER TO: ACS, P.O. BOX 30, DENVER, CO 80201-0030. CURRENT MEDICAID SUPPLY BULLETIN AND 10 C.C.R. 2505-10, SEC. 8.590.3 (A).
CDA5	*INACTIVE* THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. PLEASE RESUBMIT PAR WITH THE INVOICED ACQUISITION COST FOR THIS ITEM TO: ACS, P.O. BOX 30, DENVER, CO 80201-0030. CURRENT MEDICAID SUPPLY BULLETIN AND 10 C.C.R. 2505-10, SEC. 8.590.6 (A-IK).
CDA6	*INACTIVE* THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. WHEELCHAIR PURCHASES MUST HAVE THE MANUFACTURER, BRAND NAME AND MODEL NAME. PLEASE RESUBMIT PAR WITH THE INFORMATION REQUESTED ABOVE TO: ACS, P.O. BOX 30, DENVER, CO 80201-0030.
CDA7	*INACTIVE* THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. REQUESTING PROVIDERS MUST HAVE PRESCRIPTIVE AUTHORITY FOR THIS ITEM. PLEASE RESUBMIT PAR WITH THE NAME OF THE PRESCRIBING PHYSICIAN TO: ACS, P.O. BOX 30, DENVER, CO 80201-0030. CURRENT MEDICAID SUPPLY BULLETIN.
CDA8	*INACTIVE* THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. THE PRIOR AUTHORIZATION REQUEST REQUIRES A PHYSICIAN SIGNATURE. PLEASE RESUBMIT PAR WITH A PHYSICIAN SIGNATURE TO: ACS, P.O. BOX 30, DENVER, CO 80201-0030.
CDA9	*INACTIVE* THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. PROCEDURE CODE REQUESTED IS INVALID/INCORRECT OR INCOMPLETE. PLEASE RESUBMIT PAR WITH PROPER CODE(S) FROM THE CURRENT MEDICAID SUPPLY BULLETIN TO: ACS, P.O. BOX 30, DENVER, CO 80201-0030.
CDB1	*INACTIVE* THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. PLEASE RESUBMIT PAR WITH THE NAME OF MEDS, FREQUENCY, ROUTE AND LENGTH OF NEED TO: ACS, P.O. BOX 30, DENVER, CO 80201-0030. CURRENT MEDICAID SUPPLY BULLETIN AND 10 C.C.R. 2505-10, SEC. 8. 590.3.D.
CDB2	*INACTIVE* THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. PLEASE RESUBMIT PAR WITH THE NUMBER OF UNITS REQUESTED TO: ACS, P.O. BOX 30, DENVER, CO 80201-0030.
CDB3	*INACTIVE* THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. PAR DATES MUST BE FOR ONE YEAR. PLEASE RESUBMIT PAR WITH CORRECTED DATE SPAN OR PROVIDE AN EXPLANATION AS TO WHY DATES ARE LESS THAN ONE YEAR TO: ACS, P.O. BOX 30, DENVER, CO 80201-0030. PLEASE REFER TO THE CURRENT MEDICAID SUPPLY BULLETIN.
CDB4	*INACTIVE* THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. ADDITIONAL INFORMATION IS REQUIRED FOR THIS ITEM. PLEASE RESUBMIT PAR AND INCLUDE WHETHER THESE ITEMS ARE INTENDED FOR USE WITH A CLIENT OWNED PIECE OF EQUIPMENT TO: ACS, P.O. BOX 30, DENVER, CO 80201-0030. CURRENT MEDICAID SUPPLY BULLETIN.
CDB5	*INACTIVE* THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. ADDITIONAL INFORMATION IS REQUIRED FOR THIS ITEM. PLEASE RESUBMIT PAR AND DESCRIBE 1) THE CLIENT LEVEL OF IMPAIRMENT, 2) WHAT HAS BEEN USED IN THE PAST, 3) IF THE CLIENT HAS AVAILABLE ASSISTANCE 4) WHY THIS CLIENT IS IN NEED OF THIS EQUIPMENT/SUPPLY TO: ACS, P.O. BOX 30, DENVER, CO 80201-0030.

DENIAL CODE	LONG DESCRIPTION
CDB6	*INACTIVE* THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. ADDITIONAL INFORMATION IS REQUIRED FOR THIS ITEM. PLEASE RESUBMIT PAR AND DESCRIBE 1) EXACTLY WHY THIS ITEM IS NEEDED, 2) WHAT IT WILL BE USED FOR, 3) THE INTENDED USE FOR THIS ITEM TO: ACS, P.O. BOX 30, DENVER, CO 80201-0030.
CDB7	*INACTIVE* THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. PRODUCT INFORMATION IS REQUIRED ON THIS ITEM. PLEASE RESUBMIT PAR WITH PRODUCT INFORMATION TO: ACS, P.O. BOX 30, DENVER, CO 80201-0030.
CDB8	*INACTIVE* THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. A SERIAL NUMBER IS REQUIRED FOR ALL REPAIRS. PLEASE RESUBMIT PAR WITH THE SERIAL NUMBER FOR THE REPAIR TO: ACS, P.O. BOX 30, DENVER, CO 80201-0030.
CDB9	*INACTIVE* THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. HOSPITAL BED QUESTIONNAIRE #1 IS NEEDED TO REVIEW THIS REQUEST. PLEASE RESUBMIT PAR WITH THE INFORMATION REQUESTED TO: ACS, P.O. BOX 30, DENVER, CO 80201-0030.
CDC1	*INACTIVE* THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. PRESSURE RELIEF MATTRESS QUESTIONNAIRE #2 IS NEEDED TO REVIEW THIS REQUEST. PLEASE RESUBMIT PRIOR AUTHORIZATION REQUEST WITH THE INFORMATION REQUESTED TO: ACS, P.O. BOX 30, DENVER, CO 80201-0030.
CDC2	*INACTIVE* THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. PATIENT LIFT QUESTIONNAIRE #3 IS NEEDED TO REVIEW THIS REQUEST. PLEASE RESUBMIT PAR WITH THE INFORMATION REQUESTED TO: ACS, P.O. BOX 30, DENVER, CO 80201-0030.
CDC3	*INACTIVE* THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. ELECTRIC/POWER LIFT QUESTIONNAIRE #3 IS NEEDED TO REVIEW THIS REQUEST. PLEASE RESUBMIT PAR WITH THE INFORMATION REQUESTED TO: ACS, P.O. BOX 30, DENVER, CO 80201-0030.
CDC4	*INACTIVE* THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. SEAT LIFT QUESTIONNAIRE #4 IS NEEDED TO REVIEW THIS REQUEST. PLEASE RESUBMIT PAR WITH THE INFORMATION REQUESTED TO: ACS, P.O. BOX 30, DENVER, CO 80201-0030.
CDC5	*INACTIVE* THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. BLOOD PRESSURE UNIT/MONITOR QUESTIONNAIRE #5 IS NEEDED TO REVIEW THIS REQUEST. PLEASE RESUBMIT PAR WITH THE INFORMATION REQUESTED TO: ACS, P.O. BOX 30, DENVER, CO 80201-0030.
CDC6	*INACTIVE* THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. PULSE OXIMETER QUESTIONNAIRE #6 (WITH SAO2 READINGS) IS NEEDED TO REVIEW THIS REQUEST. PLEASE RESUBMIT PAR WITH THE INFORMATION REQUESTED TO: ACS, P.O. BOX 30, DENVER, CO 80201-0030.
CDC7	*INACTIVE* THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. APNEA MONITOR QUESTIONNAIRE #7 IS NEEDED TO REVIEW THIS REQUEST. PLEASE RESUBMIT PAR WITH THE INFORMATION REQUESTED TO: ACS, P.O. BOX 30, DENVER, CO 80201-0030.
CDC8	*INACTIVE* THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. CPAP/BIPAP QUESTIONNAIRE #8 WITH COPY OF SLEEP STUDY IS NEEDED TO REVIEW THIS REQUEST. PLEASE RESUBMIT PAR WITH THE INFORMATION REQUESTED TO: ACS, P.O. BOX 30, DENVER, CO 80201-0030.
CDC9	*INACTIVE* THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. TENS OR NMES QUESTIONNAIRE #9 IS NEEDED TO REVIEW THIS REQUEST. PLEASE RESUBMIT PAR WITH THE INFORMATION REQUESTED TO: ACS, P.O. BOX 30, DENVER, CO 80201-0030.
CDD1	*INACTIVE* THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. ORAL AND ENTERAL NUTRITION FORMULA QUESTIONNAIRE #10 (WITH PARTICULAR ATTENTION TO THE NUMBER OF CALORIES PER DAY) IS NEEDED TO REVIEW THIS REQUEST. PLEASE RESUBMIT PAR WITH THE INFORMATION REQUESTED TO: ACS, P.O. BOX 30, DENVER, CO 80201-0030.
CDD2	*INACTIVE* THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. ADULT ORTHOTICS AND PROSTHETICS QUESTIONNAIRE #11 IS NEEDED TO REVIEW THIS REQUEST. PLEASE RESUBMIT PAR WITH THE INFORMATION REQUESTED TO: ACS, P.O. BOX 30, DENVER, CO 80201-0030.
CDD3	*INACTIVE* THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. WOUND CLOSURE THERAPY QUESTIONNAIRE #12 IS NEEDED TO REVIEW THIS REQUEST. PLEASE RESUBMIT PAR WITH THE INFORMATION REQUESTED TO: ACS, P.O. BOX 30, DENVER, CO 80201-0030.
CDD4	*INACTIVE* THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. AUGMENTATIVE COMMUNICATION DEVICE QUESTIONNAIRE #13 IS NEEDED TO REVIEW THIS REQUEST. PLEASE RESUBMIT PAR WITH THE INFORMATION REQUESTED TO: ACS, P.O. BOX 30, DENVER, CO 80201-0030.

DENIAL CODE	LONG DESCRIPTION
CDD5	*INACTIVE* THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. MECHANICAL HIGH FREQUENCY CHEST WALL OSCILLATION QUESTIONNAIRE #14 IS NEEDED TO REVIEW THIS REQUEST. PLEASE RESUBMIT PAR WITH INFORMATION REQUESTED TO: ACS, P.O. BOX 30, DENVER, CO 80201-0030.
CDD6	*INACTIVE* THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. WHEELCHAIR TILT/RECLINE DEVICE QUESTIONNAIRE #15 IS NEEDED TO REVIEW THIS REQUEST. PLEASE RESUBMIT PAR WITH THE INFORMATION REQUESTED TO: ACS, P.O. BOX 30, DENVER, CO 80201-0030.
CDD7	*INACTIVE* THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. THE QUESTIONNAIRE FORM YOU SUBMITTED IS NO LONGER VALID. PLEASE RESUBMIT PAR WITH THE CURRENT QUESTIONNAIRE FORM TO: ACS, P.O. BOX 30, DENVER, CO 80201-0030.
CE01	THIS VISION SERVICE WAS NOT PROVIDED BY AN OPHTHALMOLOGIST, OPTOMETRIST OR OPTICIAN.
CE02	THE CLINICAL INFORMATION DOES NOT SUBSTANTIATE MEDICAL NECESSITY.
CF01	PROOF OF PRIOR MEDICAID ORTHODONTIC APPROVAL FROM ANOTHER STATE WAS NOT SUBMITTED.
CF02	TMJ PAR INFORMATION FROM THE PRIMARY SURGEON WAS INCOMPLETE
CF03	CONDITION DOES NOT QUALIFY AS A HANDICAPPING MALOCCLUSION.
CF04	CROWNS AND FIXED PROSTHESES THAT FAIL IN LESS THAN FIVE YEARS DO NOT MEET A REASONABLE STANDARD OF CARE AND THE BILLING PROVIDER IS EXPECTED TO REPLACE THEM AT THEIR OWN EXPENSE.
CF05	THE SERVICES/TREATMENTS ARE NOT A COVERED BENEFIT FOR EVALUATION PROCEDURES.
CF06	THE SERVICES/TREATMENTS ARE NOT A COVERED BENEFIT FOR DIAGNOSTIC IMAGING PROCEDURES.
CF07	THE SERVICES/TREATMENTS ARE NOT A COVERED BENEFIT FOR PREVENTIVE SERVICES.
CF08	THE SERVICES/TREATMENTS ARE NOT A COVERED BENEFIT FOR MINOR RESTORATIVE SERVICES.
CF09	THE SERVICES/TREATMENTS ARE NOT A COVERED BENEFIT FOR MAJOR RESTORATIVE SERVICES.
CF10	THE SERVICES/TREATMENTS ARE NOT A COVERED BENEFIT FOR ENDODONTIC SERVICES.
CF11	THE SERVICES/TREATMENTS ARE NOT A COVERED BENEFIT FOR PERIODONTAL TREATMENT.
CF12	THE SERVICES/TREATMENTS ARE NOT A COVERED BENEFIT FOR REMOVABLE PROSTHETICS.
CF13	THE SERVICES/TREATMENTS ARE NOT A COVERED BENEFIT FOR ORAL SURGERY, PALLIATIVE TREATMENT AND ANESTHESIA.
CF14	THE SERVICES/TREATMENTS ARE NOT A COVERED BENEFIT FOR ADULT CLIENTS UNDER ANY CIRCUMSTANCES.
CF15	PRIOR AUTHORIZATION REQUEST WAS NOT SUBMITTED.
CF16	DENTAL SERVICES SHALL ONLY BE PROVIDED BY A LICENSED DENTIST OR DENTAL HYGIENIST WHO IS ENROLLED WITH COLORADO MEDICAID.
CF17	DENTAL SERVICES DESCRIBED IN 8.201.2 SHALL BE AVAILABLE TO ADULT CLIENTS AGE 21 YEARS AND OLDER.
CF18	DENTAL SERVICES FOR ADULTS 21 YEARS OF AGE AND OLDER ARE LIMITED TO A TOTAL OF $1,000 PER ADULT MEDICAID RECIPIENT PER STATE FISCAL YEAR.
CH10	*INACTIVE* NURSING VISITS SOLELY FOR THE PURPOSE OF ASSESS AND TEACH ARE NOT BILLABLE IN THIS CASE.
CH11	*INACTIVE* NURSING VISITS ARE UNREASONABLE IN AMOUNT, FREQUENCY, OR DURATION.
CH12	*INACTIVE* HOME HEALTH AIDE UNITS ARE REQUESTED, NO SKILLED TASKS ARE IDENTIFIED.
CH13	*INACTIVE* HOME HEALTH AIDE VISITS ARE NOT MEDICALLY NECESSARY.
CH14	*INACTIVE* HOME HEALTH SERVICES SHALL BE PROVIDED AT THE CLIENT PLACE OF RESIDENCE EXCEPT FOR EPSDT EXTRAORDINARY HH WHICH IS PRIOR AUTHORIZED USING A DIFFERENT PROCESS AND FORM.
CH15	*INACTIVE* THE CLIENT IS 18 YEARS OLD OR OVER AND SKILLED THERAPIES ARE NOT A BENEFIT UNDER LONG TERM HOME HEALTH.
CH16	*INACTIVE* EXTENDED HOME HEALTH AIDE VISITS REQUESTED WITHOUT SUBMITTING SUFFICIENT INFORMATION ABOUT SERVICES ON EACH VISIT.
CH17	*INACTIVE* DOCUMENTATION TO SUPPORT PRN VISITS HAS NOT BEEN SUBMITTED.
CH18	*INACTIVE* WRITTEN INSTRUCTIONS FROM THE THERAPIST OR OTHER MEDICAL PROFESSIONAL ARE REQUIRED TO SUPPORT THE NEED FOR ROM WHEN IT IS THE ONLY SKILLED SERVICE PERFORMED BY A HOME HEALTH AIDE.
CH19	*INACTIVE* MEDICATION SET-UP BY A NURSE IS THE ONLY REASON FOR VISITS AND DOCUMENTATION THAT THE PHARMACY WAS CONTACTED IS MISSING.

DENIAL CODE	LONG DESCRIPTION
CH2	*INACTIVE* INFORMATION SUBMITTED DOES NOT SUPPORT THE NEED FOR THE SERVICES REQUESTED, YOU MAY RE-SUBMIT THE PAR DESCRIBING IN MORE DETAIL CURRENT MEDICAL CONDITIONS SUPPORTING THE NEED FOR SERVICES.
CH20	*INACTIVE* DOCUMENTATION DOES NOT SUPPORT THE NEED FOR TWO HOME HEALTH AIDES AT THE SAME TIME FOR A TWO-PERSON TRANSFER.
CH21	*INACTIVE* CLIENT PAR IS SENT TO THE WRONG AUTHORIZING AGENT, EPSDT HH, PDN AND OUTPATIENT THERAPY SHOULD BE SUBMITTED TO CFMC AT PO BOX 17300, DENVER, CO 80217.
CH22	*INACTIVE* BASED ON THE NEEDS OF THE CLIENT, AUTHORIZATION IS BEING GIVEN FOR A LESSER AMOUNT OF SERVICES THAN REQUESTED.
CH23	*INACTIVE* PAR FORM HAS BEEN SUBMITTED LATER THAN 10 DAYS FROM THE HCFA-485 "FROM" DATE. PAR DATES HAVE BEEN ADJUSTED.
CH24	*INACTIVE* REVISIONS FOR INCREASES IN SERVICES SHALL BE SUBMITTED AND PROCESSED ACCORDING TO THE SAME REQUIREMENTS AS FOR NEW PARS, WITH A CURRENT WRITTEN ASSESSMENT/PHYSICIAN ORDERS PERTAINING TO THE INCREASE.
CH25	*INACTIVE* NURSING VISITS SOLELY FOR PSYCHIATRIC COUNSELING ARE NOT REIMBURSABLE.
CH26	*INACTIVE* ANY VISIT MADE SOLELY FOR SUPERVISION OF THE HOME HEALTH AIDE SHALL NOT BE REIMBURSED.
CH27	*INACTIVE* NURSING VISITS SOLELY FOR FOOT CARE SHALL BE REIMBURSED ONLY IF THE CLIENT HAS A DOCUMENTED DIAGNOSIS THAT SUPPORTS THE NEED FOR A NURSE, AND THE CLIENT OR FAMILY CAREGIVER IS NOT ABLE OR WILLING TO PROVIDE THE FOOT CARE.
CH3	*INACTIVE* THE REQUESTED INFORMATION HAS NOT BEEN SUBMITTED. YOU MAY SUBMIT A NEW PAR WITH THE REQUESTED INFORMATION-HOME HEALTH PLAN OF CARE AND/OR THERAPY ASSESSMENTS, CURRENT CLINICAL SUMMARY.
CH30	*INACTIVE* CLIENT PAR IS SENT TO THE WRONG AUTHORIZING AGENT, PRIVATE DUTY NURSING PARS AND APPLICATION PAPERWORK SHOULD BE SUBMITTED DO DDM ASCEND VIA FAX TO 877-431-9568.
CH31	*INACTIVE* IMPROPER BILLING MAY RESULT FROM VISITS THAT ARE UNREASONABLE IN AMOUNT, FREQUENCY AND DURATION OR VISITS PERFORMED WHEN SKILLED TASKS PERFORMED ARE NOT MEDICALLY NECESSARY.
CH4	*INACTIVE* THIS SERVICE DOES NOT REQUIRE PRIOR AUTHORIZATION. SUBMIT CHARGES ON THE APPROPRIATE CLAIM FORM (ACUTE HOME HEALTH OR LONG TERM HOME HEALTH WITH ACUTE EPISODE)
CH5	*INACTIVE* THE REVENUE CODE IS ALREADY AUTHORIZED FOR THIS CLIENT, THIS PROVIDER, THIS DATE SPAN. PLEASE BILL USING THE INFORMATION ON THE ORIGINAL PAR, OR SUBMIT A NEW PAR FOR REVISION TO INCREASE SERVICES.
CH6	*INACTIVE* THE PAR THAT YOU SENT DIRECTLY TO ACS IS BEING DENIED. PLEASE SEND THIS PAR TO THE AUTHORIZING AGENT: SINGLE ENTRY POINT AGENCY IN COUNTY OF CLIENT RESIDENCE.
CH7	*INACTIVE* THE CLINICAL INFORMATION DOES NOT SUBSTANTIATE MEDICAL NECESSITY.
CH8	*INACTIVE* THE REQUESTED ADDITIONAL INFORMATION IS INSUFFICIENT. COMPLETION OF THE REQUESTED INFORMATION IS REQUIRED TO REVIEW THIS PRIOR AUTHORIZATION.
CH9	*INACTIVE* THE AGENCY IS NOT A MEDICAID PROVIDER.
CJ01	THE SERVICE IS NOT A BENEFIT OF THE COLORADO MEDICAID MEDICAL TRANSPORTATION PROGRAM.
CN01	THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. THE REQUIRED 5615 NOTED IN THE NURSING FACILITY BILLING MANUAL; GENERAL PRIOR AUTHORIZATION REQUIREMENTS IS MISSING OR INCOMPLETE. PLEASE RESUBMIT THE 5615 AND ULTC 100.2 CERTIFICATION PAGE TO THE AUTHORIZING AGENT.
CN02	THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. THE REQUIRED ULTC 100.2 CERTIFICATION PAGE NOTED IN THE NURSING FACILITY BILLING MANUAL; GENERAL PRIOR AUTHORIZATION REQUIREMENTS IS MISSING OR INCOMPLETE. PLEASE RESUBMIT THE 5615 AND ULTC 100.2 CERTIFICATION PAGE TO THE AUTHORIZING AGENT.
CN03	THIS IS A NOT FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. THE REQUIRED CLIENT'S SOCIAL SECURITY NUMBER IS INVALID OR DOES NOT MATCH THE SOCIAL SECURITY NUMBER OF FILE WITH THE COLORADO MEDICAL ASSISTANCE PROGRAM. PLEASE CORRECT AND RESUBMIT BOTH THE 5615 AND THE UTLC 100.2 CERTIFICATION PAGE TO THE AUTHORIZING AGENT.

DENIAL CODE	LONG DESCRIPTION
CN04	THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. THE REQUIRED CLIENT STATE ID NUMBER IS MISSING OR INVALID. PLEASE RESUBMIT THE 5615 AND ULTC 100.2 CERTIFICATION PAGE WITH THE CORRECT INFORMATION TO THE AUTHORIZING AGENCY LISTED IN APPENDIX D.
CN05	THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. THE CLIENT STATE ID NUMBER DOES NOT MATCH THE CLIENT NAME. PLEASE RESUBMIT THE 5615 AND ULTC 100.2 CERTIFICATION PAGE WITH THE CORRECT INFORMATION TO THE AUTHORIZING AGENCY LISTED IN APPENDIX D.
CN06	THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. THE REQUIRED CLIENT DATE OF BIRTH IS MISSING OR INVALID. PLEASE RESUBMIT THE 5615 AND ULTC 100.2 CERTIFICATION PAGE WITH THE CORRECT INFORMATION TO THE AUTHORIZING AGENCY LISTED IN APPENDIX D.
CN07	THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. THE REQUIRED BILLING PROVIDER NUMBER IS MISSING OR INVALID. PLEASE RESUBMIT THE 5615 AND ULTC 100.2 CERTIFICATION PAGE WITH THE CORRECT INFORMATION TO THE AUTHORIZING AGENCY LISTED IN APPENDIX D.
CQ01	THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. THE DATE(S) ENTERED EITHER ON THE HEADER OR DETAIL LINES ARE INVALID. PLEASE REVIEW THE DATES AND SUBMIT A NEW PAR WITH VALID DATES TO THE APPROPRIATE AUTHORIZING AGENCY LISTED IN APPENDIX D.
CQ02	THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. THE INFORMATION SUBMITTED DOES NOT SUPPORT THE NEED FOR THE MEDICAL SUPPLIES OR EQUIPMENT REQUESTED. PLEASE RESUBMIT THE PAR DESCRIBING IN MORE DETAIL THE CURRENT MEDICAL CONDITIONS THAT SUPPORT THE NEED FOR THE SUPPLIES TO THE APPROPRIATE AUTHORIZING AGENCY LISTED IN APPENDIX D.
CQ03	THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. THE ADDITIONAL INFORMATION SUBMITTED IS INSUFFICIENT. COMPLETION OF THE REQUESTED INFORMATION IS REQUIRED FOR REVIEW. PLEASE RESUBMIT PAR WITH THE REQUESTED INFORMATION TO THE APPROPRIATE AUTHORIZING AGENCY LISTED IN APPENDIX D.
CQ04	THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. SERIAL NUMBER IS REQUIRED FOR ALL REPAIRS. PLEASE RESUBMIT PAR WITH THE SERIAL NUMBER TO THE APPROPRIATE AUTHORIZING AGENCY LISTED IN APPENDIX D. CURRENT MEDICAID SUPPLY BULLETIN AND 10 C.C.R. 2505-10, SEC. 8.590.3.D.8.
CQ05	THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. PLEASE RESUBMIT PAR WITH THE INVOICED ACQUISITION COST FOR THIS ITEM TO THE APPROPRIATE AUTHORIZING AGENCY LISTED IN APPENDIX D. CURRENT MEDICAID SUPPLY BULLETIN AND 10 C.C.R. 2505-10, SEC. 8.590.4.D.5.C.
CQ06	THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. WHEELCHAIR PURCHASES MUST HAVE THE MANUFACTURER, BRAND NAME AND MODEL NAME. PLEASE RESUBMIT PAR WITH THE INFORMATION REQUESTED ABOVE TO THE APPROPRIATE AUTHORIZING AGENCY LISTED IN APPENDIX D.
CQ07	THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. REQUESTING PROVIDERS MUST HAVE PRESCRIPTIVE AUTHORITY FOR THIS ITEM. PLEASE RESUBMIT PAR WITH THE NAME OF THE PRESCRIBING PHYSICIAN TO THE APPROPRIATE AUTHORIZING AGENCY LISTED IN APPENDIX D. CURRENT MEDICAID SUPPLY BULLETIN.
CQ08	THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. THE PRIOR AUTHORIZATION REQUEST REQUIRES A PHYSICIAN'S SIGNATURE. PLEASE RESUBMIT PAR WITH A PHYSICIAN?S SIGNATURE TO THE APPROPRIATE AUTHORIZING AGENCY LISTED IN APPENDIX D.
CQ09	THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. PROCEDURE CODE REQUESTED IS INVALID/INCORRECT OR INCOMPLETE. PLEASE RESUBMIT PAR WITH PROPER CODE(S) FROM THE CURRENT MEDICAID SUPPLY BULLETIN TO THE APPROPRIATE AUTHORIZING AGENCY LISTED IN APPENDIX D.
CQ10	THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. PLEASE RESUBMIT PAR WITH THE NAME OF MEDS, FREQUENCY, ROUTE AND LENGTH OF NEED TO THE APPROPRIATE AUTHORIZING AGENCY LISTED IN APPENDIX D. CURRENT MEDICAID SUPPLY BULLETIN AND 10 C.C.R. 2505-10, SEC. 8. 590.3.D.
CQ11	THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. PLEASE RESUBMIT PAR WITH THE NUMBER OF UNITS REQUESTED TO THE APPROPRIATE AUTHORIZING AGENCY LISTED IN APPENDIX D.

DENIAL CODE	LONG DESCRIPTION
CQ12	THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. PAR DATES MUST BE FOR ONE YEAR. PLEASE RESUBMIT PAR WITH CORRECTED DATE SPAN OR PROVIDE AN EXPLANATION AS TO WHY DATES ARE LESS THAN ONE YEAR TO THE APPROPRIATE AUTHORIZING AGENCY LISTED IN APPENDIX D. PLEASE REFER TO THE CURRENT MEDICAID SUPPLY BULLETIN.
CQ13	THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. ADDITIONAL INFORMATION IS REQUIRED FOR THIS ITEM. PLEASE RESUBMIT PAR AND INCLUDE WHETHER THESE ITEMS ARE INTENDED FOR USE WITH A CLIENT OWNED PIECE OF EQUIPMENT TO THE APPROPRIATE AUTHORIZING AGENCY LISTED IN APPENDIX D. CURRENT MEDICAID SUPPLY BULLETIN.
CQ14	THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. ADDITIONAL INFORMATION IS REQUIRED FOR THIS ITEM. PLEASE RESUBMIT PAR AND DESCRIBE 1) THE CLIENT?S LEVEL OF IMPAIRMENT, 2) WHAT HAS BEEN USED IN THE PAST, 3) IF THE CLIENT HAS AVAILABLE ASSISTANCE 4) WHY THIS CLIENT IS IN NEED OF THIS EQUIPMENT/SUPPLY TO THE APPROPRIATE AUTHORIZING AGENCY LISTED IN APPENDIX D.
CQ15	THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. ADDITIONAL INFORMATION IS REQUIRED FOR THIS ITEM. PLEASE RESUBMIT PAR AND DESCRIBE 1) EXACTLY WHY THIS ITEM IS NEEDED, 2) WHAT IT WILL BE USED FOR, 3) THE INTENDED USE FOR THIS ITEM TO THE APPROPRIATE AUTHORIZING AGENCY LISTED IN APPENDIX D.
CQ16	THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. PRODUCT INFORMATION IS REQUIRED ON THIS ITEM. PLEASE RESUBMIT PAR WITH PRODUCT INFORMATION TO THE APPROPRIATE AUTHORIZING AGENCY LISTED IN APPENDIX D.
CQ17	THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. A SERIAL NUMBER IS REQUIRED FOR ALL REPAIRS. PLEASE RESUBMIT PAR WITH THE SERIAL NUMBER FOR THE REPAIR TO THE APPROPRIATE AUTHORIZING AGENCY LISTED IN APPENDIX D.
CQ18	*INACTIVE* THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. HOSPITAL BED QUESTIONNAIRE #1 IS NEEDED TO REVIEW THIS REQUEST. PLEASE RESUBMIT PAR WITH THE INFORMATION REQUESTED TO THE APPROPRIATE AUTHORIZING AGENCY LISTED IN APPENDIX D.
CQ19	*INACTIVE* THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. PRESSURE RELIEF MATTRESS QUESTIONNAIRE #2 IS NEEDED TO REVIEW THIS REQUEST. PLEASE RESUBMIT PRIOR AUTHORIZATION REQUEST WITH THE INFORMATION REQUESTED TO THE APPROPRIATE AUTHORIZING AGENCY LISTED IN APPENDIX D.
CQ20	*INACTIVE* THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. PATIENT LIFT QUESTIONNAIRE #3 IS NEEDED TO REVIEW THIS REQUEST. PLEASE RESUBMIT PAR WITH THE INFORMATION REQUESTED TO THE APPROPRIATE AUTHORIZING AGENCY LISTED IN APPENDIX D.
CQ21	*INACTIVE* THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. ELECTRIC/POWER LIFT QUESTIONNAIRE #3 IS NEEDED TO REVIEW THIS REQUEST. PLEASE RESUBMIT PAR WITH THE INFORMATION REQUESTED TO THE APPROPRIATE AUTHORIZING AGENCY LISTED IN APPENDIX D.
CQ22	*INACTIVE* THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. SEAT LIFT QUESTIONNAIRE #4 IS NEEDED TO REVIEW THIS REQUEST. PLEASE RESUBMIT PAR WITH THE INFORMATION REQUESTED TO THE APPROPRIATE AUTHORIZING AGENCY LISTED IN APPENDIX D.
CQ23	*INACTIVE* THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. BLOOD PRESSURE UNIT/MONITOR QUESTIONNAIRE #5 IS NEEDED TO REVIEW THIS REQUEST. PLEASE RESUBMIT PAR WITH THE INFORMATION REQUESTED TO THE APPROPRIATE AUTHORIZING AGENCY LISTED IN APPENDIX D.
CQ24	*INACTIVE* THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. PULSE OXIMETER QUESTIONNAIRE #6 (WITH SAO2 READINGS) IS NEEDED TO REVIEW THIS REQUEST. PLEASE RESUBMIT PAR WITH THE INFORMATION REQUESTED TO THE APPROPRIATE AUTHORIZING AGENCY LISTED IN APPENDIX D.
CQ25	*INACTIVE* THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. APNEA MONITOR QUESTIONNAIRE #7 IS NEEDED TO REVIEW THIS REQUEST. PLEASE RESUBMIT PAR WITH THE INFORMATION REQUESTED TO THE APPROPRIATE AUTHORIZING AGENCY LISTED IN APPENDIX D.

DENIAL CODE	LONG DESCRIPTION
CQ26	*INACTIVE* THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. CPAP/BIPAP QUESTIONNAIRE #8 WITH COPY OF SLEEP STUDY IS NEEDED TO REVIEW THIS REQUEST. PLEASE RESUBMIT PAR WITH THE INFORMATION REQUESTED TO THE APPROPRIATE AUTHORIZING AGENCY LISTED IN APPENDIX D.
CQ27	*INACTIVE* THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. TENS OR NMES QUESTIONNAIRE #9 IS NEEDED TO REVIEW THIS REQUEST. PLEASE RESUBMIT PAR WITH THE INFORMATION REQUESTED TO THE APPROPRIATE AUTHORIZING AGENCY LISTED IN APPENDIX D.
CQ28	*INACTIVE* THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. ORAL AND ENTERAL NUTRITION FORMULA QUESTIONNAIRE #10 (WITH PARTICULAR ATTENTION TO THE NUMBER OF CALORIES PER DAY) IS NEEDED TO REVIEW THIS REQUEST. PLEASE RESUBMIT PAR WITH THE INFORMATION REQUESTED TO THE APPROPRIATE AUTHORIZING AGENCY LISTED IN APPENDIX D.
CQ29	*INACTIVE* THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. ADULT ORTHOTICS AND PROSTHETICS QUESTIONNAIRE #11 IS NEEDED TO REVIEW THIS REQUEST. PLEASE RESUBMIT PAR WITH THE INFORMATION REQUESTED TO THE APPROPRIATE AUTHORIZING AGENCY LISTED IN APPENDIX D.
CQ30	*INACTIVE* THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. WOUND CLOSURE THERAPY QUESTIONNAIRE #12 IS NEEDED TO REVIEW THIS REQUEST. PLEASE RESUBMIT PAR WITH THE INFORMATION REQUESTED TO THE APPROPRIATE AUTHORIZING AGENCY LISTED IN APPENDIX D.
CQ31	*INACTIVE* THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. AUGMENTATIVE COMMUNICATION DEVICE QUESTIONNAIRE #13 IS NEEDED TO REVIEW THIS REQUEST. PLEASE RESUBMIT PAR WITH THE INFORMATION REQUESTED TO THE APPROPRIATE AUTHORIZING AGENCY LISTED IN APPENDIX D.
CQ32	*INACTIVE* THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. MECHANICAL HIGH FREQUENCY CHEST WALL OSCILLATION QUESTIONNAIRE #14 IS NEEDED TO REVIEW THIS REQUEST. PLEASE RESUBMIT PAR WITH THE INFORMATION REQUESTED TO THE APPROPRIATE AUTHORIZING AGENCY LISTED IN APPENDIX D.
CQ33	*INACTIVE* THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. WHEELCHAIR TILT/RECLINE DEVICE QUESTIONNAIRE #15 IS NEEDED TO REVIEW THIS REQUEST. PLEASE RESUBMIT PAR WITH THE INFORMATION REQUESTED TO THE APPROPRIATE AUTHORIZING AGENCY LISTED IN APPENDIX D.
CQ34	THIS IS NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. THE QUESTIONNAIRE FORM YOU SUBMITTED IS NO LONGER VALID. PLEASE RESUBMIT PAR WITH THE CURRENT QUESTIONNAIRE FORM TO THE APPROPRIATE AUTHORIZING AGENCY LISTED IN APPENDIX D.
CQ35	PRIOR AUTHORIZATION REQUESTS MUST BE SUBMITTED ON PAPER FOR THE FOLLOWING ITEMS: ELECTRIC WHEELCHAIRS, SCOOTERS, ORTHOTICS AND PROSTHETICS, AUGMENTATIVE COMMUNICATION DEVICES. PLEASE SEND THE PRIOR AUTHORIZATION REQUEST FOR THESE ITEMS DIRECTLY TO THE APPROPRIATE AUTHORIZING AGENCY LISTED IN APPENDIX D.
CQ36	CLIENT HAS NOT UTILIZED THE EQUIPMENT IN THE MANNER FOR WHICH IT WAS INTENDED. REPAIRS AND/OR REPLACEMENT OF EQUIPMENT WILL NOT BE ALLOWED IN CASES OF REPEATED MISUSE.
CQ37	THIS PRODUCT CANNOT BE APPROVED AS ITS PRIMARY PURPOSE IS TO EITHER ENHANCE THE PERSONAL COMFORT OF THE CLIENT OR PROVIDE CONVENIENCE FOR THE CLIENT CAREGIVER.
CQ38	THIS IS A REJECTION, NOT A FINAL DENIAL. PLEASE DO NOT SUBMIT AN APPEAL REQUEST. COMPLETION OF PAR REQUIREMENTS HAVE NOT BEEN MET.
CQ39	SAME OR SIMILAR SERVICES HAVE ALREADY BEEN PREVIOUSLY APPROVED FOR THIS CLIENT.
CY01	*INACTIVE* CLIENT PAR IS SENT TO THE WRONG AUTHORIZING AGENT. PLEASE REFER TO APPENDIX D FOR THE APPROPRIATE AUTHORIZING AGENCY WHEN SUBMITTING EPSDT HH, OR OUTPATIENT THERAPY PARS.
CY03	*INACTIVE* PAR FORM HAS BEEN SUBMITTED LATER THAN 10 BUSINESS DAYS FROM THE PAR START DATE. PAR UNITS HAVE BEEN ADJUSTED.
CY04	*INACTIVE* PAR FORM HAS BEEN SUBMITTED LATER THAN 10 BUSINESS DAYS FROM THE PAR START DATE. PAR UNITS HAVE BEEN ADJUSTED.

DENIAL CODE	LONG DESCRIPTION
CZ01	*INACTIVE* CLIENT PAR IS SENT TO THE WRONG AUTHORIZING AGENT. PLEASE REFER TO APPENDIX D FOR THE APPROPRIATE AUTHORIZING AGENCY WHEN SUBMITTING EPSDT HH, OR OUTPATIENT THERAPY PARS.
CZ02	*INACTIVE* BASED ON THE NEEDS OF THE CLIENT, AUTHORIZATION IS BEING GIVEN FOR A LESSER AMOUNT OF SERVICES THAN REQUESTED.
CZ03	PAR FORM HAS BEEN SUBMITTED LATER THAN 10 BUSINESS DAYS FROM THE PAR START DATE. PAR UNITS HAVE BEEN ADJUSTED.
CZ04	THE REQUESTED INFORMATION HAS NOT BEEN SUBMITTED. YOU MAY SUBMIT A NEW PAR WITH THE REQUESTED INFORMATION-HOME HEALTH PLAN OF CARE AND/OR THERAPY ASSESSMENTS, CURRENT CLINICAL SUMMARY.
CZ05	*INACTIVE* HOME HEALTH SERVICES SHALL BE PROVIDED AT THE CLIENT PLACE OF RESIDENCE (EXCLUDING NURSING FACILITIES AND HOSPITALS) EXCEPT FOR EPSDT EXTRAORDINARY HH WHICH IS PRIOR AUTHORIZED USING A DIFFERENT PROCESS AND FORM.
CZ06	*INACTIVE* CLIENT PAR IS SENT TO THE WRONG AUTHORIZING AGENT, PRIVATE DUTY NURSING PARS AND APPLICATION PAPERWORK SHOULD BE SUBMITTED TO THE AUTHORIZING AGENCY LISTED IN APPENDIX D.
CZ07	*INACTIVE* THE REVENUE CODE IS ALREADY AUTHORIZED FOR THIS CLIENT, THIS PROVIDER, THIS DATE SPAN. PLEASE BILL USING THE INFORMATION ON THE ORIGINAL PAR, OR SUBMIT A NEW PAR FOR REVISION TO INCREASE SERVICES.
CZ08	*INACTIVE* THE CLINICAL INFORMATION DOES NOT SUBSTANTIATE MEDICAL NECESSITY.
CZ09	*INACTIVE* THE REQUESTED ADDITIONAL INFORMATION IS INSUFFICIENT. COMPLETION OF THE REQUESTED INFORMATION IS REQUIRED TO REVIEW THIS PRIOR AUTHORIZATION.
CZ10	THE AGENCY IS NOT A MEDICAID PROVIDER.
CZ11	*INACTIVE* CLIENT PAR IS SENT TO THE WRONG AUTHORIZING AGENT. PLEASE REFER TO APPENDIX D FOR THE APPROPRIATE AUTHORIZING AGENCY.
CZ12	THE ITEM OR SERVICE REQUESTED IS NOT A MEDICAID HOME HEALTH BENEFIT.
CZ13	SKILLED THERAPIES ARE NOT A BENEFIT UNDER ADULT LONG TERM HOME HEALTH.
CZ14	REVISIONS FOR INCREASES TO HOME HEALTH SERVICES SHALL BE SUBMITTED AND PROCESSED ACCORDING TO THE SAME REQUIREMENTS DEFINED FOR NEW PARS, AND SHALL BE SUBMITTED TIMELY AND INCLUDE A CURRENT PLAN OF CARE, PHYSICIAN?S ORDERS AND ANY OTHER REQUIRED DOCUMENTATION TO SUPPORT THE REVISION AS LISTED IN THE HOME HEALTH BENEFIT COVERAGE STANDARD.
CZ15	BASED ON THE NEEDS OF THE CLIENT, AUTHORIZATION IS BEING GIVEN FOR A LESSER AMOUNT OF SERVICES THAN REQUESTED.
CZ16	THIS CLIENT IS 21 YEARS OR OLDER AND HOME HEALTH SERVICES SHALL BE PROVIDED AT THE CLIENT PLACE OF RESIDENCE (EXCLUDING NURSING FACILITIES AND HOSPITALS).
CZ17	THE CLIENT IS 18 YEARS OR OLDER AND THE PAR WAS SENT TO THE WRONG AUTHORIZING AGENT; ADULT LONG TERM HOME HEALTH PARS AND APPLICABLE PAPERWORK SHOULD BE SUBMITTED TO THE AUTHORIZING AGENCY LISTED IN APPENDIX D.
CZ18	THE REVENUE CODE IS ALREADY AUTHORIZED FOR THIS CLIENT, THIS PROVIDER AND/OR THIS DATE SPAN. PLEASE BILL USING THE INFORMATION ON THE ORIGINAL PAR, OR SUBMIT A NEW PAR REVISION TO INCREASE OR CHANGE SERVICES.
CZ19	THE CLINICAL INFORMATION DOES NOT SUBSTANTIATE MEDICAL NECESSITY.
CZ20	THE INFORMATION SUBMITTED IS INSUFFICIENT TO MAKE A MEDICAL NECESSITY DETERMINATION. ADDITIONAL INFORMATION IS REQUIRED TO REVIEW THIS PRIOR AUTHORIZATION.
CZ21	THE COLORADO MEDICAL ASSISTANCE PROGRAM PREVIOUSLY SENT A LETTER NOTIFYING YOU OF A DECREASE IN YOUR HOME HEALTH SERVICES AND WANTS TO MAKE SURE YOU HAVE RECEIVED ALL OF THE INFORMATION YOU NEED. YOU MAY BE ELIGIBLE FOR A PLAN TO DECREASE THE AMOUNT OF SERVICES OVER A THREE MONTH PERIOD OF TIME TO HELP ADJUST TO THE CHANGE. YOU MAY TALK WITH YOUR CASE MANAGER OR HOME HEALTH PROVIDER TO MAKE A STEP-DOWN PLAN IF YOU NEED ONE. IF YOU HAVE NOT HEARD FROM YOUR CASE MANAGER OR PROVIDER, OR IF YOU HAVE ANY QUESTIONS, PLEASE CALL 303-866-3447.
P001	THE BILLING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THE SERVICES.

DENIAL CODE	LONG DESCRIPTION
P002	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P003	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P005	THE PRIOR AUTHORIZATION CAN NOT BE END DATED. THE PRIOR AUTHORIZATION STATUS IS NOT APPROVED OR APPROVED WITH REVISIONS.
P006	PLEASE FURNISH THE PROCEDURE CODE AND CORRESPONDING DESCRIPTION.
P008	THE BILLING PROVIDER NUMBER IS INVALID.
P009	THE BILLING PROVIDER NUMBER IS INVALID.
P010	THE REQUESTED END DATE IS INVALID.
P011	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P012	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P013	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P014	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P015	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P016	THE REQUESTED START DATE IS MISSING OR INVALID.
P019	THE REQUESTED START DATE IS MISSING OR INVALID.
P020	THE RENDERING PROVIDER NUMBER IS INVALID.
P021	THE RENDERING PROVIDER NUMBER IS INVALID.
P022	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P023	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P024	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P026	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P027	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P030	FIRST MODIFIER IS INVALID.
P031	FIRST MODIFIER IS INVALID.
P032	SECOND MODIFIER IS INVALID.
P033	SECOND MODIFIER IS INVALID.
P034	THIRD MODIFIER IS INVALID.
P035	THIRD MODIFIER IS INVALID.
P036	FOURTH MODIFIER IS INVALID.
P037	FOURTH MODIFIER IS INVALID.
P038	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P039	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P040	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P041	CLIENTS FIRST NAME IS MISSING.
P042	CLIENTS LAST NAME IS MISSING.
P043	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P044	BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES REQUESTED.
P045	FIRST MODIFIER IS INVALID.
P046	SECOND MODIFIER IS INVALID.
P047	THIRD MODIFIER IS INVALID.
P048	FOURTH MODIFIER IS INVALID.
P052	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P053	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P054	RENDERING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES FOR THE BENEFIT PLAN.
P055	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.

DENIAL CODE	LONG DESCRIPTION
P061	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P062	THE CLIENT ID AND/OR NAME INDICATED ON THE PA REQUEST IS INCORRECT. THE CLIENT ID AND/OR NAME HAS BEEN UPDATED. PLEASE VERIFY THE ID AND/OR NAME IS CORRECT.
P064	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
P067	THE FREQUENCY OF HOURS REQUESTED ARE NOT APPROPRIATE FOR THIS CLIENT AND HAVE BEEN MODIFIED ACCORDINGLY.
P079	BILLING PROVIDER IS ON PAYMENT SUSPENSION DUE TO CREDIBLE ALLEGATION OF FRAUD.
P120	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAS BEEN REDUCED.
P121	THE SERVICE/ PROCEDURE REQUESTED IS NOT SUPPORTED BY SUBMITTED DOCUMENTATION.
P126	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
P128	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.
P138	SERVICE(S) DO NOT MEET COLORADO MEDICAID GUIDELINES.
P167	REQUESTED DOCUMENTATION HAS NOT BEEN SUBMITTED.
P178	THE SERVICE REQUESTED IS NOT MEDICALLY NECESSARY.
P179	THE MEDICAL NECESSITY FOR THIS SERVICE IS NOT SUPPORTED BY THE SUBMITTED DOCUMENTATION.
P233	THE DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE ADDITIONAL CARE.
P257	THIS CLIENTS FUNCTIONAL ASSESSMENT SCORES PLACE THIS CLIENT OUTSIDE ELIGIBILITY FOR DAY TREATMENT.
P274	OUR RECORDS INDICATE THIS CLIENT IS INVOLVED IN EFFECTIVE AND APPROPRIATE SERVICE ELSEWHERE.
P292	INTENSIVE REHABILITATION HOURS ARE NO LONGER APPROPRIATE AS INDICATED BY HISTORY, DIAGNOSIS, AND/ OR FUNCTIONAL ASSESSMENT SCORES.
P328	THE SERVICES REQUESTED INCLUDE NON-COVERED SERVICES, AND HOURS ARE REDUCED ACCORDINGLY.
P339	THE CLIENTS PAST HISTORY INDICATES REDUCED TREATMENT HOURS ARE WARRANTED.
P342	THE REQUEST DOES NOT MEET GENERALLY ACCEPTED CONDITIONS REQUIRING FLUORIDE TREATMENTS.
P346	SERVICES EXCEED COLORADO MEDICAID LIMITATION AND DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE MEDICAL NECESSITY OF THE SERVICE.
P349	THE SERVICE REQUESTED WAS PERFORMED LESS THAN FIVE YEARS AGO.
P353	THE EXISTING APPLIANCE HAS NOT BEEN WORN FOR THREE YEARS.
P367	THE CLIENT HAS BEEN TOTALLY WITHOUT TEETH AND AN APPLIANCE FOR FIVE YEARS.
P392	THE CLIENT IS MISSING AN ANTERIOR TOOTH AND/OR HAS TWO OR MORE POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P405	THE SERVICE(S) REQUESTED COULD ADEQUATELY BE PERFORMED IN THE DENTAL OFFICE.
P406	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE OF GOOD PERIODONTAL HEALTH (AMERICAN ACADEMY OF PERIODONTOLOGY PERIODONTAL CLASSIFICATION OF TYPE I OR II).
P407	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE VISIBLE ON RADIOGRAPHS THAT AT LEAST 50 PERCENT OF THE CLINICAL CROWN IS INTACT.
P409	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING SIX OR MORE TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED, INCLUDING THIRD MOLARS.
P410	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING ONE OR MORE ANTERIOR TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED.
P411	DOCUMENTATION DOES NOT SUPPORT THE NEED FOR PERIODONTIC SERVICES. POCKETS ARE LESS THAN 4MM AND/OR GREATER THAN 6MM FOR CLIENT AND/OR THE CLIENT IS UNDER THE AGE OF 13.
P412	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA.
P413	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA. THIS PA HAS BEEN GRANTED AS APPROVED NOT APPROVED WITH REVISIONS. THE DURATION REQUESTED MAY HAVE BEEN REDUCED TO REFLECT COVERAGE LIMITATIONS, PRESCRIBER ORDERS, CONFLICTI
P417	THE SERVICE(S) REQUESTED COULD BE ADEQUATELY PERFORMED WITH LOCAL ANESTHESIA.
P437	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO POOR ORAL HYGIENE.
P444	THIS LINE ITEM IS A DUPLICATE OF ANOTHER LINE ITEM ON THIS PRIOR AUTHORIZATION (PA) REQUEST. PLEASE CORRECT.

DENIAL CODE	LONG DESCRIPTION
P446	THIS IS A DUPLICATE OF AN EXISTING PRIOR AUTHORIZATION (PA) REQUEST. YOU MAY CONTACT PROVIDER SERVICES IF YOU REQUIRE ASSISTANCE. DUPLICATE PA REQUEST
P448	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO DECAY HISTORY.
P449	QUESTIONABLE LONG TERM PROGNOSIS DUE TO GUM AND BONE DISEASE.
P456	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO APPARENT ROOT INFECTION.
P457	OUR RECORDS INDICATE THIS CLIENT HAS EXCEEDED ESTABLISHED PROGRAM LIMITATIONS. COLORADO MEDICAID WILL NOT AUTHORIZE NEW DENTURES.
P458	DOCUMENTATION PROVIDED INDICATES A LESS ELABORATE PROCEDURE SHOULD BE CONSIDERED.
P502	RENTAL ONLY ALLOWED; MEDICAL NEED FOR PURCHASE HAS NOT BEEN DOCUMENTED.
P503	PURCHASE ONLY ALLOWED; MEDICAL NEED FOR RENTAL HAS NOT BEEN DOCUMENTED.
P504	OCCUPATIONAL THERAPY GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P505	THE SERVICE REQUESTED IS INCLUDED IN THE NURSING HOME RATE STRUCTURE.
P511	THIS NATIONAL DRUG CODE IS ONLY BILLABLE AS PART OF A COMPOUND DRUG.
P515	THE PRESENCE OF A HANDICAPPING MALOCCLUSION OR HANDICAPPING DENTOFACIAL DEFORMITY IS NOT SUPPORTED BY THE DOCUMENTATION SUBMITTED.
P521	THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVERED BY COLORADO MEDICAID.
P522	GASTRO-INTESTINAL SURGERY FOR THE PURPOSE OF WEIGHT CONTROL IS COVERED ONLY AS A LIFE THREATENING PROCEDURE.
P523	THE TREATMENT REQUEST IS NOT CONSISTENT WITH THE CLIENT'S DIAGNOSIS.
P524	PSYCHOTHERAPY PROVIDED IN THE CLIENTS HOME IS NOT A COVERED BENEFIT OF COLORADO MEDICAID.
P525	THE INFORMATION PROVIDED IS NOT CONSISTENT WITH THE INTENSITY OF SERVICES REQUESTED.
P526	INTENSIVE MULTIPLE MODALITY TREATMENT IS NOT CONSISTENT WITH THE INFORMATION PROVIDED.
P527	MULTIPLE PROVIDERS OF TREATMENT ARE NOT INDICATED FOR THIS CLIENT.
P528	THE DURATION OF TREATMENT SESSIONS EXCEED CURRENT COLORADO MEDICAID GUIDELINES.
P534	DOCUMENTATION OF POOR PHYSICAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P535	OTHER PHYSICAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P536	THE PHYSICAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P537	USE OF PHYSICAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P538	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF A PHYSICAL THERAPIST.
P539	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS AND LIVING ARRANGEMENT.
P540	GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P541	THE PROCEDURE(S) REQUESTED ARE NOT MEDICAL IN NATURE.
P542	DOCUMENTATION OF POOR OCCUPATIONAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P543	DOCUMENTATION OF POOR SPEECH THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P544	OTHER OCCUPATIONAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P546	THE OCCUPATIONAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P547	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF PHYSICAL THERAPY.
P548	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P549	ACTIVITIES TO PROMOTE DIVERSION OR GENERAL MOTIVATION ARE NONCOVERED COLORADO MEDICAID SERVICES.
P550	REVISIONS OF THE REQUEST IS NECESSITATED BY THE CLIENTS MINIMAL PROGRESS.

DENIAL CODE	LONG DESCRIPTION
P551	RESTORATIVE NURSING INVOLVEMENT COULD BE INCREASED.
P552	CLIENTS DEMONSTRATED RESPONSE TO CURRENT THERAPY DOES NOT WARRANT THE INTENSE FREQUENCY REQUESTED.
P553	MAINTENANCE IS TWO TIMES PER WEEK OR LESS.
P554	THE SPEECH THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P555	USE OF OCCUPATIONAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P556	USE OF SPEECH THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P557	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF AN OCCUPATIONAL THERAPIST.
P558	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
P559	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P560	THE MATERIALS/ SERVICES REQUESTED ARE PRINCIPALLY COSMETIC IN NATURE.
P561	THE LENS FORMULA DOES NOT JUSTIFY REPLACEMENT.
P562	THE CHANGE IN THE LENS FORMULA DOES NOT WARRANT MULTIPLE REPLACEMENTS.
P563	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P564	LENSES ONLY ARE APPROVED; PLEASE DISPENSE A CONTRACTED FRAME. THE NON-CONTRACTED FRAME IS NOT MEDICALLY JUSTIFIED.
P565	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P566	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P567	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF OCCUPATIONAL THERAPY.
P568	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF SPEECH THERAPY.
P569	LEVEL, INTENSITY, OR EXTENT OF SERVICE(S) REQUESTED HAS BEEN MODIFIED CONSISTENT WITH MEDICAL NEED AS DEFINED IN THE PLAN OF CARE.
P570	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P571	THE SERVICE ASKED FOR IS NOT COVERED BY COLORADO MEDICAID AS THESE TASKS CAN BE DONE BY NURSES OR ACTIVITY STAFF.
P572	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P573	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.
P574	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P575	MEDICAL NEED FOR EQUIPMENT/ SUPPLY REQUESTED IS NOT SUPPORTED BY DOCUMENTATION SUBMITTED.
P576	OTHER SPEECH THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P577	DOCUMENTATION SUBMITTED IDENTIFIES THAT THE CLIENT HAS FEWER THAN TWO POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P582	LESS EXPENSIVE ALTERNATIVE SERVICES ARE AVAILABLE FOR THIS CLIENT.
P634	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P711	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING PERIODONTAL SCALING AND ROOT PLANNING.
P712	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING GINGIVECTOMY.
P754	AN APPROVED SUBSTANCE ABUSE DAY TREATMENT PROGRAM CANNOT EXCEED A SIX WEEK PERIOD.
P761	THE CLIENT DOES NOT APPEAR TO BE ABLE OR WILLING TO ABSTAIN FROM ALCOHOL/DRUG USAGE WHILE IN TREATMENT. THEREFORE, SUBSTANCE ABUSE DAY TREATMENT SERVICES ARE NOT APPROVED.
P764	THIS CLIENT HAS COMPLETED INTENSIVE SUBSTANCE ABUSE TREATMENT WITHIN THE PAST 12 MONTHS. THE DOCUMENTATION PROVIDED IS NOT ADEQUATE TO JUSTIFY ADDITIONAL INTENSIVE TREATMENT AT THIS TIME.

DENIAL CODE	LONG DESCRIPTION
P785	A LESS THAN SIX-WEEK HEALING PERIOD HAS BEEN SPECIFIED FOR THIS PRIOR AUTHORIZATION. THEREFORE IT IS NOT NECESSARY TO WAIT THE FULL SIX WEEKS AFTER EXTRACTIONS BEFORE TAKING DENTURE IMPRESSIONS.
P818	SIX-WEEK HEALING TIME IS REQUIRED BETWEEN EDENTULATION AND FINAL IMPRESSIONS. PAYMENT FOR DENTURES WILL BE DENIED OR RECOUPED IF HEALING PERIOD IS NOT OBSERVED.
P849	COLORADO MEDICAID HAS DETERMINED THERE WERE (ARE) SEVERAL HOME HEALTH AGENCIES WILLING TO PROVIDE MEDICALLY NECESSARY SKILLED NURSING SERVICES TO THIS CLIENT.
P864	THE DOCUMENTATION YOU HAVE SUBMITTED DOES NOT MEET THE REQUIREMENTS OF COLORADO MEDICAID.
P873	THE MEDICAL NECESSITY FOR THE HOURS REQUESTED IS NOT SUPPORTED BY THE INFORMATION SUBMITTED.
P874	THE DOCUMENTATION SUBMITTED INDICATES THE TASKS SPECIFIED CAN BE COMPLETED DURING THE VISITS APPROVED.
P878	THE DOCUMENTATION SUBMITTED DOES NOT INDICATE THAT MEDICALLY ORIENTED TASKS ARE MEDICALLY NECESSARY; THEREFORE PERSONAL CARE SERVICES HAVE BEEN APPROVED.
P880	THE QUANTITY OF SERVICES AUTHORIZED FOR THIS CLIENTS PERSONAL CARE HAS BEEN AMENDED BASED ON INFORMATION RECEIVED FROM ONE OR MORE OF THESE SOURCES: THE CLIENT, THEIR PHYSICIAN, AND/OR THE IN-HOME VISIT BY STAFF OF THE OIG (OFFICE OF INSPECTOR GENERAL).
P885	THE USE OF THIS DRUG FOR THE INTENDED PURPOSE IS NOT COVERED BY COLORADO MEDICAID, CONSISTENT WITH COLORADO ADMINISTRATIVE CODE AND FEDERAL LAW.
P924	THE MEDICAL RECORDS SUBMITTED WITH THE CURRENT REQUEST CONFLICT OR DISAGREE WITH OUR MEDICAL RECORDS ON THIS CLIENT.
P950	INDEPENDENT NURSES, PLEASE NOTE PAYABLE SERVICES MAY NOT EXCEED 12 HOURS/DAY OR 60 HOURS/WEEK.
P951	SERVICES CAN ONLY BE AUTHORIZED THROUGH ONE YEAR FROM THE PRESCRIPTION DATE.
P952	LEAD INSPECTION IS A COVERED COLORADO MEDICAID SERVICE WHEN THE CHILD HAS BEEN SHOWN TO HAVE LEAD POISONING (E.G., CHILD HAS A BLOOD LEAD LEVEL > 19 UG/DL OR TWO CONSECUTIVE BLOOD LEAD LEVELS OF 15-19 UG/DL DONE AT LEAST 90 DAYS APART). THE INSPECTION MUS
P953	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P954	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P956	THE REQUEST CAN ONLY BE BACKDATED A MAXIMUM OF 14 DAYS FROM FIRST DATE RECEIVED BY COLORADO MEDICAID.
P957	COMPLETE PERIODONTAL CHARTING AT TIME OF SERVICE, AND SUBMIT CHARTING, COPY OF OPERATIVE REPORT, TOGETHER WITH A COPY OF THE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF), F-11035, TO PA UNIT ATTENTION DENTAL CONTSULTANT.
P958	NOTE THAT CODE D4341 HAS BEEN CHANGED. REFER TO THE DECISION NOTICE FOR AUTHORIZED QUANTITY.
P960	YOUR PA HAS BEEN APPROVED FOR 90 DAYS. THE 90 DAY APPROVAL DOES NOT IMPLY THE PA REQUEST MEETS PRIOR AUTHORIZATION CRITERIA. AFTER ADDITIONAL INFORMATION IS AVAILABLE IN INTERCHANGE, COLORADO MEDICAID WILL CREATE AN AMENDMENT REQUEST TO EXTEND THE PA FOR
P961	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P962	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
PA10	THE REQUESTED END DATE IS INVALID.
PA12	PLEASE FURNISH A WRITTEN DESCRIPTION OF THE CLIENTS DIAGNOSIS.
PA13	PROVIDE DIAGNOSES WITH DATES OF ONSET.
PA14	IDENTIFY PROBLEMS TO BE TREATED.
PA15	THE AUDIOLOGISTS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1), F-11020, AND PRIOR AUTHORIZATION REQUEST/HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2), F-11021.

DENIAL CODE	LONG DESCRIPTION
PA16	THE PHYSICIANS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION/PHYSICIAN OTOLOGICAL REPORT (PA/POR), F-11019.
PA17	SUBMIT BRIEF HISTORY WITH REFERRAL INFORMATION, LIVING SITUATION, FUNCTIONAL STATUS, AND OTHER PERTINENT INFORMATION. WHAT CHANGE OF STATUS RESULTED IN REFERRAL AT THIS TIME?
PA18	PLEASE FURNISH THE CLIENTS HEIGHT AND WEIGHT.
PA19	PLEASE SUBMIT CLINICAL INFORMATION SUFFICIENT TO VERIFY THE NEED FOR THE REQUESTED SERVICE(S).
PA20	PLEASE RESUBMIT WITH COMPLETE PERIODONTAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PA21	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL EDUCATIONAL PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA22	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL PROGRAM PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA23	REFER TO THE DURABLE MEDICAL EQUIPMENT INDEX FOR APPROPRIATE CODE AND DESCRIPTION. DO NOT USE AN "UNLISTED" CODE.
PA24	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUALIZED FAMILY SERVICE PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA25	INFORMATION ON THE REQUEST FORM IS ILLEGIBLE, AND THE REQUEST CANNOT BE PROCESSED.
PA26	RE-EVALUATE YOUR GOALS. EMPHASIS SHOULD BE ON FUNCTIONAL SELF-CARE. GOALS MUST BE RELATED TO FUNCTIONAL OUTCOME.
PA27	PLEASE CLARIFY THE NUMBER OF HOURS PER WEEK REQUESTED.
PA28	PLEASE CLARIFY THE NUMBER OF HOURS PER DAY REQUESTED.
PA29	PLEASE CLARIFY THE NUMBER OF VISITS PER DAY REQUESTED.
PA30	ATTACH SUPPORTIVE DOCUMENTATION; HOME EXERCISE PROGRAM AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA31	THE DIAGNOSIS CODE INDICATED ON THE REQUEST DOES NOT CORRESPOND TO THE DIAGNOSIS CODE DESCRIPTION.
PA32	PLEASE SUBMIT ADDITIONAL INFORMATION SUFFICIENT TO VERIFY APPROPRIATENESS AND NEED FOR TRANSPLANT.
PA33	PLEASE SUBMIT THE INITIAL AND PROGRESSIVE OBJECTIVE FINDINGS.
PA34	ATTACH SUPPORTIVE DOCUMENTATION, FACILITY PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA35	PLEASE SUBMIT THE CLIENTS ORIGINAL COMPLAINTS AND EXAMINATION FINDINGS.
PA36	ATTACH SUPPORTIVE DOCUMENTATION, IN-HOME AUTISM PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA37	PLEASE SUBMIT YOUR TREATMENT PLAN FOR THIS CLIENT.
PA38	ATTACH SUPPORTIVE DOCUMENTATION AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA39	INITIAL EVALUATIONS MUST BE PERFORMED BY AN OCCUPATIONAL THERAPIST REGISTERED (OTR), PER AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA) STANDARDS.
PA41	IDENTIFY THE PLACE OF SERVICE AND ITS EFFECT ON SUPPORTING THE DESIRED TREATMENT OUTCOME.
PA42	PLEASE INDICATE THE HOURS OF USE OF OXYGEN PER 24-HOUR PERIOD.
PA43	PROVIDE BASELINE DOCUMENTATION FOR THIS CLIENTS LIMITATIONS USING UNITS OF MEASUREMENT THAT ARE APPLIED CONSISTENTLY WHEN REPORTING STATUS.
PA44	IDENTIFY FUNCTIONAL LIMITATIONS AS THEY ARE RELATED TO IDENTIFIED CONDITIONS.
PA46	CORRELATE PLAN OF CARE TO REQUESTED PROCEDURE CODES.
PA47	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE FREQUENCY/DURATION REQUESTED.
PA48	PLEASE PROVIDE THE NAME AND CREDENTIALS OF THE RENDERING PROVIDER.
PA50	COLORADO MEDICAID RECORDS INDICATE THE CLIENT OWNS A WHEELCHAIR. DOCUMENT THE REASON AND NEED FOR REPLACEMENT AND COST TO REPAIR CURRENT WHEELCHAIR.
PA51	PLEASE DISTINGUISH PRIMARY AND SUPPORTIVE MODALITIES.
PA52	PLEASE SUBMIT A PROGRESS REPORT.

DENIAL CODE	LONG DESCRIPTION
PA53	MULTIPLE FAMILY CLIENTS TREATMENT BY THE SAME PROVIDER REQUIRES FURTHER INFORMATION DOCUMENTING COORDINATION OF TREATMENT PLAN.
PA54	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE MINUTES REQUESTED.
PA55	MEDICAL NECESSITY OF TREATMENT REQUIRES ADDITIONAL DOCUMENTATION.
PA56	GIVEN AGE, DIAGNOSES, CURRENT LEVEL OF FUNCTION, PAST RESPONSE TO TREATMENT, AND LIVING SITUATION, EXPAND ON POTENTIAL FOR SIGNIFICANT FUNCTIONAL PROGRESS WITHIN THE NEXT SIX MONTHS. EMPHASIZE WHY PROGRESS IS EXPECTED WITH SERVICES AT THIS TIME.
PA57	SUBMIT THE INITIAL FINDINGS. INCLUDE A COMPREHENSIVE EVALUATION.
PA58	SUBMIT PROGRESSIVE, OBJECTIVE FINDINGS. INCLUDE A PERTINENT RE-EVALUATION.
PA59	PLEASE SUPPLY INFORMATION REGARDING THE CLIENTS MEDICATION REQUIREMENTS, IF ANY.
PA60	PLEASE SPECIFY IF THE CLIENT IS IN AN EDUCATIONAL SETTING.
PA61	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA62	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
PA63	THE SKILLS OF A THERAPIST ARE PURPOSEFUL AND SKILLED INTERVENTIONS REQUIRED TO CONTINUALLY DESIGN, IMPLEMENT, REASSESS, MODIFY/GRADE, AND/OR DISCONTINUE A PLAN OF CARE IN A TIMELY MANNER, BASED ON THE COMPLEXITY OF THE CLIENTS MEDICAL CONDITION AND/OR CO
PA64	PLEASE SUBMIT A THERAPY PLAN OF CARE, INCLUDING A CURRENT, DATED EVALUATION.
PA65	A PLAN OF CARE SIGNED AND DATED BY THE PHYSICIAN IS REQUIRED.
PA66	THE SKILLS OF A THERAPIST ARE REQUIRED WHEN ONLY THE THERAPIST CAN SAFELY AND EFFECTIVELY DELIVER THE THERAPEUTIC PROCEDURES BECAUSE OF THEIR UNIQUE KNOWLEDGE, TRAINING, AND EXPERTISE. DESCRIBE THE REASON THAT SOMEONE OTHER THAN A THERAPIST CANNOT SAFELY
PA67	PLEASE SPECIFY IF THE CLIENTS WORK SITE DEMANDS GOOD BINAURAL HEARING.
PA68	DESCRIBE THE REASON, BASED ON THE CLIENTS COGNITIVE, PHYSICAL, COMMUNICATION, OR RESOURCE STATUS, THAT A HOME PROGRAM, EQUIPMENT, OR ENVIRONMENTAL ADAPTATIONS ALONE CANNOT MEET CLIENTS NEEDS.
PA69	PLEASE SPECIFY IF THE CLIENT HAS AN ACCOMPANYING DISABILITY THAT ADDS TO THE HEARING PROBLEM.
PA70	DISTINGUISH REQUESTED PROCEDURES AND GOALS FROM OTHER SERVICES THIS CLIENT RECEIVES. THEY MAY NOT BE DUPLICATIVE.
PA71	PLEASE INDICATE THE NUMBER OF DAYS REQUESTED.
PA73	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA74	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA75	PLEASE DOCUMENT CARRYOVER OF THE THERAPY PROGRAM TO NURSING.
PA76	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA79	PROVIDE EVIDENCE OF SIGNIFICANT FUNCTIONAL PROGRESS IN LAST SIX MONTHS.
PA84	THE GRANT DATE OF THIS REQUEST CANNOT BE PRIOR TO THE SIGNATURE DATE OF THE PRESCRIBING PHYSICIAN.
PA86	PROVIDE EVIDENCE OF SKILLS GAINED IN THERAPY CARRYING OVER TO OTHER SETTINGS WITHIN SIX MONTHS.
PA87	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE NUMBER OF SESSIONS REQUESTED.
PA88	THE REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL SCOPE OF PRACTICE.
PA89	PRIOR AUTHORIZATION IS NOT REQUIRED UNTIL LIMITATION OF SERVICE HAS BEEN REACHED.
PA91	PLEASE SUBMIT REQUIRED X-RAYS.
PA92	PLEASE PROVIDE AN EXPLANATION FOR THE MATERIAL SUBMITTED WITH THE REQUEST.
PA95	PLEASE DESCRIBE HOW THE PROVISION OF THIS SERVICE WOULD PREVENT INSTITUTIONALIZATION OF THE CLIENT.
PA96	COULD THE EXISTING DENTURE(S) BE RELINED OR REBASED? IF NOT, PLEASE EXPLAIN WHY NOT.

DENIAL CODE	LONG DESCRIPTION
PA97	REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL STANDARDS OF PRACTICE.
PA98	PLEASE INDICATE IF THE CLIENT IS CURRENTLY BEING TUBE FED.
PB02	PLEASE PROVIDE THE REQUIRED DATED SIGNATURES ON THE ATTACHMENTS.
PB03	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING THE LOSS/DESTRUCTION/THEFT OF THE HEARING AID.
PB04	DESCRIBE THE CLIENTS ABILITY TO STAND OR AMBULATE SUFFICIENTLY TO ACCOMPLISH SELF-CARE ACTIVITIES.
PB07	PLEASE SUBMIT AN ORTHODONTIC STUDY MODEL OR DIAGNOSTIC CASTS.
PB09	PLEASE PROVIDE A PHOTOGRAPH OF THE INVOLVED AREA(S).
PB10	PLEASE PROVIDE AN ESTIMATION (IN GRAMS) OF THE TOTAL AMOUNT OF TISSUE TO BE RESECTED.
PB11	PLEASE SUBMIT THE PLAN OF CARE FOR CO-TREATMENT.
PB12	FURNISH A DETAILED DESCRIPTION FOR THE PROCEDURE CODE REQUESTED.
PB13	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB15	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB18	PLEASE COMPLETE THE ATTACHED OUT-OF-STATE PROVIDER DATA SHEET, F-11001, AND RESUBMIT.
PB20	A SIGNED AND DATED PRESCRIPTION IS REQUIRED WITHIN THREE MONTHS OF RECEIPT BY COLORADO MEDICAID FOR INITIAL REQUESTS AND WITHIN 12 MONTHS OF RECEIPT BY COLORADO MEDICAID FOR SUBSEQUENT REQUESTS.
PB21	PLEASE COMPLETE THE APPROPRIATE PRIOR AUTHORIZATION ATTACHMENT. CONTACT PROVIDER SERVICES OR THE PRIOR AUTHORIZATION UNIT FOR ASSISTANCE.
PB23	PHYSICAL THERAPY ASSISTANT NOTES AND ALL FORMS SUBMITTED MUST BE COSIGNED BY A REGISTERED PHYSICAL THERAPIST.
PB31	ARE YOU REQUESTING A COMPLETE APPLIANCE, OR REPLACEMENT PARTS?
PB32	THE PROCEDURE CODE INDICATED ON THE REQUEST DOES NOT MATCH THE DESCRIPTION OF SERVICE; PLEASE CORRECT AND RESUBMIT.
PB35	THE SERVICE REQUESTED DOES NOT REQUIRE PRIOR AUTHORIZATION.
PB41	PLEASE FURNISH A CURRENT MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT, F-11090 (DATED WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID).
PB45	THE CERTIFICATION PERIOD ON THE PLAN OF CARE (POC) DOES NOT COVER THE REQUESTED GRANT/START DATE. PLEASE RESUBMIT YOUR REQUEST WITH A NEW POC.
PB49	A CERTIFIED OCCUPATIONAL THERAPY ASSISTANTS NOTES MUST BE COSIGNED BY AN OCCUPATIONAL THERAPIST REGISTERED.
PB51	ADDITIONAL INFORMATION IS REQUIRED ON PRIOR AUTHORIZATION TO ENABLE PRICING.
PB54	REQUESTED SERVICES DO NOT MATCH SERVICES ON THE PHYSICIANS ORDERS.
PB59	PLEASE PROVIDE AN INDIVIDUAL EDUCATIONAL PLAN (IEP), WHICH HAS BEEN SIGNED BY THE PROVIDER NO EARLIER THAN NINE MONTHS PRIOR TO RECEIPT AT COLORADO MEDICAID; OTHERWISE, DOCUMENT WHY NO IEP EXISTS.
PB65	PLEASE FURNISH THE ANTICIPATED TOTAL CHARGES FOR THIS REQUEST.
PB66	A PHOTOCOPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED; THE DATE MUST BE WITHIN SIX MONTHS OF RECEIPT BY COLORADO MEDICAID.
PB67	THE PRESCRIPTION DATE MUST INCLUDE MONTH, DAY, AND YEAR.
PB68	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID.
PB73	THE SERVICES IDENTIFIED ON THE PLAN OF CARE DO NOT APPEAR APPROPRIATE FOR THE PROCEDURE CODE(S) REQUESTED ON THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018.
PB74	THE CLIENT/PROVIDER DOES NOT HAVE RETROACTIVE ENROLLMENT.
PB75	THE REQUESTED START DATE IS MORE THAN 14 DAYS BEFORE OR 62 DAYS AFTER RECEIPT.
PB82	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
PB83	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A HOME HEALTH AIDE. PLEASE RESUBMIT AS A PERSONAL CARE WORKER OR PROVIDE ADDITIONAL DOCUMENTATION.
PB86	THE SERVICES REQUESTED ARE NOT BEING PROVIDED IN THE CLIENTS RESIDENCE. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL.

DENIAL CODE	LONG DESCRIPTION
PB87	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A NURSE. PLEASE RESUBMIT AS A HOME HEALTH AIDE OR PROVIDE ADDITIONAL DOCUMENTATION.
PB92	PLEASE FURNISH THE CLIENTS COMPLETE ADDRESS.
PB94	IF THE CLIENT IS A RESIDENT OF A NURSING HOME, SUPPLY THE COMPLETE NAME AND ADDRESS OF THE NURSING HOME.
PB99	THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018, MUST BE SIGNED AND DATED.
PC01	PLEASE SUPPLY THE RENDERING PROVIDERS PROVIDER NUMBER.
PC03	THE DRUG ENFORCEMENT ADMINISTRATION NUMBER IS MISSING OR INVALID.
PC06	PLEASE DESCRIBE YOUR PROGRAM; INCLUDE ENTRY DATE, TERMINATION DATE, HOURS PER WEEK, AND NUMBER OF WEEKS OF PRIMARY INTENSIVE SERVICE REQUESTED.
PC07	PLEASE DESCRIBE YOUR "AFTERCARE/FOLLOW-UP" PLANS FOR THIS CLIENT.
PC08	PLEASE SUPPLY DOCUMENTATION OF PREVIOUS SUBSTANCE ABUSE SERVICES WITH DATE(S) AND OUTCOME.
PC09	PLEASE DESCRIBE IN DETAIL THE TREATMENT OBJECTIVES/GOALS FOR THIS CLIENT.
PC10	PLEASE DESCRIBE THE FAMILY SITUATION/DYNAMICS. EXPLAIN HOW THE FAMILY WILL BE INCORPORATED INTO THE CLIENTS PLAN OF CARE.
PC12	PLEASE EXPLAIN IF YOUR SERVICE ENCOURAGES THE CLIENT TO ATTEND SELF-HELP GROUPS.
PC13	PLEASE SUPPLY A SPECIFIC SCHEDULE OF ACTIVITIES, INCLUDING DAY, TIME OF DAY, LENGTH OF SESSION, AND SERVICE TO BE RENDERED DURING THAT TIME.
PC15	PLEASE FURNISH DIAGNOSTIC RATIONALE.
PC17	PLEASE DOCUMENT IF THE CLIENT EVER RECEIVED SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT.
PC19	PLEASE FURNISH MORE EXTENSIVE AND IN-DEPTH HISTORICAL AND PSYCHOSOCIAL DATA.
PC20	PLEASE SUPPLY THE DATE THE CLIENT BECAME TOTALLY ENDENTULOUS.
PC23	PLEASE SUBMIT A PHYSICIANS STATEMENT REGARDING THE MEDICAL NECESSITY OF DENTURES FOR THIS CLIENT. THE PHYSICIANS STATEMENT MUST DOCUMENT THE MEDICAL NEED FOR DENTURES.
PC24	THE SERVICE REQUESTED WAS PREVIOUSLY AUTHORIZED. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT INDICATING THIS FACT IS REQUIRED.
PC25	PLEASE SUPPLY SUFFICIENT MITIGATING CIRCUMSTANCES TO WARRANT THE CONSTRUCTION OF NEW DENTURES(S).
PC26	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
PC28	PLEASE SUBMIT A PHYSICIANS STATEMENT INDICATING DENTURES ARE NECESSARY FOR THIS NURSING HOME CLIENT.
PC29	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING LOSS OR DESTRUCTION OF DENTURE(S). INCLUDE SIGNED STATEMENT FROM CLIENT OR FACILITY DIRECTOR REGARDING HOW, WHEN AND WHERE LOST.
PC30	PLEASE PROVIDE COMPLETE INTRAORAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PC31	PLEASE DESCRIBE ANY RELATED DEFORMITIES OF THE FEET.
PC34	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD WITH REQUESTED DME ITEM(S) AND DOCUMENT IF THE CLIENT CAN USE SAFELY AND INDEPENDENTLY.
PC35	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD AND DESCRIBE THE RESULTS AND EFFECTIVENESS OF THE SERVICE REQUESTED.
PC39	PLEASE INDICATE LITER FLOW PER MINUTE, HOURS OF USE PER 24 HOUR PERIOD, AND THE EXPECTED DURATION OF NEED.
PC40	THE ITEM DOES NOT REQUIRE PRIOR AUTHORIZATION UNTIL THE LIFE EXPECTANCY HAS BEEN REACHED.
PC41	PLEASE SUPPLY INFORMATION INDICATING THE NECESSITY OF POSITIONING THE CLIENT'S BODY IN MULTIPLE POSITIONS.
PC42	PLEASE INDICATE IF THE BED HEIGHT MUST BE CHANGED TO ALLOW FOR SAFE TRANSFER OR ADEQUATE BED CARE.
PC43	SUPPLY A PHYSICIANS STATEMENT INDICATING TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR UNIT HAS REDUCED PAIN, IMPROVED/INCREASED THE CLIENTS ACTIVITY LEVEL, AND/OR REDUCED CLIENTS USE OF PAIN MEDICATION.

DENIAL CODE	LONG DESCRIPTION
PC44	A CURRENT AUTHORIZATION FOR THIS SERVICE IS ON FILE FOR ANOTHER PROVIDER. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT OF THAT FACT IS REQUIRED BY THE CLIENT OF FIRST PROVIDER.
PC59	DOCUMENT DECLINE OR PROGRESS IN SPECIFIC, MEASURABLE, OBJECTIVE TERMS.
PC60	DOCUMENT IF CLIENT HAS DEMONSTRATED A GOOD APPOINTMENT COMPLIANCE RECORD.
PC61	THE PHYSICIANS SIGNATURE DATE MUST NOT EXCEED 90 DAYS FROM THE DATE OF RECEIPT BY COLORADO MEDICAID.
PC62	REQUESTS FOR A CONTINUATION OF THERAPY SHOULD NOT BE SUBMITTED MORE THAN FOUR WEEKS PRIOR TO THE EXPIRATION DATE OF THE CURRENT AUTHORIZATION.
PC63	PLEASE FURNISH THE STYLE AND MANUFACTURER OF THE FRAME.
PC64	PLEASE FURNISH THE CLIENTS LENS FORMULA.
PC66	ALL REQUESTS FOR TINTS REQUIRE DOCUMENTATION OF THE VISUAL OR MEDICAL CONDITION RELATED TO PHOTOPHOBIA.
PC67	PLEASE DOCUMENT THE REASON AND JUSTIFICATION FOR REPLACEMENT BEYOND THE FIRST LENS/FRAME.
PC68	DOCUMENT IF ALL REMAINING MAXILLARY AND/OR MANDIBULAR TEETH ARE DECAY-FREE, PROPERLY RESTORED, AND PERIODONTICALLY SOUND.
PC72	SUPPLY MORE DETAIL REGARDING PROGRESS (ATTACHMENT OF GOALS, ETC.). CORRELATE PROGRESS TO PREVIOUS GOALS AND IDENTIFIED LIMITATIONS.
PC77	PLEASE SUBMIT A PLAN OF CARE DESCRIBING THE SERVICES THAT WOULD BE PROVIDED.
PC78	PLEASE DOCUMENT SPECIFIC, MEASURABLE GOALS.
PC82	THE PRIOR AUTHORIZATION (PA) SYSTEM CAN PROCESS ONLY 26 DETAILS PER PA REQUEST. PLEASE RESUBMIT YOUR REQUEST WITH NO MORE THAN 26 DETAILS.
PC83	PLEASE SUPPLY A PHYSICIANS PRESCRIPTION DATED WITHIN ONE MONTH OF REQUESTED SUBSTANCE ABUSE DAY TREATMENT.
PC84	PLEASE PROVIDE INFORMATION INDICATING THIS CLIENT IS APPROPRIATELY DETOXIFIED FROM ALCOHOL AND/OR OTHER DRUGS.
PC85	PLEASE PROVIDE INFORMATION TO INDICATE THE CLIENTS ABILITY TO ABSTAIN FROM ALCOHOL OR DRUGS WHILE IN THE SUBSTANCE ABUSE DAY TREATMENT PROGRAM.
PC86	PLEASE INDICATE IF THIS CLIENT IS WILLING TO PARTICIPATE IN AFTERCARE OR CONTINUING CARE SERVICES.
PC87	PROVIDE MORE INFORMATION ON TREATMENT HISTORY; INCLUDE SERVICE PROVIDED, DATES, AND OUTCOME. PROVIDE DETAIL OF PREVIOUS TREATMENT.
PC88	PLEASE PROVIDE MORE RATIONALE FOR THE APPROPRIATENESS AND MEDICAL NECESSITY OF SUBSTANCE ABUSE DAY TREATMENT.
PC89	PROVIDE A TREATMENT PLAN THAT CONTAINS MEASURABLE GOALS AND OBJECTIVES CORRESPONDING TO THE IDENTIFIED DEFICIT.
PC91	PLEASE PROVIDE MORE INFORMATION ON FAMILY INVOLVEMENT TREATMENT.
PC92	PLEASE PROVIDE MORE HISTORY AND EXPLANATION ABOUT THE ISSUE OF ABSTINENCE FOR THIS CLIENT.
PC94	PLEASE PROVIDE THE ANTICIPATED BEGINNING DATE AND/OR THE ESTIMATED SUBSTANCE ABUSE DAY TREATMENT DISCHARGE DATE.
PC95	PLEASE SUPPLY JUSTIFICATION FOR BEGINNING CLIENT IN SERVICE PRIOR TO AUTHORIZATION BEING OBTAINED.
PC96	THE INITIAL THREE HOURS OF SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IN A CALENDAR YEAR DO NOT REQUIRE PRIOR AUTHORIZATION.
PC97	REIMBURSEMENT FOR INITIAL SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IS LIMITED TO THREE HOURS IN A CALENDAR YEAR AND DOES NOT REQUIRE PRIOR AUTHORIZATION.
PC98	THIS DRUG IS CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE BILL USING THE APPROPRIATE NATIONAL DRUG CODE (NDC) OR SUBMIT A COMPLETED DRUG ADDITION REQUEST FORM IF THE NDC IS NOT LISTED IN THE DRUG INDEX.
PC99	THIS DRUG IS NOT CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL, CURRENT ADMINISTRATIVE RULE, OR COLORADO DRUG INDEX FOR COVERAGE LIMITATIONS.
PD01	DOCUMENT THAT CLIENT HAS ACHIEVED GOOD ORAL HYGIENE, PERIODONTAL CASE TYPE 1 OR 2, AND IS MOTIVATED TO MAINTAIN SAME.

DENIAL CODE	LONG DESCRIPTION
PD03	PLEASE PROVIDE AN ARTERIAL BLOOD GAS READING OR PULSE OXIMETRY RESULTS DONE ON ROOM AIR SIGNED AND DATED BY A MEDICAL DOCTOR. THIS SHOULD BE DONE WITHIN 60 DAYS OF REQUESTED SERVICE.
PD04	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 30 DAYS OF RECEIPT BY COLORADO MEDICAID.
PD07	SUBMIT A PHOTOCOPY OF A VALID PRESCRIPTION, ISSUED WITHIN THE PAST YEAR, OR COMPLETE SECTION B OF THE PRIOR AUTHORIZATION/DRUG ATTACHMENT (PA/DGA), F-11049.
PD10	BRAND MEDICALLY NECESSARY MUST BE IN THE PRESCRIBERS OWN HANDWRITING AND WRITTEN DIRECTLY ON THE PRESCRIPTION OR A SEPARATE ORDER ATTACHED TO THE ORIGINAL PRESCRIPTION.
PD12	COMPLETE DENTURES, PARTIAL DENTURES, DENTURE RELINES, AND FIXED PROSTHODONTIC SERVICES ARE NOT COVERED SERVICES FOR ADULTS FOR DATES OF SERVICE ON AND AFTER OCTOBER 1, 1995.
PD22	PLEASE COMPLETE ALL REQUIRED ELEMENTS ON THE PERSONAL CARE SCREENING TOOL (PCST), F-11133.
PD24	THIS PRIOR AUTHORIZATION REQUEST IS UNABLE TO BE PROCESSED. PLEASE RESUBMIT WITH ADDITIONAL REQUIRED FORMS, INCLUDING THE ENTIRE PERSONAL CARE SCREENING TOOL (PCST), F-11133; PERSONAL CARE ADDENDUM, F-11136; AND SUPPORTING DOCUMENTATION, AS DIRECTED.
PD25	THERE IS A PERSONAL CARE SCREENING TOOL (PCST), F-11133, COMPLETED BY ANOTHER AGENCY. CONTACT THE AGENCY TO TRANSFER SCREEN.
PD26	THERE IS A LIMITED TERM CARE FUNCTIONAL SCREEN (LTC-FS) COMPLETED BY ANOTHER AGENCY. THE PERSONAL CARE SCREENING TOOL (PCST), F-11133, INFORMATION IS IN CONFLICT WITH LTC-FS.
PD27	ONLY ONE LEVEL OF FUNCTION MAY BE SELECTED FOR ALL ELEMENTS EXCEPT TOILETING. COLORADO MEDICAID IS UNABLE TO PROCESS THE PRIOR AUTHORIZATION REQUEST.
PD28	NO UNITS MAY BE REQUESTED USING THIS PRIOR AUTHORIZATION PROCESS. PLEASE SUBMIT WITH THE APPROPRIATE ATTACHMENTS FOR REQUESTING SPECIFIC PERSONAL CARE WORKER UNITS.
PD29	CLIENT IS NOT ELIGIBLE FOR THE REQUESTED SERVICE(S) AS OF THE REQUESTED START DATE.
PD30	NO TRAVEL TIME MAY BE AUTHORIZED WHEN NO PERSONAL CARE WORKER SERVICE IS AUTHORIZED.
PD32	PROVIDER NOT CERTIFIED TO RENDER THE SERVICE(S) REQUESTED.
PD34	BASED ON THE DOCUMENTATION SUBMITTED, THIS REQUEST CAN NOT BE PRIOR AUTHORIZED. REFER TO THE PA MESSAGES FROM THE CONSULTANT FOR COMPLETE EXPLANATION.
PD98	PLEASE DOCUMENT HOW AND WHEN EACH PREVIOUSLY AUTHORIZED PRO RE NATA VISIT WAS USED.

Out-of-State (OOS) Outpatient

Denial Code	Long Description
0201	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
0233	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0235	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0237	CLIENT IDENTIFICATION NUMBER DOES NOT MATCH CLIENTS FIRST NAME.
0238	THE CLIENT IDENTIFICATION NUMBER DOES NOT MATCH THE CLIENTS LAST NAME.
0242	SECONDARY DIAGNOSIS CODE IS INVALID.
0248	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0249	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0251	PROCEDURE CODE MODIFIER IN FIRST POSITION IS INVALID.
0252	THE PROCEDURE CODE MODIFIER IN SECOND POSITION IS INVALID FOR REQUESTED START DATE OR DATE OF RECEIPT.
0253	THE PROCEDURE CODE MODIFIER IN THIRD POSITION IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
0258	THE PRIMARY DIAGNOSIS CODE IS REQUIRED.
0272	THE PRIMARY DIAGNSOSIS CODE IS INVALID.
0400	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.

Denial Code	Long Description
0853	HCPCS - ANNUAL UPDATE
0885	NEVER EVENTS MODIFIERS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
0886	NEVER EVENTS DIAGNOSIS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
1000	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
1002	RENDERING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1003	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1007	RENDERING PROVIDER ID IS NOT ON FILE.
1047	THE RENDERING PROVIDERS CERTIFICATION HAS BEEN CANCELLED.
1048	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1801	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
1804	A CERTIFIED SUBSTANCE ABUSE DAY TREATMENT PROVIDER MUST SUBMIT A SUBSTANCE ABUSE DAY TREATMENT PROCEDURE CODE.
1806	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
1808	THE BILLING PROVIDER DOES NOT HAVE THE REQUIRED CERTIFICATION ADDENDUM ON FILE.
1900	THE BILLING PROVIDERS TAXONOMY CODE IS INVALID.
1901	THE RENDERING PROVIDERS TAXONOMY CODE IS INVALID.
1927	A NATIONAL PROVIDER IDENTIFIER IS REQUIRED FOR THE BILLING PROVIDER.
1934	A NATIONAL PROVIDER INDENTIFIER IS REQUIRED FOR THE RENDERING PROVIDER.
1936	THE BILLING PROVIDER NUMBER IS INVALID.
1937	THE RENDERING PROVIDER NUMBER IS INVALID.
1960	INTERNAL PROCESSING IS REQUIRED.
1963	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.
1964	THE BILLING PROVIDER INDICATED IS NOT ALLOWABLE AS A BILLING PROVIDER.
1965	RENDERING PROVIDER NUMBER IS MISSING/INVALID FOR THIS PROCEDURE PROVIDER.
1974	PRESCRIBING/REFERRING/ORDERING PROVIDER INDICATED IS NOT CERTIFIED AS A PRESCRIBING/REFERRING/ORDERING PROVIDER.
1975	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
1976	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
2001	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2003	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2017	THE CLIENT IS ENROLLED IN A MEDICAID OR OTHER MANAGED CARE PROGRAM.
2037	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2603	CLIENT LOCKED-IN TO A PROVIDER OR ENROLLED IN A HOSPICE. CONTACT CLIENTS HOSPICE FOR PAYMENT OF SERVICES OR RESUBMIT WITH DOCUMENTATION OF UNRELATED NATURE OF CARE.
3324	THE MODIFIER HAS BEEN DISCONTINUED BY THE CENTERS OF MEDICARE AND MEDICAID SERVICES OR THE AMERICAN MEDICAL ASSOCIATION FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
3337	THE PROCEDURE CODE HAS BEEN TERMINATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AMERICAN MEDICAL ASSOCIATION, OR AMERICAN DENTAL ASSOCIATION FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT. RESUBMIT WITH VALID A PROCEDURE CODE.
3339	THE PROCEDURE BILLED IS NOT PAYABLE ACCORDING TO DEFICIT REDUCTION ACT (DEFRA) GUIDELINES.
3351	THE PROCEDURE IS NOT COVERED FOR CLIENTS WITH A NURSING HOME AUTHORIZATION ON THE REQUESTED START DATE OR DATE OF RECEIPT.
3353	THE PROCEDURE IS NOT A COVERED SERVICE FOR HOME AND COMMUNITY-BASED WAIVER CLIENTS.
4021	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4027	THE DIAGNOSIS CODE IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
4031	THE PROCEDURE SUBMITTED IS NOT APPROPRIATE FOR CLIENTS GENDER.
4032	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4034	THE PROCEDURE CODE HAS AN AGE RESTRICTION.
4036	THE PLACE OF SERVICE CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4040	THE PRIMARY DIAGNOSIS CODE IS NOT ON FILE.
4041	THE SECONDARY DIAGNOSIS IS NOT ON FILE.
4046	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.

Denial Code	Long Description
4127	INTERNAL PROCESSING IS REQUIRED.
4131	INTERNAL PROCESSING IS REQUIRED.
4141	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4149	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4150	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4236	ETIOLOGY DIAGNOSIS CODE(S) (E-CODES) ARE INVALID AS THE PRIMARY DIAGNOSIS.
4244	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4245	THE FOURTH POSITION MODIFIER IS INVALID FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT.
4256	THE PROCEDURE CODE AND MODIFIER COMBINATION IS NOT PAYABLE FOR THE CLIENTS BENEFIT PLAN.
4257	THE MODIFIERS SUBMITTED ARE EITHER INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT OR THE MODIFIERS ARE MISSING.
4311	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4315	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4316	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4371	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4372	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4711	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR CLIENTS AGE.
4714	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS AGE.
4731	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS DIAGNOSIS.
4742	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4743	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4744	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4745	DIAGNOSIS AND/OR PROCEDURE AND/OR PLACE OF SERVICE (POS) CODE IS NOT COVERED FOR EXPRESS ENROLLMENT CLIENTS.
4746	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4801	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4802	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
4821	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
4871	PLEASE REFER TO PA MESSAGES FOR RETURN INFORMATION.
4963	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS GENDER.
4990	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
7500	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
7509	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
P001	THE BILLING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THE SERVICES.
P002	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P003	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P005	THE PRIOR AUTHORIZATION CAN NOT BE END DATED. THE PRIOR AUTHORIZATION STATUS IS NOT APPROVED OR APPROVED WITH REVISIONS.
P006	PLEASE FURNISH THE PROCEDURE CODE AND CORRESPONDING DESCRIPTION.
P008	THE BILLING PROVIDER NUMBER IS INVALID.
P009	THE BILLING PROVIDER NUMBER IS INVALID.
P010	THE REQUESTED END DATE IS INVALID.
P011	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P012	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P013	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P014	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.

Denial Code	Long Description
P015	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P016	THE REQUESTED START DATE IS MISSING OR INVALID.
P019	THE REQUESTED START DATE IS MISSING OR INVALID.
P020	THE RENDERING PROVIDER NUMBER IS INVALID.
P021	THE RENDERING PROVIDER NUMBER IS INVALID.
P022	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P023	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P024	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P026	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P027	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P030	FIRST MODIFIER IS INVALID.
P031	FIRST MODIFIER IS INVALID.
P032	SECOND MODIFIER IS INVALID.
P033	SECOND MODIFIER IS INVALID.
P034	THIRD MODIFIER IS INVALID.
P035	THIRD MODIFIER IS INVALID.
P036	FOURTH MODIFIER IS INVALID.
P037	FOURTH MODIFIER IS INVALID.
P038	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P039	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P040	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P041	CLIENTS FIRST NAME IS MISSING.
P042	CLIENTS LAST NAME IS MISSING.
P043	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P044	BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES REQUESTED.
P045	FIRST MODIFIER IS INVALID.
P046	SECOND MODIFIER IS INVALID.
P047	THIRD MODIFIER IS INVALID.
P048	FOURTH MODIFIER IS INVALID.
P052	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P053	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P054	RENDERING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES FOR THE BENEFIT PLAN.
P055	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P061	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P062	THE CLIENT ID AND/OR NAME INDICATED ON THE PA REQUEST IS INCORRECT. THE CLIENT ID AND/OR NAME HAS BEEN UPDATED. PLEASE VERIFY THE ID AND/OR NAME IS CORRECT.
P064	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
P067	THE FREQUENCY OF HOURS REQUESTED ARE NOT APPROPRIATE FOR THIS CLIENT AND HAVE BEEN MODIFIED ACCORDINGLY.
P079	BILLING PROVIDER IS ON PAYMENT SUSPENSION DUE TO CREDIBLE ALLEGATION OF FRAUD.
P120	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAS BEEN REDUCED.
P121	THE SERVICE/ PROCEDURE REQUESTED IS NOT SUPPORTED BY SUBMITTED DOCUMENTATION.
P126	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
P128	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.
P138	SERVICE(S) DO NOT MEET COLORADO MEDICAID GUIDELINES.
P167	REQUESTED DOCUMENTATION HAS NOT BEEN SUBMITTED.

Denial Code	Long Description
P178	THE SERVICE REQUESTED IS NOT MEDICALLY NECESSARY.
P179	THE MEDICAL NECESSITY FOR THIS SERVICE IS NOT SUPPORTED BY THE SUBMITTED DOCUMENTATION.
P233	THE DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE ADDITIONAL CARE.
P257	THIS CLIENTS FUNCTIONAL ASSESSMENT SCORES PLACE THIS CLIENT OUTSIDE ELIGIBILITY FOR DAY TREATMENT.
P274	OUR RECORDS INDICATE THIS CLIENT IS INVOLVED IN EFFECTIVE AND APPROPRIATE SERVICE ELSEWHERE.
P292	INTENSIVE REHABILITATION HOURS ARE NO LONGER APPROPRIATE AS INDICATED BY HISTORY, DIAGNOSIS, AND/ OR FUNCTIONAL ASSESSMENT SCORES.
P328	THE SERVICES REQUESTED INCLUDE NON-COVERED SERVICES, AND HOURS ARE REDUCED ACCORDINGLY.
P339	THE CLIENTS PAST HISTORY INDICATES REDUCED TREATMENT HOURS ARE WARRANTED.
P342	THE REQUEST DOES NOT MEET GENERALLY ACCEPTED CONDITIONS REQUIRING FLUORIDE TREATMENTS.
P346	SERVICES EXCEED COLORADO MEDICAID LIMITATION AND DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE MEDICAL NECESSITY OF THE SERVICE.
P349	THE SERVICE REQUESTED WAS PERFORMED LESS THAN FIVE YEARS AGO.
P353	THE EXISTING APPLIANCE HAS NOT BEEN WORN FOR THREE YEARS.
P367	THE CLIENT HAS BEEN TOTALLY WITHOUT TEETH AND AN APPLIANCE FOR FIVE YEARS.
P392	THE CLIENT IS MISSING AN ANTERIOR TOOTH AND/OR HAS TWO OR MORE POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P405	THE SERVICE(S) REQUESTED COULD ADEQUATELY BE PERFORMED IN THE DENTAL OFFICE.
P406	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE OF GOOD PERIODONTAL HEALTH (AMERICAN ACADEMY OF PERIODONTOLOGY PERIODONTAL CLASSIFICATION OF TYPE I OR II).
P407	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE VISIBLE ON RADIOGRAPHS THAT AT LEAST 50 PERCENT OF THE CLINICAL CROWN IS INTACT.
P409	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING SIX OR MORE TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED, INCLUDING THIRD MOLARS.
P410	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING ONE OR MORE ANTERIOR TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED.
P411	DOCUMENTATION DOES NOT SUPPORT THE NEED FOR PERIODONTIC SERVICES. POCKETS ARE LESS THAN 4MM AND/OR GREATER THAN 6MM FOR CLIENT AND/OR THE CLIENT IS UNDER THE AGE OF 13.
P412	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA.
P413	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA. THIS PA HAS BEEN GRANTED AS APPROVED NOT APPROVED WITH REVISIONS. THE DURATION REQUESTED MAY HAVE BEEN REDUCED TO REFLECT COVERAGE LIMITATIONS, PRESCRIBER ORDERS, CONFLICTI
P417	THE SERVICE(S) REQUESTED COULD BE ADEQUATELY PERFORMED WITH LOCAL ANESTHESIA.
P437	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO POOR ORAL HYGIENE.
P444	THIS LINE ITEM IS A DUPLICATE OF ANOTHER LINE ITEM ON THIS PRIOR AUTHORIZATION (PA) REQUEST. PLEASE CORRECT.
P446	THIS IS A DUPLICATE OF AN EXISTING PRIOR AUTHORIZATION (PA) REQUEST. YOU MAY CONTACT PROVIDER SERVICES IF YOU REQUIRE ASSISTANCE. DUPLICATE PA REQUEST
P448	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO DECAY HISTORY.
P449	QUESTIONABLE LONG TERM PROGNOSIS DUE TO GUM AND BONE DISEASE.
P456	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO APPARENT ROOT INFECTION.
P457	OUR RECORDS INDICATE THIS CLIENT HAS EXCEEDED ESTABLISHED PROGRAM LIMITATIONS. COLORADO MEDICAID WILL NOT AUTHORIZE NEW DENTURES.
P458	DOCUMENTATION PROVIDED INDICATES A LESS ELABORATE PROCEDURE SHOULD BE CONSIDERED.
P502	RENTAL ONLY ALLOWED; MEDICAL NEED FOR PURCHASE HAS NOT BEEN DOCUMENTED.
P503	PURCHASE ONLY ALLOWED; MEDICAL NEED FOR RENTAL HAS NOT BEEN DOCUMENTED.
P504	OCCUPATIONAL THERAPY GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P505	THE SERVICE REQUESTED IS INCLUDED IN THE NURSING HOME RATE STRUCTURE.
P511	THIS NATIONAL DRUG CODE IS ONLY BILLABLE AS PART OF A COMPOUND DRUG.
P515	THE PRESENCE OF A HANDICAPPING MALOCCLUSION OR HANDICAPPING DENTOFACIAL DEFORMITY IS NOT SUPPORTED BY THE DOCUMENTATION SUBMITTED.

Denial Code	Long Description
P521	THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVERED BY COLORADO MEDICAID.
P522	GASTRO-INTESTINAL SURGERY FOR THE PURPOSE OF WEIGHT CONTROL IS COVERED ONLY AS A LIFE THREATENING PROCEDURE.
P523	THE TREATMENT REQUEST IS NOT CONSISTENT WITH THE CLIENT'S DIAGNOSIS.
P524	PSYCHOTHERAPY PROVIDED IN THE CLIENTS HOME IS NOT A COVERED BENEFIT OF COLORADO MEDICAID.
P525	THE INFORMATION PROVIDED IS NOT CONSISTENT WITH THE INTENSITY OF SERVICES REQUESTED.
P526	INTENSIVE MULTIPLE MODALITY TREATMENT IS NOT CONSISTENT WITH THE INFORMATION PROVIDED.
P527	MULTIPLE PROVIDERS OF TREATMENT ARE NOT INDICATED FOR THIS CLIENT.
P528	THE DURATION OF TREATMENT SESSIONS EXCEED CURRENT COLORADO MEDICAID GUIDELINES.
P534	DOCUMENTATION OF POOR PHYSICAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P535	OTHER PHYSICAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P536	THE PHYSICAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P537	USE OF PHYSICAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P538	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF A PHYSICAL THERAPIST.
P539	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS AND LIVING ARRANGEMENT.
P540	GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P541	THE PROCEDURE(S) REQUESTED ARE NOT MEDICAL IN NATURE.
P542	DOCUMENTATION OF POOR OCCUPATIONAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P543	DOCUMENTATION OF POOR SPEECH THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P544	OTHER OCCUPATIONAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P546	THE OCCUPATIONAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P547	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF PHYSICAL THERAPY.
P548	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P549	ACTIVITIES TO PROMOTE DIVERSION OR GENERAL MOTIVATION ARE NONCOVERED COLORADO MEDICAID SERVICES.
P550	REVISIONS OF THE REQUEST IS NECESSITATED BY THE CLIENTS MINIMAL PROGRESS.
P551	RESTORATIVE NURSING INVOLVEMENT COULD BE INCREASED.
P552	CLIENTS DEMONSTRATED RESPONSE TO CURRENT THERAPY DOES NOT WARRANT THE INTENSE FREQUENCY REQUESTED.
P553	MAINTENANCE IS TWO TIMES PER WEEK OR LESS.
P554	THE SPEECH THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P555	USE OF OCCUPATIONAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P556	USE OF SPEECH THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P557	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF AN OCCUPATIONAL THERAPIST.
P558	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
P559	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P560	THE MATERIALS/ SERVICES REQUESTED ARE PRINCIPALLY COSMETIC IN NATURE.
P561	THE LENS FORMULA DOES NOT JUSTIFY REPLACEMENT.
P562	THE CHANGE IN THE LENS FORMULA DOES NOT WARRANT MULTIPLE REPLACEMENTS.
P563	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.

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P564	LENSES ONLY ARE APPROVED; PLEASE DISPENSE A CONTRACTED FRAME. THE NON-CONTRACTED FRAME IS NOT MEDICALLY JUSTIFIED.
P565	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P566	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P567	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF OCCUPATIONAL THERAPY.
P568	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF SPEECH THERAPY.
P569	LEVEL, INTENSITY, OR EXTENT OF SERVICE(S) REQUESTED HAS BEEN MODIFIED CONSISTENT WITH MEDICAL NEED AS DEFINED IN THE PLAN OF CARE.
P570	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P571	THE SERVICE ASKED FOR IS NOT COVERED BY COLORADO MEDICAID AS THESE TASKS CAN BE DONE BY NURSES OR ACTIVITY STAFF.
P572	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P573	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.
P574	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P575	MEDICAL NEED FOR EQUIPMENT/ SUPPLY REQUESTED IS NOT SUPPORTED BY DOCUMENTATION SUBMITTED.
P576	OTHER SPEECH THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P577	DOCUMENTATION SUBMITTED IDENTIFIES THAT THE CLIENT HAS FEWER THAN TWO POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P582	LESS EXPENSIVE ALTERNATIVE SERVICES ARE AVAILABLE FOR THIS CLIENT.
P634	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P711	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING PERIODONTAL SCALING AND ROOT PLANNING.
P712	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING GINGIVECTOMY.
P754	AN APPROVED SUBSTANCE ABUSE DAY TREATMENT PROGRAM CANNOT EXCEED A SIX WEEK PERIOD.
P761	THE CLIENT DOES NOT APPEAR TO BE ABLE OR WILLING TO ABSTAIN FROM ALCOHOL/DRUG USAGE WHILE IN TREATMENT. THEREFORE, SUBSTANCE ABUSE DAY TREATMENT SERVICES ARE NOT APPROVED.
P764	THIS CLIENT HAS COMPLETED INTENSIVE SUBSTANCE ABUSE TREATMENT WITHIN THE PAST 12 MONTHS. THE DOCUMENTATION PROVIDED IS NOT ADEQUATE TO JUSTIFY ADDITIONAL INTENSIVE TREATMENT AT THIS TIME.
P785	A LESS THAN SIX-WEEK HEALING PERIOD HAS BEEN SPECIFIED FOR THIS PRIOR AUTHORIZATION. THEREFORE IT IS NOT NECESSARY TO WAIT THE FULL SIX WEEKS AFTER EXTRACTIONS BEFORE TAKING DENTURE IMPRESSIONS.
P818	SIX-WEEK HEALING TIME IS REQUIRED BETWEEN EDENTULATION AND FINAL IMPRESSIONS. PAYMENT FOR DENTURES WILL BE DENIED OR RECOUPED IF HEALING PERIOD IS NOT OBSERVED.
P849	COLORADO MEDICAID HAS DETERMINED THERE WERE (ARE) SEVERAL HOME HEALTH AGENCIES WILLING TO PROVIDE MEDICALLY NECESSARY SKILLED NURSING SERVICES TO THIS CLIENT.
P864	THE DOCUMENTATION YOU HAVE SUBMITTED DOES NOT MEET THE REQUIREMENTS OF COLORADO MEDICAID.
P873	THE MEDICAL NECESSITY FOR THE HOURS REQUESTED IS NOT SUPPORTED BY THE INFORMATION SUBMITTED.
P874	THE DOCUMENTATION SUBMITTED INDICATES THE TASKS SPECIFIED CAN BE COMPLETED DURING THE VISITS APPROVED.
P878	THE DOCUMENTATION SUBMITTED DOES NOT INDICATE THAT MEDICALLY ORIENTED TASKS ARE MEDICALLY NECESSARY; THEREFORE PERSONAL CARE SERVICES HAVE BEEN APPROVED.
P880	THE QUANTITY OF SERVICES AUTHORIZED FOR THIS CLIENTS PERSONAL CARE HAS BEEN AMENDED BASED ON INFORMATION RECEIVED FROM ONE OR MORE OF THESE SOURCES: THE CLIENT, THEIR PHYSICIAN, AND/OR THE IN-HOME VISIT BY STAFF OF THE OIG (OFFICE OF INSPECTOR GENERAL).

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P885	THE USE OF THIS DRUG FOR THE INTENDED PURPOSE IS NOT COVERED BY COLORADO MEDICAID, CONSISTENT WITH COLORADO ADMINISTRATIVE CODE AND FEDERAL LAW.
P924	THE MEDICAL RECORDS SUBMITTED WITH THE CURRENT REQUEST CONFLICT OR DISAGREE WITH OUR MEDICAL RECORDS ON THIS CLIENT.
P950	INDEPENDENT NURSES, PLEASE NOTE PAYABLE SERVICES MAY NOT EXCEED 12 HOURS/DAY OR 60 HOURS/WEEK.
P951	SERVICES CAN ONLY BE AUTHORIZED THROUGH ONE YEAR FROM THE PRESCRIPTION DATE.
P952	LEAD INSPECTION IS A COVERED COLORADO MEDICAID SERVICE WHEN THE CHILD HAS BEEN SHOWN TO HAVE LEAD POISONING (E.G., CHILD HAS A BLOOD LEAD LEVEL > 19 UG/DL OR TWO CONSECUTIVE BLOOD LEAD LEVELS OF 15-19 UG/DL DONE AT LEAST 90 DAYS APART). THE INSPECTION MUS
P953	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P954	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P956	THE REQUEST CAN ONLY BE BACKDATED A MAXIMUM OF 14 DAYS FROM FIRST DATE RECEIVED BY COLORADO MEDICAID.
P957	COMPLETE PERIODONTAL CHARTING AT TIME OF SERVICE, AND SUBMIT CHARTING, COPY OF OPERATIVE REPORT, TOGETHER WITH A COPY OF THE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF), F-11035, TO PA UNIT ATTENTION DENTAL CONTSULTANT.
P958	NOTE THAT CODE D4341 HAS BEEN CHANGED. REFER TO THE DECISION NOTICE FOR AUTHORIZED QUANTITY.
P960	YOUR PA HAS BEEN APPROVED FOR 90 DAYS. THE 90 DAY APPROVAL DOES NOT IMPLY THE PA REQUEST MEETS PRIOR AUTHORIZATION CRITERIA. AFTER ADDITIONAL INFORMATION IS AVAILABLE IN INTERCHANGE, COLORADO MEDICAID WILL CREATE AN AMENDMENT REQUEST TO EXTEND THE PA FOR
P961	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P962	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
PA10	THE REQUESTED END DATE IS INVALID.
PA12	PLEASE FURNISH A WRITTEN DESCRIPTION OF THE CLIENTS DIAGNOSIS.
PA13	PROVIDE DIAGNOSES WITH DATES OF ONSET.
PA14	IDENTIFY PROBLEMS TO BE TREATED.
PA15	THE AUDIOLOGISTS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1), F-11020, AND PRIOR AUTHORIZATION REQUEST/HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2), F-11021.
PA16	THE PHYSICIANS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION/PHYSICIAN OTOLOGICAL REPORT (PA/POR), F-11019.
PA17	SUBMIT BRIEF HISTORY WITH REFERRAL INFORMATION, LIVING SITUATION, FUNCTIONAL STATUS, AND OTHER PERTINENT INFORMATION. WHAT CHANGE OF STATUS RESULTED IN REFERRAL AT THIS TIME?
PA18	PLEASE FURNISH THE CLIENTS HEIGHT AND WEIGHT.
PA19	PLEASE SUBMIT CLINICAL INFORMATION SUFFICIENT TO VERIFY THE NEED FOR THE REQUESTED SERVICE(S).
PA20	PLEASE RESUBMIT WITH COMPLETE PERIODONTAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PA21	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL EDUCATIONAL PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA22	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL PROGRAM PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA23	REFER TO THE DURABLE MEDICAL EQUIPMENT INDEX FOR APPROPRIATE CODE AND DESCRIPTION. DO NOT USE AN "UNLISTED" CODE.
PA24	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUALIZED FAMILY SERVICE PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA25	INFORMATION ON THE REQUEST FORM IS ILLEGIBLE, AND THE REQUEST CANNOT BE PROCESSED.

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PA26	RE-EVALUATE YOUR GOALS. EMPHASIS SHOULD BE ON FUNCTIONAL SELF-CARE. GOALS MUST BE RELATED TO FUNCTIONAL OUTCOME.
PA27	PLEASE CLARIFY THE NUMBER OF HOURS PER WEEK REQUESTED.
PA28	PLEASE CLARIFY THE NUMBER OF HOURS PER DAY REQUESTED.
PA29	PLEASE CLARIFY THE NUMBER OF VISITS PER DAY REQUESTED.
PA30	ATTACH SUPPORTIVE DOCUMENTATION; HOME EXERCISE PROGRAM AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA31	THE DIAGNOSIS CODE INDICATED ON THE REQUEST DOES NOT CORRESPOND TO THE DIAGNOSIS CODE DESCRIPTION.
PA32	PLEASE SUBMIT ADDITIONAL INFORMATION SUFFICIENT TO VERIFY APPROPRIATENESS AND NEED FOR TRANSPLANT.
PA33	PLEASE SUBMIT THE INITIAL AND PROGRESSIVE OBJECTIVE FINDINGS.
PA34	ATTACH SUPPORTIVE DOCUMENTATION, FACILITY PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA35	PLEASE SUBMIT THE CLIENTS ORIGINAL COMPLAINTS AND EXAMINATION FINDINGS.
PA36	ATTACH SUPPORTIVE DOCUMENTATION, IN-HOME AUTISM PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA37	PLEASE SUBMIT YOUR TREATMENT PLAN FOR THIS CLIENT.
PA38	ATTACH SUPPORTIVE DOCUMENTATION AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA39	INITIAL EVALUATIONS MUST BE PERFORMED BY AN OCCUPATIONAL THERAPIST REGISTERED (OTR), PER AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA) STANDARDS.
PA41	IDENTIFY THE PLACE OF SERVICE AND ITS EFFECT ON SUPPORTING THE DESIRED TREATMENT OUTCOME.
PA42	PLEASE INDICATE THE HOURS OF USE OF OXYGEN PER 24-HOUR PERIOD.
PA43	PROVIDE BASELINE DOCUMENTATION FOR THIS CLIENTS LIMITATIONS USING UNITS OF MEASUREMENT THAT ARE APPLIED CONSISTENTLY WHEN REPORTING STATUS.
PA44	IDENTIFY FUNCTIONAL LIMITATIONS AS THEY ARE RELATED TO IDENTIFIED CONDITIONS.
PA46	CORRELATE PLAN OF CARE TO REQUESTED PROCEDURE CODES.
PA47	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE FREQUENCY/DURATION REQUESTED.
PA48	PLEASE PROVIDE THE NAME AND CREDENTIALS OF THE RENDERING PROVIDER.
PA50	COLORADO MEDICAID RECORDS INDICATE THE CLIENT OWNS A WHEELCHAIR. DOCUMENT THE REASON AND NEED FOR REPLACEMENT AND COST TO REPAIR CURRENT WHEELCHAIR.
PA51	PLEASE DISTINGUISH PRIMARY AND SUPPORTIVE MODALITIES.
PA52	PLEASE SUBMIT A PROGRESS REPORT.
PA53	MULTIPLE FAMILY CLIENTS TREATMENT BY THE SAME PROVIDER REQUIRES FURTHER INFORMATION DOCUMENTING COORDINATION OF TREATMENT PLAN.
PA54	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE MINUTES REQUESTED.
PA55	MEDICAL NECESSITY OF TREATMENT REQUIRES ADDITIONAL DOCUMENTATION.
PA56	GIVEN AGE, DIAGNOSES, CURRENT LEVEL OF FUNCTION, PAST RESPONSE TO TREATMENT, AND LIVING SITUATION, EXPAND ON POTENTIAL FOR SIGNIFICANT FUNCTIONAL PROGRESS WITHIN THE NEXT SIX MONTHS. EMPHASIZE WHY PROGRESS IS EXPECTED WITH SERVICES AT THIS TIME.
PA57	SUBMIT THE INITIAL FINDINGS. INCLUDE A COMPREHENSIVE EVALUATION.
PA58	SUBMIT PROGRESSIVE, OBJECTIVE FINDINGS. INCLUDE A PERTINENT RE-EVALUATION.
PA59	PLEASE SUPPLY INFORMATION REGARDING THE CLIENTS MEDICATION REQUIREMENTS, IF ANY.
PA60	PLEASE SPECIFY IF THE CLIENT IS IN AN EDUCATIONAL SETTING.
PA61	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA62	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
PA63	THE SKILLS OF A THERAPIST ARE PURPOSEFUL AND SKILLED INTERVENTIONS REQUIRED TO CONTINUALLY DESIGN, IMPLEMENT, REASSESS, MODIFY/GRADE, AND/OR DISCONTINUE A PLAN OF CARE IN A TIMELY MANNER, BASED ON THE COMPLEXITY OF THE CLIENTS MEDICAL CONDITION AND/OR CO

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PA64	PLEASE SUBMIT A THERAPY PLAN OF CARE, INCLUDING A CURRENT, DATED EVALUATION.
PA65	A PLAN OF CARE SIGNED AND DATED BY THE PHYSICIAN IS REQUIRED.
PA66	THE SKILLS OF A THERAPIST ARE REQUIRED WHEN ONLY THE THERAPIST CAN SAFELY AND EFFECTIVELY DELIVER THE THERAPEUTIC PROCEDURES BECAUSE OF THEIR UNIQUE KNOWLEDGE, TRAINING, AND EXPERTISE. DESCRIBE THE REASON THAT SOMEONE OTHER THAN A THERAPIST CANNOT SAFELY
PA67	PLEASE SPECIFY IF THE CLIENTS WORK SITE DEMANDS GOOD BINAURAL HEARING.
PA68	DESCRIBE THE REASON, BASED ON THE CLIENTS COGNITIVE, PHYSICAL, COMMUNICATION, OR RESOURCE STATUS, THAT A HOME PROGRAM, EQUIPMENT, OR ENVIRONMENTAL ADAPTATIONS ALONE CANNOT MEET CLIENTS NEEDS.
PA69	PLEASE SPECIFY IF THE CLIENT HAS AN ACCOMPANYING DISABILITY THAT ADDS TO THE HEARING PROBLEM.
PA70	DISTINGUISH REQUESTED PROCEDURES AND GOALS FROM OTHER SERVICES THIS CLIENT RECEIVES. THEY MAY NOT BE DUPLICATIVE.
PA71	PLEASE INDICATE THE NUMBER OF DAYS REQUESTED.
PA73	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA74	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA75	PLEASE DOCUMENT CARRYOVER OF THE THERAPY PROGRAM TO NURSING.
PA76	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA79	PROVIDE EVIDENCE OF SIGNIFICANT FUNCTIONAL PROGRESS IN LAST SIX MONTHS.
PA84	THE GRANT DATE OF THIS REQUEST CANNOT BE PRIOR TO THE SIGNATURE DATE OF THE PRESCRIBING PHYSICIAN.
PA86	PROVIDE EVIDENCE OF SKILLS GAINED IN THERAPY CARRYING OVER TO OTHER SETTINGS WITHIN SIX MONTHS.
PA87	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE NUMBER OF SESSIONS REQUESTED.
PA88	THE REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL SCOPE OF PRACTICE.
PA89	PRIOR AUTHORIZATION IS NOT REQUIRED UNTIL LIMITATION OF SERVICE HAS BEEN REACHED.
PA91	PLEASE SUBMIT REQUIRED X-RAYS.
PA92	PLEASE PROVIDE AN EXPLANATION FOR THE MATERIAL SUBMITTED WITH THE REQUEST.
PA95	PLEASE DESCRIBE HOW THE PROVISION OF THIS SERVICE WOULD PREVENT INSTITUTIONALIZATION OF THE CLIENT.
PA96	COULD THE EXISTING DENTURE(S) BE RELINED OR REBASED? IF NOT, PLEASE EXPLAIN WHY NOT.
PA97	REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL STANDARDS OF PRACTICE.
PA98	PLEASE INDICATE IF THE CLIENT IS CURRENTLY BEING TUBE FED.
PB02	PLEASE PROVIDE THE REQUIRED DATED SIGNATURES ON THE ATTACHMENTS.
PB03	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING THE LOSS/DESTRUCTION/THEFT OF THE HEARING AID.
PB04	DESCRIBE THE CLIENTS ABILITY TO STAND OR AMBULATE SUFFICIENTLY TO ACCOMPLISH SELF-CARE ACTIVITIES.
PB07	PLEASE SUBMIT AN ORTHODONTIC STUDY MODEL OR DIAGNOSTIC CASTS.
PB09	PLEASE PROVIDE A PHOTOGRAPH OF THE INVOLVED AREA(S).
PB10	PLEASE PROVIDE AN ESTIMATION (IN GRAMS) OF THE TOTAL AMOUNT OF TISSUE TO BE RESECTED.
PB11	PLEASE SUBMIT THE PLAN OF CARE FOR CO-TREATMENT.
PB12	FURNISH A DETAILED DESCRIPTION FOR THE PROCEDURE CODE REQUESTED.
PB13	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB15	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB18	PLEASE COMPLETE THE ATTACHED OUT-OF-STATE PROVIDER DATA SHEET, F-11001, AND RESUBMIT.
PB20	A SIGNED AND DATED PRESCRIPTION IS REQUIRED WITHIN THREE MONTHS OF RECEIPT BY COLORADO MEDICAID FOR INITIAL REQUESTS AND WITHIN 12 MONTHS OF RECEIPT BY COLORADO MEDICAID FOR SUBSEQUENT REQUESTS.
PB21	PLEASE COMPLETE THE APPROPRIATE PRIOR AUTHORIZATION ATTACHMENT. CONTACT PROVIDER SERVICES OR THE PRIOR AUTHORIZATION UNIT FOR ASSISTANCE.

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PB23	PHYSICAL THERAPY ASSISTANT NOTES AND ALL FORMS SUBMITTED MUST BE COSIGNED BY A REGISTERED PHYSICAL THERAPIST.
PB31	ARE YOU REQUESTING A COMPLETE APPLIANCE, OR REPLACEMENT PARTS?
PB32	THE PROCEDURE CODE INDICATED ON THE REQUEST DOES NOT MATCH THE DESCRIPTION OF SERVICE; PLEASE CORRECT AND RESUBMIT.
PB35	THE SERVICE REQUESTED DOES NOT REQUIRE PRIOR AUTHORIZATION.
PB41	PLEASE FURNISH A CURRENT MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT, F-11090 (DATED WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID).
PB45	THE CERTIFICATION PERIOD ON THE PLAN OF CARE (POC) DOES NOT COVER THE REQUESTED GRANT/START DATE. PLEASE RESUBMIT YOUR REQUEST WITH A NEW POC.
PB49	A CERTIFIED OCCUPATIONAL THERAPY ASSISTANTS NOTES MUST BE COSIGNED BY AN OCCUPATIONAL THERAPIST REGISTERED.
PB51	ADDITIONAL INFORMATION IS REQUIRED ON PRIOR AUTHORIZATION TO ENABLE PRICING.
PB54	REQUESTED SERVICES DO NOT MATCH SERVICES ON THE PHYSICIANS ORDERS.
PB59	PLEASE PROVIDE AN INDIVIDUAL EDUCATIONAL PLAN (IEP), WHICH HAS BEEN SIGNED BY THE PROVIDER NO EARLIER THAN NINE MONTHS PRIOR TO RECEIPT AT COLORADO MEDICAID; OTHERWISE, DOCUMENT WHY NO IEP EXISTS.
PB65	PLEASE FURNISH THE ANTICIPATED TOTAL CHARGES FOR THIS REQUEST.
PB66	A PHOTOCOPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED; THE DATE MUST BE WITHIN SIX MONTHS OF RECEIPT BY COLORADO MEDICAID.
PB67	THE PRESCRIPTION DATE MUST INCLUDE MONTH, DAY, AND YEAR.
PB68	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID.
PB73	THE SERVICES IDENTIFIED ON THE PLAN OF CARE DO NOT APPEAR APPROPRIATE FOR THE PROCEDURE CODE(S) REQUESTED ON THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018.
PB74	THE CLIENT/PROVIDER DOES NOT HAVE RETROACTIVE ENROLLMENT.
PB75	THE REQUESTED START DATE IS MORE THAN 14 DAYS BEFORE OR 62 DAYS AFTER RECEIPT.
PB82	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
PB83	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A HOME HEALTH AIDE. PLEASE RESUBMIT AS A PERSONAL CARE WORKER OR PROVIDE ADDITIONAL DOCUMENTATION.
PB86	THE SERVICES REQUESTED ARE NOT BEING PROVIDED IN THE CLIENTS RESIDENCE. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL.
PB87	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A NURSE. PLEASE RESUBMIT AS A HOME HEALTH AIDE OR PROVIDE ADDITIONAL DOCUMENTATION.
PB92	PLEASE FURNISH THE CLIENTS COMPLETE ADDRESS.
PB94	IF THE CLIENT IS A RESIDENT OF A NURSING HOME, SUPPLY THE COMPLETE NAME AND ADDRESS OF THE NURSING HOME.
PB99	THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018, MUST BE SIGNED AND DATED.
PC01	PLEASE SUPPLY THE RENDERING PROVIDERS PROVIDER NUMBER.
PC03	THE DRUG ENFORCEMENT ADMINISTRATION NUMBER IS MISSING OR INVALID.
PC06	PLEASE DESCRIBE YOUR PROGRAM; INCLUDE ENTRY DATE, TERMINATION DATE, HOURS PER WEEK, AND NUMBER OF WEEKS OF PRIMARY INTENSIVE SERVICE REQUESTED.
PC07	PLEASE DESCRIBE YOUR "AFTERCARE/FOLLOW-UP" PLANS FOR THIS CLIENT.
PC08	PLEASE SUPPLY DOCUMENTATION OF PREVIOUS SUBSTANCE ABUSE SERVICES WITH DATE(S) AND OUTCOME.
PC09	PLEASE DESCRIBE IN DETAIL THE TREATMENT OBJECTIVES/GOALS FOR THIS CLIENT.
PC10	PLEASE DESCRIBE THE FAMILY SITUATION/DYNAMICS. EXPLAIN HOW THE FAMILY WILL BE INCORPORATED INTO THE CLIENTS PLAN OF CARE.
PC12	PLEASE EXPLAIN IF YOUR SERVICE ENCOURAGES THE CLIENT TO ATTEND SELF-HELP GROUPS.
PC13	PLEASE SUPPLY A SPECIFIC SCHEDULE OF ACTIVITIES, INCLUDING DAY, TIME OF DAY, LENGTH OF SESSION, AND SERVICE TO BE RENDERED DURING THAT TIME.
PC15	PLEASE FURNISH DIAGNOSTIC RATIONALE.
PC17	PLEASE DOCUMENT IF THE CLIENT EVER RECEIVED SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT.
PC19	PLEASE FURNISH MORE EXTENSIVE AND IN-DEPTH HISTORICAL AND PSYCHOSOCIAL DATA.

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PC20	PLEASE SUPPLY THE DATE THE CLIENT BECAME TOTALLY ENDENTULOUS.
PC23	PLEASE SUBMIT A PHYSICIANS STATEMENT REGARDING THE MEDICAL NECESSITY OF DENTURES FOR THIS CLIENT. THE PHYSICIANS STATEMENT MUST DOCUMENT THE MEDICAL NEED FOR DENTURES.
PC24	THE SERVICE REQUESTED WAS PREVIOUSLY AUTHORIZED. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT INDICATING THIS FACT IS REQUIRED.
PC25	PLEASE SUPPLY SUFFICIENT MITIGATING CIRCUMSTANCES TO WARRANT THE CONSTRUCTION OF NEW DENTURES(S).
PC26	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
PC28	PLEASE SUBMIT A PHYSICIANS STATEMENT INDICATING DENTURES ARE NECESSARY FOR THIS NURSING HOME CLIENT.
PC29	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING LOSS OR DESTRUCTION OF DENTURE(S). INCLUDE SIGNED STATEMENT FROM CLIENT OR FACILITY DIRECTOR REGARDING HOW, WHEN AND WHERE LOST.
PC30	PLEASE PROVIDE COMPLETE INTRAORAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PC31	PLEASE DESCRIBE ANY RELATED DEFORMITIES OF THE FEET.
PC34	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD WITH REQUESTED DME ITEM(S) AND DOCUMENT IF THE CLIENT CAN USE SAFELY AND INDEPENDENTLY.
PC35	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD AND DESCRIBE THE RESULTS AND EFFECTIVENESS OF THE SERVICE REQUESTED.
PC39	PLEASE INDICATE LITER FLOW PER MINUTE, HOURS OF USE PER 24 HOUR PERIOD, AND THE EXPECTED DURATION OF NEED.
PC40	THE ITEM DOES NOT REQUIRE PRIOR AUTHORIZATION UNTIL THE LIFE EXPECTANCY HAS BEEN REACHED.
PC41	PLEASE SUPPLY INFORMATION INDICATING THE NECESSITY OF POSITIONING THE CLIENT'S BODY IN MULTIPLE POSITIONS.
PC42	PLEASE INDICATE IF THE BED HEIGHT MUST BE CHANGED TO ALLOW FOR SAFE TRANSFER OR ADEQUATE BED CARE.
PC43	SUPPLY A PHYSICIANS STATEMENT INDICATING TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR UNIT HAS REDUCED PAIN, IMPROVED/INCREASED THE CLIENTS ACTIVITY LEVEL, AND/OR REDUCED CLIENTS USE OF PAIN MEDICATION.
PC44	A CURRENT AUTHORIZATION FOR THIS SERVICE IS ON FILE FOR ANOTHER PROVIDER. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT OF THAT FACT IS REQUIRED BY THE CLIENT OF FIRST PROVIDER.
PC59	DOCUMENT DECLINE OR PROGRESS IN SPECIFIC, MEASURABLE, OBJECTIVE TERMS.
PC60	DOCUMENT IF CLIENT HAS DEMONSTRATED A GOOD APPOINTMENT COMPLIANCE RECORD.
PC61	THE PHYSICIANS SIGNATURE DATE MUST NOT EXCEED 90 DAYS FROM THE DATE OF RECEIPT BY COLORADO MEDICAID.
PC62	REQUESTS FOR A CONTINUATION OF THERAPY SHOULD NOT BE SUBMITTED MORE THAN FOUR WEEKS PRIOR TO THE EXPIRATION DATE OF THE CURRENT AUTHORIZATION.
PC63	PLEASE FURNISH THE STYLE AND MANUFACTURER OF THE FRAME.
PC64	PLEASE FURNISH THE CLIENTS LENS FORMULA.
PC66	ALL REQUESTS FOR TINTS REQUIRE DOCUMENTATION OF THE VISUAL OR MEDICAL CONDITION RELATED TO PHOTOPHOBIA.
PC67	PLEASE DOCUMENT THE REASON AND JUSTIFICATION FOR REPLACEMENT BEYOND THE FIRST LENS/FRAME.
PC68	DOCUMENT IF ALL REMAINING MAXILLARY AND/OR MANDIBULAR TEETH ARE DECAY-FREE, PROPERLY RESTORED, AND PERIODONTICALLY SOUND.
PC72	SUPPLY MORE DETAIL REGARDING PROGRESS (ATTACHMENT OF GOALS, ETC.). CORRELATE PROGRESS TO PREVIOUS GOALS AND IDENTIFIED LIMITATIONS.
PC77	PLEASE SUBMIT A PLAN OF CARE DESCRIBING THE SERVICES THAT WOULD BE PROVIDED.
PC78	PLEASE DOCUMENT SPECIFIC, MEASURABLE GOALS.
PC82	THE PRIOR AUTHORIZATION (PA) SYSTEM CAN PROCESS ONLY 26 DETAILS PER PA REQUEST. PLEASE RESUBMIT YOUR REQUEST WITH NO MORE THAN 26 DETAILS.
PC83	PLEASE SUPPLY A PHYSICIANS PRESCRIPTION DATED WITHIN ONE MONTH OF REQUESTED SUBSTANCE ABUSE DAY TREATMENT.

Denial Code	Long Description
PC84	PLEASE PROVIDE INFORMATION INDICATING THIS CLIENT IS APPROPRIATELY DETOXIFIED FROM ALCOHOL AND/OR OTHER DRUGS.
PC85	PLEASE PROVIDE INFORMATION TO INDICATE THE CLIENTS ABILITY TO ABSTAIN FROM ALCOHOL OR DRUGS WHILE IN THE SUBSTANCE ABUSE DAY TREATMENT PROGRAM.
PC86	PLEASE INDICATE IF THIS CLIENT IS WILLING TO PARTICIPATE IN AFTERCARE OR CONTINUING CARE SERVICES.
PC87	PROVIDE MORE INFORMATION ON TREATMENT HISTORY; INCLUDE SERVICE PROVIDED, DATES, AND OUTCOME. PROVIDE DETAIL OF PREVIOUS TREATMENT.
PC88	PLEASE PROVIDE MORE RATIONALE FOR THE APPROPRIATENESS AND MEDICAL NECESSITY OF SUBSTANCE ABUSE DAY TREATMENT.
PC89	PROVIDE A TREATMENT PLAN THAT CONTAINS MEASURABLE GOALS AND OBJECTIVES CORRESPONDING TO THE IDENTIFIED DEFICIT.
PC91	PLEASE PROVIDE MORE INFORMATION ON FAMILY INVOLVEMENT TREATMENT.
PC92	PLEASE PROVIDE MORE HISTORY AND EXPLANATION ABOUT THE ISSUE OF ABSTINENCE FOR THIS CLIENT.
PC94	PLEASE PROVIDE THE ANTICIPATED BEGINNING DATE AND/OR THE ESTIMATED SUBSTANCE ABUSE DAY TREATMENT DISCHARGE DATE.
PC95	PLEASE SUPPLY JUSTIFICATION FOR BEGINNING CLIENT IN SERVICE PRIOR TO AUTHORIZATION BEING OBTAINED.
PC96	THE INITIAL THREE HOURS OF SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IN A CALENDAR YEAR DO NOT REQUIRE PRIOR AUTHORIZATION.
PC97	REIMBURSEMENT FOR INITIAL SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IS LIMITED TO THREE HOURS IN A CALENDAR YEAR AND DOES NOT REQUIRE PRIOR AUTHORIZATION.
PC98	THIS DRUG IS CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE BILL USING THE APPROPRIATE NATIONAL DRUG CODE (NDC) OR SUBMIT A COMPLETED DRUG ADDITION REQUEST FORM IF THE NDC IS NOT LISTED IN THE DRUG INDEX.
PC99	THIS DRUG IS NOT CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL, CURRENT ADMINISTRATIVE RULE, OR COLORADO DRUG INDEX FOR COVERAGE LIMITATIONS.
PD01	DOCUMENT THAT CLIENT HAS ACHIEVED GOOD ORAL HYGIENE, PERIODONTAL CASE TYPE 1 OR 2, AND IS MOTIVATED TO MAINTAIN SAME.
PD03	PLEASE PROVIDE AN ARTERIAL BLOOD GAS READING OR PULSE OXIMETRY RESULTS DONE ON ROOM AIR SIGNED AND DATED BY A MEDICAL DOCTOR. THIS SHOULD BE DONE WITHIN 60 DAYS OF REQUESTED SERVICE.
PD04	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 30 DAYS OF RECEIPT BY COLORADO MEDICAID.
PD07	SUBMIT A PHOTOCOPY OF A VALID PRESCRIPTION, ISSUED WITHIN THE PAST YEAR, OR COMPLETE SECTION B OF THE PRIOR AUTHORIZATION/DRUG ATTACHMENT (PA/DGA), F-11049.
PD10	BRAND MEDICALLY NECESSARY MUST BE IN THE PRESCRIBERS OWN HANDWRITING AND WRITTEN DIRECTLY ON THE PRESCRIPTION OR A SEPARATE ORDER ATTACHED TO THE ORIGINAL PRESCRIPTION.
PD12	COMPLETE DENTURES, PARTIAL DENTURES, DENTURE RELINES, AND FIXED PROSTHODONTIC SERVICES ARE NOT COVERED SERVICES FOR ADULTS FOR DATES OF SERVICE ON AND AFTER OCTOBER 1, 1995.
PD22	PLEASE COMPLETE ALL REQUIRED ELEMENTS ON THE PERSONAL CARE SCREENING TOOL (PCST), F-11133.
PD24	THIS PRIOR AUTHORIZATION REQUEST IS UNABLE TO BE PROCESSED. PLEASE RESUBMIT WITH ADDITIONAL REQUIRED FORMS, INCLUDING THE ENTIRE PERSONAL CARE SCREENING TOOL (PCST), F-11133; PERSONAL CARE ADDENDUM, F-11136; AND SUPPORTING DOCUMENTATION, AS DIRECTED.
PD25	THERE IS A PERSONAL CARE SCREENING TOOL (PCST), F-11133, COMPLETED BY ANOTHER AGENCY. CONTACT THE AGENCY TO TRANSFER SCREEN.
PD26	THERE IS A LIMITED TERM CARE FUNCTIONAL SCREEN (LTC-FS) COMPLETED BY ANOTHER AGENCY. THE PERSONAL CARE SCREENING TOOL (PCST), F-11133, INFORMATION IS IN CONFLICT WITH LTC-FS.
PD27	ONLY ONE LEVEL OF FUNCTION MAY BE SELECTED FOR ALL ELEMENTS EXCEPT TOILETING. COLORADO MEDICAID IS UNABLE TO PROCESS THE PRIOR AUTHORIZATION REQUEST.
PD28	NO UNITS MAY BE REQUESTED USING THIS PRIOR AUTHORIZATION PROCESS. PLEASE SUBMIT WITH THE APPROPRIATE ATTACHMENTS FOR REQUESTING SPECIFIC PERSONAL CARE WORKER UNITS.

Denial Code	Long Description
PD29	CLIENT IS NOT ELIGIBLE FOR THE REQUESTED SERVICE(S) AS OF THE REQUESTED START DATE.
PD30	NO TRAVEL TIME MAY BE AUTHORIZED WHEN NO PERSONAL CARE WORKER SERVICE IS AUTHORIZED.
PD32	PROVIDER NOT CERTIFIED TO RENDER THE SERVICE(S) REQUESTED.
PD34	BASED ON THE DOCUMENTATION SUBMITTED, THIS REQUEST CAN NOT BE PRIOR AUTHORIZED. REFER TO THE PA MESSAGES FROM THE CONSULTANT FOR COMPLETE EXPLANATION.
PD98	PLEASE DOCUMENT HOW AND WHEN EACH PREVIOUSLY AUTHORIZED PRO RE NATA VISIT WAS USED.

Occupational Therapy

Denial Code	Long Description
0201	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
0233	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0235	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0237	CLIENT IDENTIFICATION NUMBER DOES NOT MATCH CLIENTS FIRST NAME.
0238	THE CLIENT IDENTIFICATION NUMBER DOES NOT MATCH THE CLIENTS LAST NAME.
0242	SECONDARY DIAGNOSIS CODE IS INVALID.
0248	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0249	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0251	PROCEDURE CODE MODIFIER IN FIRST POSITION IS INVALID.
0252	THE PROCEDURE CODE MODIFIER IN SECOND POSITION IS INVALID FOR REQUESTED START DATE OR DATE OF RECEIPT.
0253	THE PROCEDURE CODE MODIFIER IN THIRD POSITION IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
0258	THE PRIMARY DIAGNOSIS CODE IS REQUIRED.
0272	THE PRIMARY DIAGNSOSIS CODE IS INVALID.
0400	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0853	HCPCS - ANNUAL UPDATE
0885	NEVER EVENTS MODIFIERS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
0886	NEVER EVENTS DIAGNOSIS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
1000	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
1002	RENDERING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1003	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1007	RENDERING PROVIDER ID IS NOT ON FILE.
1047	THE RENDERING PROVIDERS CERTIFICATION HAS BEEN CANCELLED.
1048	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1801	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
1804	A CERTIFIED SUBSTANCE ABUSE DAY TREATMENT PROVIDER MUST SUBMIT A SUBSTANCE ABUSE DAY TREATMENT PROCEDURE CODE.
1806	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
1808	THE BILLING PROVIDER DOES NOT HAVE THE REQUIRED CERTIFICATION ADDENDUM ON FILE.
1900	THE BILLING PROVIDERS TAXONOMY CODE IS INVALID.
1901	THE RENDERING PROVIDERS TAXONOMY CODE IS INVALID.
1927	A NATIONAL PROVIDER IDENTIFIER IS REQUIRED FOR THE BILLING PROVIDER.
1934	A NATIONAL PROVIDER INDENTIFIER IS REQUIRED FOR THE RENDERING PROVIDER.
1936	THE BILLING PROVIDER NUMBER IS INVALID.
1937	THE RENDERING PROVIDER NUMBER IS INVALID.
1960	INTERNAL PROCESSING IS REQUIRED.
1963	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.

Denial Code	Long Description
1964	THE BILLING PROVIDER INDICATED IS NOT ALLOWABLE AS A BILLING PROVIDER.
1965	RENDERING PROVIDER NUMBER IS MISSING/INVALID FOR THIS PROCEDURE PROVIDER.
1974	PRESCRIBING/REFERRING/ORDERING PROVIDER INDICATED IS NOT CERTIFIED AS A PRESCRIBING/REFERRING/ORDERING PROVIDER.
1975	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
1976	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
2001	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2003	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2017	THE CLIENT IS ENROLLED IN A MEDICAID OR OTHER MANAGED CARE PROGRAM.
2037	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2603	CLIENT LOCKED-IN TO A PROVIDER OR ENROLLED IN A HOSPICE. CONTACT CLIENTS HOSPICE FOR PAYMENT OF SERVICES OR RESUBMIT WITH DOCUMENTATION OF UNRELATED NATURE OF CARE.
3324	THE MODIFIER HAS BEEN DISCONTINUED BY THE CENTERS OF MEDICARE AND MEDICAID SERVICES OR THE AMERICAN MEDICAL ASSOCIATION FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
3337	THE PROCEDURE CODE HAS BEEN TERMINATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AMERICAN MEDICAL ASSOCIATION, OR AMERICAN DENTAL ASSOCIATION FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT. RESUBMIT WITH VALID A PROCEDURE CODE.
3339	THE PROCEDURE BILLED IS NOT PAYABLE ACCORDING TO DEFICIT REDUCTION ACT (DEFRA) GUIDELINES.
3351	THE PROCEDURE IS NOT COVERED FOR CLIENTS WITH A NURSING HOME AUTHORIZATION ON THE REQUESTED START DATE OR DATE OF RECEIPT.
3353	THE PROCEDURE IS NOT A COVERED SERVICE FOR HOME AND COMMUNITY-BASED WAIVER CLIENTS.
4021	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4027	THE DIAGNOSIS CODE IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
4031	THE PROCEDURE SUBMITTED IS NOT APPROPRIATE FOR CLIENTS GENDER.
4032	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4034	THE PROCEDURE CODE HAS AN AGE RESTRICTION.
4036	THE PLACE OF SERVICE CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4040	THE PRIMARY DIAGNOSIS CODE IS NOT ON FILE.
4041	THE SECONDARY DIAGNOSIS IS NOT ON FILE.
4046	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4127	INTERNAL PROCESSING IS REQUIRED.
4131	INTERNAL PROCESSING IS REQUIRED.
4141	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4149	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4150	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4236	ETIOLOGY DIAGNOSIS CODE(S) (E-CODES) ARE INVALID AS THE PRIMARY DIAGNOSIS.
4244	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4245	THE FOURTH POSITION MODIFIER IS INVALID FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT.
4256	THE PROCEDURE CODE AND MODIFIER COMBINATION IS NOT PAYABLE FOR THE CLIENTS BENEFIT PLAN.
4257	THE MODIFIERS SUBMITTED ARE EITHER INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT OR THE MODIFIERS ARE MISSING.
4311	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4315	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4316	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4371	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4372	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4711	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR CLIENTS AGE.
4714	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS AGE.
4731	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS DIAGNOSIS.
4742	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4743	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4744	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.

Denial Code	Long Description
4745	DIAGNOSIS AND/OR PROCEDURE AND/OR PLACE OF SERVICE (POS) CODE IS NOT COVERED FOR EXPRESS ENROLLMENT CLIENTS.
4746	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4801	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4802	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
4821	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
4871	PLEASE REFER TO PA MESSAGES FOR RETURN INFORMATION.
4963	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS GENDER.
4990	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
7500	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
7509	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
P001	THE BILLING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THE SERVICES.
P002	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P003	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P005	THE PRIOR AUTHORIZATION CAN NOT BE END DATED. THE PRIOR AUTHORIZATION STATUS IS NOT APPROVED OR APPROVED WITH REVISIONS.
P006	PLEASE FURNISH THE PROCEDURE CODE AND CORRESPONDING DESCRIPTION.
P008	THE BILLING PROVIDER NUMBER IS INVALID.
P009	THE BILLING PROVIDER NUMBER IS INVALID.
P010	THE REQUESTED END DATE IS INVALID.
P011	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P012	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P013	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P014	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P015	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P016	THE REQUESTED START DATE IS MISSING OR INVALID.
P019	THE REQUESTED START DATE IS MISSING OR INVALID.
P020	THE RENDERING PROVIDER NUMBER IS INVALID.
P021	THE RENDERING PROVIDER NUMBER IS INVALID.
P022	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P023	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P024	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P026	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P027	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P030	FIRST MODIFIER IS INVALID.
P031	FIRST MODIFIER IS INVALID.
P032	SECOND MODIFIER IS INVALID.
P033	SECOND MODIFIER IS INVALID.
P034	THIRD MODIFIER IS INVALID.
P035	THIRD MODIFIER IS INVALID.
P036	FOURTH MODIFIER IS INVALID.
P037	FOURTH MODIFIER IS INVALID.
P038	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P039	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.

Denial Code	Long Description
P040	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P041	CLIENTS FIRST NAME IS MISSING.
P042	CLIENTS LAST NAME IS MISSING.
P043	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P044	BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES REQUESTED.
P045	FIRST MODIFIER IS INVALID.
P046	SECOND MODIFIER IS INVALID.
P047	THIRD MODIFIER IS INVALID.
P048	FOURTH MODIFIER IS INVALID.
P052	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P053	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P054	RENDERING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES FOR THE BENEFIT PLAN.
P055	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P061	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P062	THE CLIENT ID AND/OR NAME INDICATED ON THE PA REQUEST IS INCORRECT. THE CLIENT ID AND/OR NAME HAS BEEN UPDATED. PLEASE VERIFY THE ID AND/OR NAME IS CORRECT.
P064	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
P067	THE FREQUENCY OF HOURS REQUESTED ARE NOT APPROPRIATE FOR THIS CLIENT AND HAVE BEEN MODIFIED ACCORDINGLY.
P079	BILLING PROVIDER IS ON PAYMENT SUSPENSION DUE TO CREDIBLE ALLEGATION OF FRAUD.
P120	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAS BEEN REDUCED.
P121	THE SERVICE/ PROCEDURE REQUESTED IS NOT SUPPORTED BY SUBMITTED DOCUMENTATION.
P126	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
P128	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.
P138	SERVICE(S) DO NOT MEET COLORADO MEDICAID GUIDELINES.
P167	REQUESTED DOCUMENTATION HAS NOT BEEN SUBMITTED.
P178	THE SERVICE REQUESTED IS NOT MEDICALLY NECESSARY.
P179	THE MEDICAL NECESSITY FOR THIS SERVICE IS NOT SUPPORTED BY THE SUBMITTED DOCUMENTATION.
P233	THE DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE ADDITIONAL CARE.
P257	THIS CLIENTS FUNCTIONAL ASSESSMENT SCORES PLACE THIS CLIENT OUTSIDE ELIGIBILITY FOR DAY TREATMENT.
P274	OUR RECORDS INDICATE THIS CLIENT IS INVOLVED IN EFFECTIVE AND APPROPRIATE SERVICE ELSEWHERE.
P292	INTENSIVE REHABILITATION HOURS ARE NO LONGER APPROPRIATE AS INDICATED BY HISTORY, DIAGNOSIS, AND/ OR FUNCTIONAL ASSESSMENT SCORES.
P328	THE SERVICES REQUESTED INCLUDE NON-COVERED SERVICES, AND HOURS ARE REDUCED ACCORDINGLY.
P339	THE CLIENTS PAST HISTORY INDICATES REDUCED TREATMENT HOURS ARE WARRANTED.
P342	THE REQUEST DOES NOT MEET GENERALLY ACCEPTED CONDITIONS REQUIRING FLUORIDE TREATMENTS.
P346	SERVICES EXCEED COLORADO MEDICAID LIMITATION AND DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE MEDICAL NECESSITY OF THE SERVICE.
P349	THE SERVICE REQUESTED WAS PERFORMED LESS THAN FIVE YEARS AGO.
P353	THE EXISTING APPLIANCE HAS NOT BEEN WORN FOR THREE YEARS.
P367	THE CLIENT HAS BEEN TOTALLY WITHOUT TEETH AND AN APPLIANCE FOR FIVE YEARS.
P392	THE CLIENT IS MISSING AN ANTERIOR TOOTH AND/OR HAS TWO OR MORE POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P405	THE SERVICE(S) REQUESTED COULD ADEQUATELY BE PERFORMED IN THE DENTAL OFFICE.
P406	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE OF GOOD PERIODONTAL HEALTH (AMERICAN ACADEMY OF PERIODONTOLOGY PERIODONTAL CLASSIFICATION OF TYPE I OR II).
P407	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE VISIBLE ON RADIOGRAPHS THAT AT LEAST 50 PERCENT OF THE CLINICAL CROWN IS INTACT.

Denial Code	Long Description
P409	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING SIX OR MORE TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED, INCLUDING THIRD MOLARS.
P410	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING ONE OR MORE ANTERIOR TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED.
P411	DOCUMENTATION DOES NOT SUPPORT THE NEED FOR PERIODONTIC SERVICES. POCKETS ARE LESS THAN 4MM AND/OR GREATER THAN 6MM FOR CLIENT AND/OR THE CLIENT IS UNDER THE AGE OF 13.
P412	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA.
P413	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA. THIS PA HAS BEEN GRANTED AS APPROVED NOT APPROVED WITH REVISIONS. THE DURATION REQUESTED MAY HAVE BEEN REDUCED TO REFLECT COVERAGE LIMITATIONS, PRESCRIBER ORDERS, CONFLICTI
P417	THE SERVICE(S) REQUESTED COULD BE ADEQUATELY PERFORMED WITH LOCAL ANESTHESIA.
P437	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO POOR ORAL HYGIENE.
P444	THIS LINE ITEM IS A DUPLICATE OF ANOTHER LINE ITEM ON THIS PRIOR AUTHORIZATION (PA) REQUEST. PLEASE CORRECT.
P446	THIS IS A DUPLICATE OF AN EXISTING PRIOR AUTHORIZATION (PA) REQUEST. YOU MAY CONTACT PROVIDER SERVICES IF YOU REQUIRE ASSISTANCE. DUPLICATE PA REQUEST
P448	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO DECAY HISTORY.
P449	QUESTIONABLE LONG TERM PROGNOSIS DUE TO GUM AND BONE DISEASE.
P456	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO APPARENT ROOT INFECTION.
P457	OUR RECORDS INDICATE THIS CLIENT HAS EXCEEDED ESTABLISHED PROGRAM LIMITATIONS. COLORADO MEDICAID WILL NOT AUTHORIZE NEW DENTURES.
P458	DOCUMENTATION PROVIDED INDICATES A LESS ELABORATE PROCEDURE SHOULD BE CONSIDERED.
P502	RENTAL ONLY ALLOWED; MEDICAL NEED FOR PURCHASE HAS NOT BEEN DOCUMENTED.
P503	PURCHASE ONLY ALLOWED; MEDICAL NEED FOR RENTAL HAS NOT BEEN DOCUMENTED.
P504	OCCUPATIONAL THERAPY GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P505	THE SERVICE REQUESTED IS INCLUDED IN THE NURSING HOME RATE STRUCTURE.
P511	THIS NATIONAL DRUG CODE IS ONLY BILLABLE AS PART OF A COMPOUND DRUG.
P515	THE PRESENCE OF A HANDICAPPING MALOCCLUSION OR HANDICAPPING DENTOFACIAL DEFORMITY IS NOT SUPPORTED BY THE DOCUMENTATION SUBMITTED.
P521	THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVERED BY COLORADO MEDICAID.
P522	GASTRO-INTESTINAL SURGERY FOR THE PURPOSE OF WEIGHT CONTROL IS COVERED ONLY AS A LIFE THREATENING PROCEDURE.
P523	THE TREATMENT REQUEST IS NOT CONSISTENT WITH THE CLIENT'S DIAGNOSIS.
P524	PSYCHOTHERAPY PROVIDED IN THE CLIENTS HOME IS NOT A COVERED BENEFIT OF COLORADO MEDICAID.
P525	THE INFORMATION PROVIDED IS NOT CONSISTENT WITH THE INTENSITY OF SERVICES REQUESTED.
P526	INTENSIVE MULTIPLE MODALITY TREATMENT IS NOT CONSISTENT WITH THE INFORMATION PROVIDED.
P527	MULTIPLE PROVIDERS OF TREATMENT ARE NOT INDICATED FOR THIS CLIENT.
P528	THE DURATION OF TREATMENT SESSIONS EXCEED CURRENT COLORADO MEDICAID GUIDELINES.
P534	DOCUMENTATION OF POOR PHYSICAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P535	OTHER PHYSICAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P536	THE PHYSICAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P537	USE OF PHYSICAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P538	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF A PHYSICAL THERAPIST.
P539	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS AND LIVING ARRANGEMENT.
P540	GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P541	THE PROCEDURE(S) REQUESTED ARE NOT MEDICAL IN NATURE.

Denial Code	Long Description
P542	DOCUMENTATION OF POOR OCCUPATIONAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P543	DOCUMENTATION OF POOR SPEECH THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P544	OTHER OCCUPATIONAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P546	THE OCCUPATIONAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P547	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF PHYSICAL THERAPY.
P548	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P549	ACTIVITIES TO PROMOTE DIVERSION OR GENERAL MOTIVATION ARE NONCOVERED COLORADO MEDICAID SERVICES.
P550	REVISIONS OF THE REQUEST IS NECESSITATED BY THE CLIENTS MINIMAL PROGRESS.
P551	RESTORATIVE NURSING INVOLVEMENT COULD BE INCREASED.
P552	CLIENTS DEMONSTRATED RESPONSE TO CURRENT THERAPY DOES NOT WARRANT THE INTENSE FREQUENCY REQUESTED.
P553	MAINTENANCE IS TWO TIMES PER WEEK OR LESS.
P554	THE SPEECH THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P555	USE OF OCCUPATIONAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P556	USE OF SPEECH THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P557	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF AN OCCUPATIONAL THERAPIST.
P558	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
P559	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P560	THE MATERIALS/ SERVICES REQUESTED ARE PRINCIPALLY COSMETIC IN NATURE.
P561	THE LENS FORMULA DOES NOT JUSTIFY REPLACEMENT.
P562	THE CHANGE IN THE LENS FORMULA DOES NOT WARRANT MULTIPLE REPLACEMENTS.
P563	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P564	LENSES ONLY ARE APPROVED; PLEASE DISPENSE A CONTRACTED FRAME. THE NON-CONTRACTED FRAME IS NOT MEDICALLY JUSTIFIED.
P565	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P566	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P567	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF OCCUPATIONAL THERAPY.
P568	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF SPEECH THERAPY.
P569	LEVEL, INTENSITY, OR EXTENT OF SERVICE(S) REQUESTED HAS BEEN MODIFIED CONSISTENT WITH MEDICAL NEED AS DEFINED IN THE PLAN OF CARE.
P570	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P571	THE SERVICE ASKED FOR IS NOT COVERED BY COLORADO MEDICAID AS THESE TASKS CAN BE DONE BY NURSES OR ACTIVITY STAFF.
P572	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P573	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.
P574	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P575	MEDICAL NEED FOR EQUIPMENT/ SUPPLY REQUESTED IS NOT SUPPORTED BY DOCUMENTATION SUBMITTED.
P576	OTHER SPEECH THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.

Denial Code	Long Description
P577	DOCUMENTATION SUBMITTED IDENTIFIES THAT THE CLIENT HAS FEWER THAN TWO POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P582	LESS EXPENSIVE ALTERNATIVE SERVICES ARE AVAILABLE FOR THIS CLIENT.
P634	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P711	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING PERIODONTAL SCALING AND ROOT PLANNING.
P712	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING GINGIVECTOMY.
P754	AN APPROVED SUBSTANCE ABUSE DAY TREATMENT PROGRAM CANNOT EXCEED A SIX WEEK PERIOD.
P761	THE CLIENT DOES NOT APPEAR TO BE ABLE OR WILLING TO ABSTAIN FROM ALCOHOL/DRUG USAGE WHILE IN TREATMENT. THEREFORE, SUBSTANCE ABUSE DAY TREATMENT SERVICES ARE NOT APPROVED.
P764	THIS CLIENT HAS COMPLETED INTENSIVE SUBSTANCE ABUSE TREATMENT WITHIN THE PAST 12 MONTHS. THE DOCUMENTATION PROVIDED IS NOT ADEQUATE TO JUSTIFY ADDITIONAL INTENSIVE TREATMENT AT THIS TIME.
P785	A LESS THAN SIX-WEEK HEALING PERIOD HAS BEEN SPECIFIED FOR THIS PRIOR AUTHORIZATION. THEREFORE IT IS NOT NECESSARY TO WAIT THE FULL SIX WEEKS AFTER EXTRACTIONS BEFORE TAKING DENTURE IMPRESSIONS.
P818	SIX-WEEK HEALING TIME IS REQUIRED BETWEEN EDENTULATION AND FINAL IMPRESSIONS. PAYMENT FOR DENTURES WILL BE DENIED OR RECOUPED IF HEALING PERIOD IS NOT OBSERVED.
P849	COLORADO MEDICAID HAS DETERMINED THERE WERE (ARE) SEVERAL HOME HEALTH AGENCIES WILLING TO PROVIDE MEDICALLY NECESSARY SKILLED NURSING SERVICES TO THIS CLIENT.
P864	THE DOCUMENTATION YOU HAVE SUBMITTED DOES NOT MEET THE REQUIREMENTS OF COLORADO MEDICAID.
P873	THE MEDICAL NECESSITY FOR THE HOURS REQUESTED IS NOT SUPPORTED BY THE INFORMATION SUBMITTED.
P874	THE DOCUMENTATION SUBMITTED INDICATES THE TASKS SPECIFIED CAN BE COMPLETED DURING THE VISITS APPROVED.
P878	THE DOCUMENTATION SUBMITTED DOES NOT INDICATE THAT MEDICALLY ORIENTED TASKS ARE MEDICALLY NECESSARY; THEREFORE PERSONAL CARE SERVICES HAVE BEEN APPROVED.
P880	THE QUANTITY OF SERVICES AUTHORIZED FOR THIS CLIENTS PERSONAL CARE HAS BEEN AMENDED BASED ON INFORMATION RECEIVED FROM ONE OR MORE OF THESE SOURCES: THE CLIENT, THEIR PHYSICIAN, AND/OR THE IN-HOME VISIT BY STAFF OF THE OIG (OFFICE OF INSPECTOR GENERAL).
P885	THE USE OF THIS DRUG FOR THE INTENDED PURPOSE IS NOT COVERED BY COLORADO MEDICAID, CONSISTENT WITH COLORADO ADMINISTRATIVE CODE AND FEDERAL LAW.
P924	THE MEDICAL RECORDS SUBMITTED WITH THE CURRENT REQUEST CONFLICT OR DISAGREE WITH OUR MEDICAL RECORDS ON THIS CLIENT.
P950	INDEPENDENT NURSES, PLEASE NOTE PAYABLE SERVICES MAY NOT EXCEED 12 HOURS/DAY OR 60 HOURS/WEEK.
P951	SERVICES CAN ONLY BE AUTHORIZED THROUGH ONE YEAR FROM THE PRESCRIPTION DATE.
P952	LEAD INSPECTION IS A COVERED COLORADO MEDICAID SERVICE WHEN THE CHILD HAS BEEN SHOWN TO HAVE LEAD POISONING (E.G., CHILD HAS A BLOOD LEAD LEVEL > 19 UG/DL OR TWO CONSECUTIVE BLOOD LEAD LEVELS OF 15-19 UG/DL DONE AT LEAST 90 DAYS APART). THE INSPECTION MUS
P953	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P954	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P956	THE REQUEST CAN ONLY BE BACKDATED A MAXIMUM OF 14 DAYS FROM FIRST DATE RECEIVED BY COLORADO MEDICAID.
P957	COMPLETE PERIODONTAL CHARTING AT TIME OF SERVICE, AND SUBMIT CHARTING, COPY OF OPERATIVE REPORT, TOGETHER WITH A COPY OF THE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF), F-11035, TO PA UNIT ATTENTION DENTAL CONTSULTANT.
P958	NOTE THAT CODE D4341 HAS BEEN CHANGED. REFER TO THE DECISION NOTICE FOR AUTHORIZED QUANTITY.

Denial Code	Long Description
P960	YOUR PA HAS BEEN APPROVED FOR 90 DAYS. THE 90 DAY APPROVAL DOES NOT IMPLY THE PA REQUEST MEETS PRIOR AUTHORIZATION CRITERIA. AFTER ADDITIONAL INFORMATION IS AVAILABLE IN INTERCHANGE, COLORADO MEDICAID WILL CREATE AN AMENDMENT REQUEST TO EXTEND THE PA FOR
P961	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P962	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
PA10	THE REQUESTED END DATE IS INVALID.
PA12	PLEASE FURNISH A WRITTEN DESCRIPTION OF THE CLIENTS DIAGNOSIS.
PA13	PROVIDE DIAGNOSES WITH DATES OF ONSET.
PA14	IDENTIFY PROBLEMS TO BE TREATED.
PA15	THE AUDIOLOGISTS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1), F-11020, AND PRIOR AUTHORIZATION REQUEST/HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2), F-11021.
PA16	THE PHYSICIANS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION/PHYSICIAN OTOLOGICAL REPORT (PA/POR), F-11019.
PA17	SUBMIT BRIEF HISTORY WITH REFERRAL INFORMATION, LIVING SITUATION, FUNCTIONAL STATUS, AND OTHER PERTINENT INFORMATION. WHAT CHANGE OF STATUS RESULTED IN REFERRAL AT THIS TIME?
PA18	PLEASE FURNISH THE CLIENTS HEIGHT AND WEIGHT.
PA19	PLEASE SUBMIT CLINICAL INFORMATION SUFFICIENT TO VERIFY THE NEED FOR THE REQUESTED SERVICE(S).
PA20	PLEASE RESUBMIT WITH COMPLETE PERIODONTAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PA21	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL EDUCATIONAL PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA22	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL PROGRAM PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA23	REFER TO THE DURABLE MEDICAL EQUIPMENT INDEX FOR APPROPRIATE CODE AND DESCRIPTION. DO NOT USE AN "UNLISTED" CODE.
PA24	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUALIZED FAMILY SERVICE PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA25	INFORMATION ON THE REQUEST FORM IS ILLEGIBLE, AND THE REQUEST CANNOT BE PROCESSED.
PA26	RE-EVALUATE YOUR GOALS. EMPHASIS SHOULD BE ON FUNCTIONAL SELF-CARE. GOALS MUST BE RELATED TO FUNCTIONAL OUTCOME.
PA27	PLEASE CLARIFY THE NUMBER OF HOURS PER WEEK REQUESTED.
PA28	PLEASE CLARIFY THE NUMBER OF HOURS PER DAY REQUESTED.
PA29	PLEASE CLARIFY THE NUMBER OF VISITS PER DAY REQUESTED.
PA30	ATTACH SUPPORTIVE DOCUMENTATION; HOME EXERCISE PROGRAM AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA31	THE DIAGNOSIS CODE INDICATED ON THE REQUEST DOES NOT CORRESPOND TO THE DIAGNOSIS CODE DESCRIPTION.
PA32	PLEASE SUBMIT ADDITIONAL INFORMATION SUFFICIENT TO VERIFY APPROPRIATENESS AND NEED FOR TRANSPLANT.
PA33	PLEASE SUBMIT THE INITIAL AND PROGRESSIVE OBJECTIVE FINDINGS.
PA34	ATTACH SUPPORTIVE DOCUMENTATION, FACILITY PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA35	PLEASE SUBMIT THE CLIENTS ORIGINAL COMPLAINTS AND EXAMINATION FINDINGS.
PA36	ATTACH SUPPORTIVE DOCUMENTATION, IN-HOME AUTISM PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA37	PLEASE SUBMIT YOUR TREATMENT PLAN FOR THIS CLIENT.
PA38	ATTACH SUPPORTIVE DOCUMENTATION AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.

Denial Code	Long Description
PA39	INITIAL EVALUATIONS MUST BE PERFORMED BY AN OCCUPATIONAL THERAPIST REGISTERED (OTR), PER AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA) STANDARDS.
PA41	IDENTIFY THE PLACE OF SERVICE AND ITS EFFECT ON SUPPORTING THE DESIRED TREATMENT OUTCOME.
PA42	PLEASE INDICATE THE HOURS OF USE OF OXYGEN PER 24-HOUR PERIOD.
PA43	PROVIDE BASELINE DOCUMENTATION FOR THIS CLIENTS LIMITATIONS USING UNITS OF MEASUREMENT THAT ARE APPLIED CONSISTENTLY WHEN REPORTING STATUS.
PA44	IDENTIFY FUNCTIONAL LIMITATIONS AS THEY ARE RELATED TO IDENTIFIED CONDITIONS.
PA46	CORRELATE PLAN OF CARE TO REQUESTED PROCEDURE CODES.
PA47	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE FREQUENCY/DURATION REQUESTED.
PA48	PLEASE PROVIDE THE NAME AND CREDENTIALS OF THE RENDERING PROVIDER.
PA50	COLORADO MEDICAID RECORDS INDICATE THE CLIENT OWNS A WHEELCHAIR. DOCUMENT THE REASON AND NEED FOR REPLACEMENT AND COST TO REPAIR CURRENT WHEELCHAIR.
PA51	PLEASE DISTINGUISH PRIMARY AND SUPPORTIVE MODALITIES.
PA52	PLEASE SUBMIT A PROGRESS REPORT.
PA53	MULTIPLE FAMILY CLIENTS TREATMENT BY THE SAME PROVIDER REQUIRES FURTHER INFORMATION DOCUMENTING COORDINATION OF TREATMENT PLAN.
PA54	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE MINUTES REQUESTED.
PA55	MEDICAL NECESSITY OF TREATMENT REQUIRES ADDITIONAL DOCUMENTATION.
PA56	GIVEN AGE, DIAGNOSES, CURRENT LEVEL OF FUNCTION, PAST RESPONSE TO TREATMENT, AND LIVING SITUATION, EXPAND ON POTENTIAL FOR SIGNIFICANT FUNCTIONAL PROGRESS WITHIN THE NEXT SIX MONTHS. EMPHASIZE WHY PROGRESS IS EXPECTED WITH SERVICES AT THIS TIME.
PA57	SUBMIT THE INITIAL FINDINGS. INCLUDE A COMPREHENSIVE EVALUATION.
PA58	SUBMIT PROGRESSIVE, OBJECTIVE FINDINGS. INCLUDE A PERTINENT RE-EVALUATION.
PA59	PLEASE SUPPLY INFORMATION REGARDING THE CLIENTS MEDICATION REQUIREMENTS, IF ANY.
PA60	PLEASE SPECIFY IF THE CLIENT IS IN AN EDUCATIONAL SETTING.
PA61	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA62	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
PA63	THE SKILLS OF A THERAPIST ARE PURPOSEFUL AND SKILLED INTERVENTIONS REQUIRED TO CONTINUALLY DESIGN, IMPLEMENT, REASSESS, MODIFY/GRADE, AND/OR DISCONTINUE A PLAN OF CARE IN A TIMELY MANNER, BASED ON THE COMPLEXITY OF THE CLIENTS MEDICAL CONDITION AND/OR CO
PA64	PLEASE SUBMIT A THERAPY PLAN OF CARE, INCLUDING A CURRENT, DATED EVALUATION.
PA65	A PLAN OF CARE SIGNED AND DATED BY THE PHYSICIAN IS REQUIRED.
PA66	THE SKILLS OF A THERAPIST ARE REQUIRED WHEN ONLY THE THERAPIST CAN SAFELY AND EFFECTIVELY DELIVER THE THERAPEUTIC PROCEDURES BECAUSE OF THEIR UNIQUE KNOWLEDGE, TRAINING, AND EXPERTISE. DESCRIBE THE REASON THAT SOMEONE OTHER THAN A THERAPIST CANNOT SAFELY
PA67	PLEASE SPECIFY IF THE CLIENTS WORK SITE DEMANDS GOOD BINAURAL HEARING.
PA68	DESCRIBE THE REASON, BASED ON THE CLIENTS COGNITIVE, PHYSICAL, COMMUNICATION, OR RESOURCE STATUS, THAT A HOME PROGRAM, EQUIPMENT, OR ENVIRONMENTAL ADAPTATIONS ALONE CANNOT MEET CLIENTS NEEDS.
PA69	PLEASE SPECIFY IF THE CLIENT HAS AN ACCOMPANYING DISABILITY THAT ADDS TO THE HEARING PROBLEM.
PA70	DISTINGUISH REQUESTED PROCEDURES AND GOALS FROM OTHER SERVICES THIS CLIENT RECEIVES. THEY MAY NOT BE DUPLICATIVE.
PA71	PLEASE INDICATE THE NUMBER OF DAYS REQUESTED.
PA73	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA74	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA75	PLEASE DOCUMENT CARRYOVER OF THE THERAPY PROGRAM TO NURSING.
PA76	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).

Denial Code	Long Description
PA79	PROVIDE EVIDENCE OF SIGNIFICANT FUNCTIONAL PROGRESS IN LAST SIX MONTHS.
PA84	THE GRANT DATE OF THIS REQUEST CANNOT BE PRIOR TO THE SIGNATURE DATE OF THE PRESCRIBING PHYSICIAN.
PA86	PROVIDE EVIDENCE OF SKILLS GAINED IN THERAPY CARRYING OVER TO OTHER SETTINGS WITHIN SIX MONTHS.
PA87	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE NUMBER OF SESSIONS REQUESTED.
PA88	THE REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL SCOPE OF PRACTICE.
PA89	PRIOR AUTHORIZATION IS NOT REQUIRED UNTIL LIMITATION OF SERVICE HAS BEEN REACHED.
PA91	PLEASE SUBMIT REQUIRED X-RAYS.
PA92	PLEASE PROVIDE AN EXPLANATION FOR THE MATERIAL SUBMITTED WITH THE REQUEST.
PA95	PLEASE DESCRIBE HOW THE PROVISION OF THIS SERVICE WOULD PREVENT INSTITUTIONALIZATION OF THE CLIENT.
PA96	COULD THE EXISTING DENTURE(S) BE RELINED OR REBASED? IF NOT, PLEASE EXPLAIN WHY NOT.
PA97	REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL STANDARDS OF PRACTICE.
PA98	PLEASE INDICATE IF THE CLIENT IS CURRENTLY BEING TUBE FED.
PB02	PLEASE PROVIDE THE REQUIRED DATED SIGNATURES ON THE ATTACHMENTS.
PB03	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING THE LOSS/DESTRUCTION/THEFT OF THE HEARING AID.
PB04	DESCRIBE THE CLIENTS ABILITY TO STAND OR AMBULATE SUFFICIENTLY TO ACCOMPLISH SELF-CARE ACTIVITIES.
PB07	PLEASE SUBMIT AN ORTHODONTIC STUDY MODEL OR DIAGNOSTIC CASTS.
PB09	PLEASE PROVIDE A PHOTOGRAPH OF THE INVOLVED AREA(S).
PB10	PLEASE PROVIDE AN ESTIMATION (IN GRAMS) OF THE TOTAL AMOUNT OF TISSUE TO BE RESECTED.
PB11	PLEASE SUBMIT THE PLAN OF CARE FOR CO-TREATMENT.
PB12	FURNISH A DETAILED DESCRIPTION FOR THE PROCEDURE CODE REQUESTED.
PB13	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB15	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB18	PLEASE COMPLETE THE ATTACHED OUT-OF-STATE PROVIDER DATA SHEET, F-11001, AND RESUBMIT.
PB20	A SIGNED AND DATED PRESCRIPTION IS REQUIRED WITHIN THREE MONTHS OF RECEIPT BY COLORADO MEDICAID FOR INITIAL REQUESTS AND WITHIN 12 MONTHS OF RECEIPT BY COLORADO MEDICAID FOR SUBSEQUENT REQUESTS.
PB21	PLEASE COMPLETE THE APPROPRIATE PRIOR AUTHORIZATION ATTACHMENT. CONTACT PROVIDER SERVICES OR THE PRIOR AUTHORIZATION UNIT FOR ASSISTANCE.
PB23	PHYSICAL THERAPY ASSISTANT NOTES AND ALL FORMS SUBMITTED MUST BE COSIGNED BY A REGISTERED PHYSICAL THERAPIST.
PB31	ARE YOU REQUESTING A COMPLETE APPLIANCE, OR REPLACEMENT PARTS?
PB32	THE PROCEDURE CODE INDICATED ON THE REQUEST DOES NOT MATCH THE DESCRIPTION OF SERVICE; PLEASE CORRECT AND RESUBMIT.
PB35	THE SERVICE REQUESTED DOES NOT REQUIRE PRIOR AUTHORIZATION.
PB41	PLEASE FURNISH A CURRENT MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT, F-11090 (DATED WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID).
PB45	THE CERTIFICATION PERIOD ON THE PLAN OF CARE (POC) DOES NOT COVER THE REQUESTED GRANT/START DATE. PLEASE RESUBMIT YOUR REQUEST WITH A NEW POC.
PB49	A CERTIFIED OCCUPATIONAL THERAPY ASSISTANTS NOTES MUST BE COSIGNED BY AN OCCUPATIONAL THERAPIST REGISTERED.
PB51	ADDITIONAL INFORMATION IS REQUIRED ON PRIOR AUTHORIZATION TO ENABLE PRICING.
PB54	REQUESTED SERVICES DO NOT MATCH SERVICES ON THE PHYSICIANS ORDERS.
PB59	PLEASE PROVIDE AN INDIVIDUAL EDUCATIONAL PLAN (IEP), WHICH HAS BEEN SIGNED BY THE PROVIDER NO EARLIER THAN NINE MONTHS PRIOR TO RECEIPT AT COLORADO MEDICAID; OTHERWISE, DOCUMENT WHY NO IEP EXISTS.
PB65	PLEASE FURNISH THE ANTICIPATED TOTAL CHARGES FOR THIS REQUEST.
PB66	A PHOTOCOPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED; THE DATE MUST BE WITHIN SIX MONTHS OF RECEIPT BY COLORADO MEDICAID.

Denial Code	Long Description
PB67	THE PRESCRIPTION DATE MUST INCLUDE MONTH, DAY, AND YEAR.
PB68	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID.
PB73	THE SERVICES IDENTIFIED ON THE PLAN OF CARE DO NOT APPEAR APPROPRIATE FOR THE PROCEDURE CODE(S) REQUESTED ON THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018.
PB74	THE CLIENT/PROVIDER DOES NOT HAVE RETROACTIVE ENROLLMENT.
PB75	THE REQUESTED START DATE IS MORE THAN 14 DAYS BEFORE OR 62 DAYS AFTER RECEIPT.
PB82	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
PB83	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A HOME HEALTH AIDE. PLEASE RESUBMIT AS A PERSONAL CARE WORKER OR PROVIDE ADDITIONAL DOCUMENTATION.
PB86	THE SERVICES REQUESTED ARE NOT BEING PROVIDED IN THE CLIENTS RESIDENCE. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL.
PB87	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A NURSE. PLEASE RESUBMIT AS A HOME HEALTH AIDE OR PROVIDE ADDITIONAL DOCUMENTATION.
PB92	PLEASE FURNISH THE CLIENTS COMPLETE ADDRESS.
PB94	IF THE CLIENT IS A RESIDENT OF A NURSING HOME, SUPPLY THE COMPLETE NAME AND ADDRESS OF THE NURSING HOME.
PB99	THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018, MUST BE SIGNED AND DATED.
PC01	PLEASE SUPPLY THE RENDERING PROVIDERS PROVIDER NUMBER.
PC03	THE DRUG ENFORCEMENT ADMINISTRATION NUMBER IS MISSING OR INVALID.
PC06	PLEASE DESCRIBE YOUR PROGRAM; INCLUDE ENTRY DATE, TERMINATION DATE, HOURS PER WEEK, AND NUMBER OF WEEKS OF PRIMARY INTENSIVE SERVICE REQUESTED.
PC07	PLEASE DESCRIBE YOUR "AFTERCARE/FOLLOW-UP" PLANS FOR THIS CLIENT.
PC08	PLEASE SUPPLY DOCUMENTATION OF PREVIOUS SUBSTANCE ABUSE SERVICES WITH DATE(S) AND OUTCOME.
PC09	PLEASE DESCRIBE IN DETAIL THE TREATMENT OBJECTIVES/GOALS FOR THIS CLIENT.
PC10	PLEASE DESCRIBE THE FAMILY SITUATION/DYNAMICS. EXPLAIN HOW THE FAMILY WILL BE INCORPORATED INTO THE CLIENTS PLAN OF CARE.
PC12	PLEASE EXPLAIN IF YOUR SERVICE ENCOURAGES THE CLIENT TO ATTEND SELF-HELP GROUPS.
PC13	PLEASE SUPPLY A SPECIFIC SCHEDULE OF ACTIVITIES, INCLUDING DAY, TIME OF DAY, LENGTH OF SESSION, AND SERVICE TO BE RENDERED DURING THAT TIME.
PC15	PLEASE FURNISH DIAGNOSTIC RATIONALE.
PC17	PLEASE DOCUMENT IF THE CLIENT EVER RECEIVED SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT.
PC19	PLEASE FURNISH MORE EXTENSIVE AND IN-DEPTH HISTORICAL AND PSYCHOSOCIAL DATA.
PC20	PLEASE SUPPLY THE DATE THE CLIENT BECAME TOTALLY ENDENTULOUS.
PC23	PLEASE SUBMIT A PHYSICIANS STATEMENT REGARDING THE MEDICAL NECESSITY OF DENTURES FOR THIS CLIENT. THE PHYSICIANS STATEMENT MUST DOCUMENT THE MEDICAL NEED FOR DENTURES.
PC24	THE SERVICE REQUESTED WAS PREVIOUSLY AUTHORIZED. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT INDICATING THIS FACT IS REQUIRED.
PC25	PLEASE SUPPLY SUFFICIENT MITIGATING CIRCUMSTANCES TO WARRANT THE CONSTRUCTION OF NEW DENTURES(S).
PC26	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
PC28	PLEASE SUBMIT A PHYSICIANS STATEMENT INDICATING DENTURES ARE NECESSARY FOR THIS NURSING HOME CLIENT.
PC29	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING LOSS OR DESTRUCTION OF DENTURE(S). INCLUDE SIGNED STATEMENT FROM CLIENT OR FACILITY DIRECTOR REGARDING HOW, WHEN AND WHERE LOST.
PC30	PLEASE PROVIDE COMPLETE INTRAORAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PC31	PLEASE DESCRIBE ANY RELATED DEFORMITIES OF THE FEET.
PC34	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD WITH REQUESTED DME ITEM(S) AND DOCUMENT IF THE CLIENT CAN USE SAFELY AND INDEPENDENTLY.
PC35	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD AND DESCRIBE THE RESULTS AND EFFECTIVENESS OF THE SERVICE REQUESTED.

Denial Code	Long Description
PC39	PLEASE INDICATE LITER FLOW PER MINUTE, HOURS OF USE PER 24 HOUR PERIOD, AND THE EXPECTED DURATION OF NEED.
PC40	THE ITEM DOES NOT REQUIRE PRIOR AUTHORIZATION UNTIL THE LIFE EXPECTANCY HAS BEEN REACHED.
PC41	PLEASE SUPPLY INFORMATION INDICATING THE NECESSITY OF POSITIONING THE CLIENT'S BODY IN MULTIPLE POSITIONS.
PC42	PLEASE INDICATE IF THE BED HEIGHT MUST BE CHANGED TO ALLOW FOR SAFE TRANSFER OR ADEQUATE BED CARE.
PC43	SUPPLY A PHYSICIANS STATEMENT INDICATING TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR UNIT HAS REDUCED PAIN, IMPROVED/INCREASED THE CLIENTS ACTIVITY LEVEL, AND/OR REDUCED CLIENTS USE OF PAIN MEDICATION.
PC44	A CURRENT AUTHORIZATION FOR THIS SERVICE IS ON FILE FOR ANOTHER PROVIDER. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT OF THAT FACT IS REQUIRED BY THE CLIENT OF FIRST PROVIDER.
PC59	DOCUMENT DECLINE OR PROGRESS IN SPECIFIC, MEASURABLE, OBJECTIVE TERMS.
PC60	DOCUMENT IF CLIENT HAS DEMONSTRATED A GOOD APPOINTMENT COMPLIANCE RECORD.
PC61	THE PHYSICIANS SIGNATURE DATE MUST NOT EXCEED 90 DAYS FROM THE DATE OF RECEIPT BY COLORADO MEDICAID.
PC62	REQUESTS FOR A CONTINUATION OF THERAPY SHOULD NOT BE SUBMITTED MORE THAN FOUR WEEKS PRIOR TO THE EXPIRATION DATE OF THE CURRENT AUTHORIZATION.
PC63	PLEASE FURNISH THE STYLE AND MANUFACTURER OF THE FRAME.
PC64	PLEASE FURNISH THE CLIENTS LENS FORMULA.
PC66	ALL REQUESTS FOR TINTS REQUIRE DOCUMENTATION OF THE VISUAL OR MEDICAL CONDITION RELATED TO PHOTOPHOBIA.
PC67	PLEASE DOCUMENT THE REASON AND JUSTIFICATION FOR REPLACEMENT BEYOND THE FIRST LENS/FRAME.
PC68	DOCUMENT IF ALL REMAINING MAXILLARY AND/OR MANDIBULAR TEETH ARE DECAY-FREE, PROPERLY RESTORED, AND PERIODONTICALLY SOUND.
PC72	SUPPLY MORE DETAIL REGARDING PROGRESS (ATTACHMENT OF GOALS, ETC.). CORRELATE PROGRESS TO PREVIOUS GOALS AND IDENTIFIED LIMITATIONS.
PC77	PLEASE SUBMIT A PLAN OF CARE DESCRIBING THE SERVICES THAT WOULD BE PROVIDED.
PC78	PLEASE DOCUMENT SPECIFIC, MEASURABLE GOALS.
PC82	THE PRIOR AUTHORIZATION (PA) SYSTEM CAN PROCESS ONLY 26 DETAILS PER PA REQUEST. PLEASE RESUBMIT YOUR REQUEST WITH NO MORE THAN 26 DETAILS.
PC83	PLEASE SUPPLY A PHYSICIANS PRESCRIPTION DATED WITHIN ONE MONTH OF REQUESTED SUBSTANCE ABUSE DAY TREATMENT.
PC84	PLEASE PROVIDE INFORMATION INDICATING THIS CLIENT IS APPROPRIATELY DETOXIFIED FROM ALCOHOL AND/OR OTHER DRUGS.
PC85	PLEASE PROVIDE INFORMATION TO INDICATE THE CLIENTS ABILITY TO ABSTAIN FROM ALCOHOL OR DRUGS WHILE IN THE SUBSTANCE ABUSE DAY TREATMENT PROGRAM.
PC86	PLEASE INDICATE IF THIS CLIENT IS WILLING TO PARTICIPATE IN AFTERCARE OR CONTINUING CARE SERVICES.
PC87	PROVIDE MORE INFORMATION ON TREATMENT HISTORY; INCLUDE SERVICE PROVIDED, DATES, AND OUTCOME. PROVIDE DETAIL OF PREVIOUS TREATMENT.
PC88	PLEASE PROVIDE MORE RATIONALE FOR THE APPROPRIATENESS AND MEDICAL NECESSITY OF SUBSTANCE ABUSE DAY TREATMENT.
PC89	PROVIDE A TREATMENT PLAN THAT CONTAINS MEASURABLE GOALS AND OBJECTIVES CORRESPONDING TO THE IDENTIFIED DEFICIT.
PC91	PLEASE PROVIDE MORE INFORMATION ON FAMILY INVOLVEMENT TREATMENT.
PC92	PLEASE PROVIDE MORE HISTORY AND EXPLANATION ABOUT THE ISSUE OF ABSTINENCE FOR THIS CLIENT.
PC94	PLEASE PROVIDE THE ANTICIPATED BEGINNING DATE AND/OR THE ESTIMATED SUBSTANCE ABUSE DAY TREATMENT DISCHARGE DATE.
PC95	PLEASE SUPPLY JUSTIFICATION FOR BEGINNING CLIENT IN SERVICE PRIOR TO AUTHORIZATION BEING OBTAINED.
PC96	THE INITIAL THREE HOURS OF SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IN A CALENDAR YEAR DO NOT REQUIRE PRIOR AUTHORIZATION.

Denial Code	Long Description
PC97	REIMBURSEMENT FOR INITIAL SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IS LIMITED TO THREE HOURS IN A CALENDAR YEAR AND DOES NOT REQUIRE PRIOR AUTHORIZATION.
PC98	THIS DRUG IS CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE BILL USING THE APPROPRIATE NATIONAL DRUG CODE (NDC) OR SUBMIT A COMPLETED DRUG ADDITION REQUEST FORM IF THE NDC IS NOT LISTED IN THE DRUG INDEX.
PC99	THIS DRUG IS NOT CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL, CURRENT ADMINISTRATIVE RULE, OR COLORADO DRUG INDEX FOR COVERAGE LIMITATIONS.
PD01	DOCUMENT THAT CLIENT HAS ACHIEVED GOOD ORAL HYGIENE, PERIODONTAL CASE TYPE 1 OR 2, AND IS MOTIVATED TO MAINTAIN SAME.
PD03	PLEASE PROVIDE AN ARTERIAL BLOOD GAS READING OR PULSE OXIMETRY RESULTS DONE ON ROOM AIR SIGNED AND DATED BY A MEDICAL DOCTOR. THIS SHOULD BE DONE WITHIN 60 DAYS OF REQUESTED SERVICE.
PD04	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 30 DAYS OF RECEIPT BY COLORADO MEDICAID.
PD07	SUBMIT A PHOTOCOPY OF A VALID PRESCRIPTION, ISSUED WITHIN THE PAST YEAR, OR COMPLETE SECTION B OF THE PRIOR AUTHORIZATION/DRUG ATTACHMENT (PA/DGA), F-11049.
PD10	BRAND MEDICALLY NECESSARY MUST BE IN THE PRESCRIBERS OWN HANDWRITING AND WRITTEN DIRECTLY ON THE PRESCRIPTION OR A SEPARATE ORDER ATTACHED TO THE ORIGINAL PRESCRIPTION.
PD12	COMPLETE DENTURES, PARTIAL DENTURES, DENTURE RELINES, AND FIXED PROSTHODONTIC SERVICES ARE NOT COVERED SERVICES FOR ADULTS FOR DATES OF SERVICE ON AND AFTER OCTOBER 1, 1995.
PD22	PLEASE COMPLETE ALL REQUIRED ELEMENTS ON THE PERSONAL CARE SCREENING TOOL (PCST), F-11133.
PD24	THIS PRIOR AUTHORIZATION REQUEST IS UNABLE TO BE PROCESSED. PLEASE RESUBMIT WITH ADDITIONAL REQUIRED FORMS, INCLUDING THE ENTIRE PERSONAL CARE SCREENING TOOL (PCST), F-11133; PERSONAL CARE ADDENDUM, F-11136; AND SUPPORTING DOCUMENTATION, AS DIRECTED.
PD25	THERE IS A PERSONAL CARE SCREENING TOOL (PCST), F-11133, COMPLETED BY ANOTHER AGENCY. CONTACT THE AGENCY TO TRANSFER SCREEN.
PD26	THERE IS A LIMITED TERM CARE FUNCTIONAL SCREEN (LTC-FS) COMPLETED BY ANOTHER AGENCY. THE PERSONAL CARE SCREENING TOOL (PCST), F-11133, INFORMATION IS IN CONFLICT WITH LTC-FS.
PD27	ONLY ONE LEVEL OF FUNCTION MAY BE SELECTED FOR ALL ELEMENTS EXCEPT TOILETING. COLORADO MEDICAID IS UNABLE TO PROCESS THE PRIOR AUTHORIZATION REQUEST.
PD28	NO UNITS MAY BE REQUESTED USING THIS PRIOR AUTHORIZATION PROCESS. PLEASE SUBMIT WITH THE APPROPRIATE ATTACHMENTS FOR REQUESTING SPECIFIC PERSONAL CARE WORKER UNITS.
PD29	CLIENT IS NOT ELIGIBLE FOR THE REQUESTED SERVICE(S) AS OF THE REQUESTED START DATE.
PD30	NO TRAVEL TIME MAY BE AUTHORIZED WHEN NO PERSONAL CARE WORKER SERVICE IS AUTHORIZED.
PD32	PROVIDER NOT CERTIFIED TO RENDER THE SERVICE(S) REQUESTED.
PD34	BASED ON THE DOCUMENTATION SUBMITTED, THIS REQUEST CAN NOT BE PRIOR AUTHORIZED. REFER TO THE PA MESSAGES FROM THE CONSULTANT FOR COMPLETE EXPLANATION.
PD98	PLEASE DOCUMENT HOW AND WHEN EACH PREVIOUSLY AUTHORIZED PRO RE NATA VISIT WAS USED.

Oral Surgery

Denial Code	Long Description
0201	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
0233	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0235	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0237	CLIENT IDENTIFICATION NUMBER DOES NOT MATCH CLIENTS FIRST NAME.
0238	THE CLIENT IDENTIFICATION NUMBER DOES NOT MATCH THE CLIENTS LAST NAME.
0242	SECONDARY DIAGNOSIS CODE IS INVALID.
0248	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.

Denial Code	Long Description
0249	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0251	PROCEDURE CODE MODIFIER IN FIRST POSITION IS INVALID.
0252	THE PROCEDURE CODE MODIFIER IN SECOND POSITION IS INVALID FOR REQUESTED START DATE OR DATE OF RECEIPT.
0253	THE PROCEDURE CODE MODIFIER IN THIRD POSITION IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
0258	THE PRIMARY DIAGNOSIS CODE IS REQUIRED.
0272	THE PRIMARY DIAGNSOSIS CODE IS INVALID.
0400	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0853	HCPCS - ANNUAL UPDATE
0885	NEVER EVENTS MODIFIERS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
0886	NEVER EVENTS DIAGNOSIS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
1000	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
1002	RENDERING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1003	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1007	RENDERING PROVIDER ID IS NOT ON FILE.
1047	THE RENDERING PROVIDERS CERTIFICATION HAS BEEN CANCELLED.
1048	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1801	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
1804	A CERTIFIED SUBSTANCE ABUSE DAY TREATMENT PROVIDER MUST SUBMIT A SUBSTANCE ABUSE DAY TREATMENT PROCEDURE CODE.
1806	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
1808	THE BILLING PROVIDER DOES NOT HAVE THE REQUIRED CERTIFICATION ADDENDUM ON FILE.
1900	THE BILLING PROVIDERS TAXONOMY CODE IS INVALID.
1901	THE RENDERING PROVIDERS TAXONOMY CODE IS INVALID.
1927	A NATIONAL PROVIDER IDENTIFIER IS REQUIRED FOR THE BILLING PROVIDER.
1934	A NATIONAL PROVIDER INDENTIFIER IS REQUIRED FOR THE RENDERING PROVIDER.
1936	THE BILLING PROVIDER NUMBER IS INVALID.
1937	THE RENDERING PROVIDER NUMBER IS INVALID.
1960	INTERNAL PROCESSING IS REQUIRED.
1963	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.
1964	THE BILLING PROVIDER INDICATED IS NOT ALLOWABLE AS A BILLING PROVIDER.
1965	RENDERING PROVIDER NUMBER IS MISSING/INVALID FOR THIS PROCEDURE PROVIDER.
1974	PRESCRIBING/REFERRING/ORDERING PROVIDER INDICATED IS NOT CERTIFIED AS A PRESCRIBING/REFERRING/ORDERING PROVIDER.
1975	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
1976	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
2001	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2003	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2017	THE CLIENT IS ENROLLED IN A MEDICAID OR OTHER MANAGED CARE PROGRAM.
2037	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2603	CLIENT LOCKED-IN TO A PROVIDER OR ENROLLED IN A HOSPICE. CONTACT CLIENTS HOSPICE FOR PAYMENT OF SERVICES OR RESUBMIT WITH DOCUMENTATION OF UNRELATED NATURE OF CARE.
3324	THE MODIFIER HAS BEEN DISCONTINUED BY THE CENTERS OF MEDICARE AND MEDICAID SERVICES OR THE AMERICAN MEDICAL ASSOCIATION FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
3337	THE PROCEDURE CODE HAS BEEN TERMINATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AMERICAN MEDICAL ASSOCIATION, OR AMERICAN DENTAL ASSOCIATION FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT. RESUBMIT WITH VALID A PROCEDURE CODE.
3339	THE PROCEDURE BILLED IS NOT PAYABLE ACCORDING TO DEFICIT REDUCTION ACT (DEFRA) GUIDELINES.
3351	THE PROCEDURE IS NOT COVERED FOR CLIENTS WITH A NURSING HOME AUTHORIZATION ON THE REQUESTED START DATE OR DATE OF RECEIPT.

Denial Code	Long Description
3353	THE PROCEDURE IS NOT A COVERED SERVICE FOR HOME AND COMMUNITY-BASED WAIVER CLIENTS.
4021	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4027	THE DIAGNOSIS CODE IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
4031	THE PROCEDURE SUBMITTED IS NOT APPROPRIATE FOR CLIENTS GENDER.
4032	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4034	THE PROCEDURE CODE HAS AN AGE RESTRICTION.
4036	THE PLACE OF SERVICE CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4040	THE PRIMARY DIAGNOSIS CODE IS NOT ON FILE.
4041	THE SECONDARY DIAGNOSIS IS NOT ON FILE.
4046	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4127	INTERNAL PROCESSING IS REQUIRED.
4131	INTERNAL PROCESSING IS REQUIRED.
4141	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4149	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4150	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4236	ETIOLOGY DIAGNOSIS CODE(S) (E-CODES) ARE INVALID AS THE PRIMARY DIAGNOSIS.
4244	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4245	THE FOURTH POSITION MODIFIER IS INVALID FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT.
4256	THE PROCEDURE CODE AND MODIFIER COMBINATION IS NOT PAYABLE FOR THE CLIENTS BENEFIT PLAN.
4257	THE MODIFIERS SUBMITTED ARE EITHER INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT OR THE MODIFIERS ARE MISSING.
4311	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4315	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4316	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4371	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4372	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4711	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR CLIENTS AGE.
4714	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS AGE.
4731	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS DIAGNOSIS.
4742	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4743	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4744	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4745	DIAGNOSIS AND/OR PROCEDURE AND/OR PLACE OF SERVICE (POS) CODE IS NOT COVERED FOR EXPRESS ENROLLMENT CLIENTS.
4746	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4801	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4802	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
4821	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
4871	PLEASE REFER TO PA MESSAGES FOR RETURN INFORMATION.
4963	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS GENDER.
4990	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
7500	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
7509	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
P001	THE BILLING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THE SERVICES.
P002	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P003	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P005	THE PRIOR AUTHORIZATION CAN NOT BE END DATED. THE PRIOR AUTHORIZATION STATUS IS NOT APPROVED OR APPROVED WITH REVISIONS.

Denial Code	Long Description
P006	PLEASE FURNISH THE PROCEDURE CODE AND CORRESPONDING DESCRIPTION.
P008	THE BILLING PROVIDER NUMBER IS INVALID.
P009	THE BILLING PROVIDER NUMBER IS INVALID.
P010	THE REQUESTED END DATE IS INVALID.
P011	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P012	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P013	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P014	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P015	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P016	THE REQUESTED START DATE IS MISSING OR INVALID.
P019	THE REQUESTED START DATE IS MISSING OR INVALID.
P020	THE RENDERING PROVIDER NUMBER IS INVALID.
P021	THE RENDERING PROVIDER NUMBER IS INVALID.
P022	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P023	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P024	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P026	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P027	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P030	FIRST MODIFIER IS INVALID.
P031	FIRST MODIFIER IS INVALID.
P032	SECOND MODIFIER IS INVALID.
P033	SECOND MODIFIER IS INVALID.
P034	THIRD MODIFIER IS INVALID.
P035	THIRD MODIFIER IS INVALID.
P036	FOURTH MODIFIER IS INVALID.
P037	FOURTH MODIFIER IS INVALID.
P038	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P039	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P040	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P041	CLIENTS FIRST NAME IS MISSING.
P042	CLIENTS LAST NAME IS MISSING.
P043	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P044	BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES REQUESTED.
P045	FIRST MODIFIER IS INVALID.
P046	SECOND MODIFIER IS INVALID.
P047	THIRD MODIFIER IS INVALID.
P048	FOURTH MODIFIER IS INVALID.
P052	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P053	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P054	RENDERING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES FOR THE BENEFIT PLAN.
P055	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P061	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P062	THE CLIENT ID AND/OR NAME INDICATED ON THE PA REQUEST IS INCORRECT. THE CLIENT ID AND/OR NAME HAS BEEN UPDATED. PLEASE VERIFY THE ID AND/OR NAME IS CORRECT.
P064	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.

Denial Code	Long Description
P067	THE FREQUENCY OF HOURS REQUESTED ARE NOT APPROPRIATE FOR THIS CLIENT AND HAVE BEEN MODIFIED ACCORDINGLY.
P079	BILLING PROVIDER IS ON PAYMENT SUSPENSION DUE TO CREDIBLE ALLEGATION OF FRAUD.
P120	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAS BEEN REDUCED.
P121	THE SERVICE/ PROCEDURE REQUESTED IS NOT SUPPORTED BY SUBMITTED DOCUMENTATION.
P126	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
P128	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.
P138	SERVICE(S) DO NOT MEET COLORADO MEDICAID GUIDELINES.
P167	REQUESTED DOCUMENTATION HAS NOT BEEN SUBMITTED.
P178	THE SERVICE REQUESTED IS NOT MEDICALLY NECESSARY.
P179	THE MEDICAL NECESSITY FOR THIS SERVICE IS NOT SUPPORTED BY THE SUBMITTED DOCUMENTATION.
P233	THE DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE ADDITIONAL CARE.
P257	THIS CLIENTS FUNCTIONAL ASSESSMENT SCORES PLACE THIS CLIENT OUTSIDE ELIGIBILITY FOR DAY TREATMENT.
P274	OUR RECORDS INDICATE THIS CLIENT IS INVOLVED IN EFFECTIVE AND APPROPRIATE SERVICE ELSEWHERE.
P292	INTENSIVE REHABILITATION HOURS ARE NO LONGER APPROPRIATE AS INDICATED BY HISTORY, DIAGNOSIS, AND/ OR FUNCTIONAL ASSESSMENT SCORES.
P328	THE SERVICES REQUESTED INCLUDE NON-COVERED SERVICES, AND HOURS ARE REDUCED ACCORDINGLY.
P339	THE CLIENTS PAST HISTORY INDICATES REDUCED TREATMENT HOURS ARE WARRANTED.
P342	THE REQUEST DOES NOT MEET GENERALLY ACCEPTED CONDITIONS REQUIRING FLUORIDE TREATMENTS.
P346	SERVICES EXCEED COLORADO MEDICAID LIMITATION AND DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE MEDICAL NECESSITY OF THE SERVICE.
P349	THE SERVICE REQUESTED WAS PERFORMED LESS THAN FIVE YEARS AGO.
P353	THE EXISTING APPLIANCE HAS NOT BEEN WORN FOR THREE YEARS.
P367	THE CLIENT HAS BEEN TOTALLY WITHOUT TEETH AND AN APPLIANCE FOR FIVE YEARS.
P392	THE CLIENT IS MISSING AN ANTERIOR TOOTH AND/OR HAS TWO OR MORE POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P405	THE SERVICE(S) REQUESTED COULD ADEQUATELY BE PERFORMED IN THE DENTAL OFFICE.
P406	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE OF GOOD PERIODONTAL HEALTH (AMERICAN ACADEMY OF PERIODONTOLOGY PERIODONTAL CLASSIFICATION OF TYPE I OR II).
P407	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE VISIBLE ON RADIOGRAPHS THAT AT LEAST 50 PERCENT OF THE CLINICAL CROWN IS INTACT.
P409	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING SIX OR MORE TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED, INCLUDING THIRD MOLARS.
P410	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING ONE OR MORE ANTERIOR TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED.
P411	DOCUMENTATION DOES NOT SUPPORT THE NEED FOR PERIODONTIC SERVICES. POCKETS ARE LESS THAN 4MM AND/OR GREATER THAN 6MM FOR CLIENT AND/OR THE CLIENT IS UNDER THE AGE OF 13.
P412	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA.
P413	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA. THIS PA HAS BEEN GRANTED AS APPROVED NOT APPROVED WITH REVISIONS. THE DURATION REQUESTED MAY HAVE BEEN REDUCED TO REFLECT COVERAGE LIMITATIONS, PRESCRIBER ORDERS, CONFLICTI
P417	THE SERVICE(S) REQUESTED COULD BE ADEQUATELY PERFORMED WITH LOCAL ANESTHESIA.
P437	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO POOR ORAL HYGIENE.
P444	THIS LINE ITEM IS A DUPLICATE OF ANOTHER LINE ITEM ON THIS PRIOR AUTHORIZATION (PA) REQUEST. PLEASE CORRECT.
P446	THIS IS A DUPLICATE OF AN EXISTING PRIOR AUTHORIZATION (PA) REQUEST. YOU MAY CONTACT PROVIDER SERVICES IF YOU REQUIRE ASSISTANCE. DUPLICATE PA REQUEST
P448	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO DECAY HISTORY.
P449	QUESTIONABLE LONG TERM PROGNOSIS DUE TO GUM AND BONE DISEASE.
P456	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO APPARENT ROOT INFECTION.

Denial Code	Long Description
P457	OUR RECORDS INDICATE THIS CLIENT HAS EXCEEDED ESTABLISHED PROGRAM LIMITATIONS. COLORADO MEDICAID WILL NOT AUTHORIZE NEW DENTURES.
P458	DOCUMENTATION PROVIDED INDICATES A LESS ELABORATE PROCEDURE SHOULD BE CONSIDERED.
P502	RENTAL ONLY ALLOWED; MEDICAL NEED FOR PURCHASE HAS NOT BEEN DOCUMENTED.
P503	PURCHASE ONLY ALLOWED; MEDICAL NEED FOR RENTAL HAS NOT BEEN DOCUMENTED.
P504	OCCUPATIONAL THERAPY GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P505	THE SERVICE REQUESTED IS INCLUDED IN THE NURSING HOME RATE STRUCTURE.
P511	THIS NATIONAL DRUG CODE IS ONLY BILLABLE AS PART OF A COMPOUND DRUG.
P515	THE PRESENCE OF A HANDICAPPING MALOCCLUSION OR HANDICAPPING DENTOFACIAL DEFORMITY IS NOT SUPPORTED BY THE DOCUMENTATION SUBMITTED.
P521	THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVERED BY COLORADO MEDICAID.
P522	GASTRO-INTESTINAL SURGERY FOR THE PURPOSE OF WEIGHT CONTROL IS COVERED ONLY AS A LIFE THREATENING PROCEDURE.
P523	THE TREATMENT REQUEST IS NOT CONSISTENT WITH THE CLIENT'S DIAGNOSIS.
P524	PSYCHOTHERAPY PROVIDED IN THE CLIENTS HOME IS NOT A COVERED BENEFIT OF COLORADO MEDICAID.
P525	THE INFORMATION PROVIDED IS NOT CONSISTENT WITH THE INTENSITY OF SERVICES REQUESTED.
P526	INTENSIVE MULTIPLE MODALITY TREATMENT IS NOT CONSISTENT WITH THE INFORMATION PROVIDED.
P527	MULTIPLE PROVIDERS OF TREATMENT ARE NOT INDICATED FOR THIS CLIENT.
P528	THE DURATION OF TREATMENT SESSIONS EXCEED CURRENT COLORADO MEDICAID GUIDELINES.
P534	DOCUMENTATION OF POOR PHYSICAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P535	OTHER PHYSICAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P536	THE PHYSICAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P537	USE OF PHYSICAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P538	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF A PHYSICAL THERAPIST.
P539	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS AND LIVING ARRANGEMENT.
P540	GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P541	THE PROCEDURE(S) REQUESTED ARE NOT MEDICAL IN NATURE.
P542	DOCUMENTATION OF POOR OCCUPATIONAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P543	DOCUMENTATION OF POOR SPEECH THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P544	OTHER OCCUPATIONAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P546	THE OCCUPATIONAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P547	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF PHYSICAL THERAPY.
P548	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P549	ACTIVITIES TO PROMOTE DIVERSION OR GENERAL MOTIVATION ARE NONCOVERED COLORADO MEDICAID SERVICES.
P550	REVISIONS OF THE REQUEST IS NECESSITATED BY THE CLIENTS MINIMAL PROGRESS.
P551	RESTORATIVE NURSING INVOLVEMENT COULD BE INCREASED.
P552	CLIENTS DEMONSTRATED RESPONSE TO CURRENT THERAPY DOES NOT WARRANT THE INTENSE FREQUENCY REQUESTED.
P553	MAINTENANCE IS TWO TIMES PER WEEK OR LESS.
P554	THE SPEECH THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.

Denial Code	Long Description
P555	USE OF OCCUPATIONAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P556	USE OF SPEECH THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P557	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF AN OCCUPATIONAL THERAPIST.
P558	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
P559	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P560	THE MATERIALS/ SERVICES REQUESTED ARE PRINCIPALLY COSMETIC IN NATURE.
P561	THE LENS FORMULA DOES NOT JUSTIFY REPLACEMENT.
P562	THE CHANGE IN THE LENS FORMULA DOES NOT WARRANT MULTIPLE REPLACEMENTS.
P563	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P564	LENSES ONLY ARE APPROVED; PLEASE DISPENSE A CONTRACTED FRAME. THE NON-CONTRACTED FRAME IS NOT MEDICALLY JUSTIFIED.
P565	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P566	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P567	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF OCCUPATIONAL THERAPY.
P568	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF SPEECH THERAPY.
P569	LEVEL, INTENSITY, OR EXTENT OF SERVICE(S) REQUESTED HAS BEEN MODIFIED CONSISTENT WITH MEDICAL NEED AS DEFINED IN THE PLAN OF CARE.
P570	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P571	THE SERVICE ASKED FOR IS NOT COVERED BY COLORADO MEDICAID AS THESE TASKS CAN BE DONE BY NURSES OR ACTIVITY STAFF.
P572	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P573	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.
P574	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P575	MEDICAL NEED FOR EQUIPMENT/ SUPPLY REQUESTED IS NOT SUPPORTED BY DOCUMENTATION SUBMITTED.
P576	OTHER SPEECH THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P577	DOCUMENTATION SUBMITTED IDENTIFIES THAT THE CLIENT HAS FEWER THAN TWO POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P582	LESS EXPENSIVE ALTERNATIVE SERVICES ARE AVAILABLE FOR THIS CLIENT.
P634	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P711	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING PERIODONTAL SCALING AND ROOT PLANNING.
P712	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING GINGIVECTOMY.
P754	AN APPROVED SUBSTANCE ABUSE DAY TREATMENT PROGRAM CANNOT EXCEED A SIX WEEK PERIOD.
P761	THE CLIENT DOES NOT APPEAR TO BE ABLE OR WILLING TO ABSTAIN FROM ALCOHOL/DRUG USAGE WHILE IN TREATMENT. THEREFORE, SUBSTANCE ABUSE DAY TREATMENT SERVICES ARE NOT APPROVED.
P764	THIS CLIENT HAS COMPLETED INTENSIVE SUBSTANCE ABUSE TREATMENT WITHIN THE PAST 12 MONTHS. THE DOCUMENTATION PROVIDED IS NOT ADEQUATE TO JUSTIFY ADDITIONAL INTENSIVE TREATMENT AT THIS TIME.
P785	A LESS THAN SIX-WEEK HEALING PERIOD HAS BEEN SPECIFIED FOR THIS PRIOR AUTHORIZATION. THEREFORE IT IS NOT NECESSARY TO WAIT THE FULL SIX WEEKS AFTER EXTRACTIONS BEFORE TAKING DENTURE IMPRESSIONS.
P818	SIX-WEEK HEALING TIME IS REQUIRED BETWEEN EDENTULATION AND FINAL IMPRESSIONS. PAYMENT FOR DENTURES WILL BE DENIED OR RECOUPED IF HEALING PERIOD IS NOT OBSERVED.
P849	COLORADO MEDICAID HAS DETERMINED THERE WERE (ARE) SEVERAL HOME HEALTH AGENCIES WILLING TO PROVIDE MEDICALLY NECESSARY SKILLED NURSING SERVICES TO THIS CLIENT.

Denial Code	Long Description
P864	THE DOCUMENTATION YOU HAVE SUBMITTED DOES NOT MEET THE REQUIREMENTS OF COLORADO MEDICAID.
P873	THE MEDICAL NECESSITY FOR THE HOURS REQUESTED IS NOT SUPPORTED BY THE INFORMATION SUBMITTED.
P874	THE DOCUMENTATION SUBMITTED INDICATES THE TASKS SPECIFIED CAN BE COMPLETED DURING THE VISITS APPROVED.
P878	THE DOCUMENTATION SUBMITTED DOES NOT INDICATE THAT MEDICALLY ORIENTED TASKS ARE MEDICALLY NECESSARY; THEREFORE PERSONAL CARE SERVICES HAVE BEEN APPROVED.
P880	THE QUANTITY OF SERVICES AUTHORIZED FOR THIS CLIENTS PERSONAL CARE HAS BEEN AMENDED BASED ON INFORMATION RECEIVED FROM ONE OR MORE OF THESE SOURCES: THE CLIENT, THEIR PHYSICIAN, AND/OR THE IN-HOME VISIT BY STAFF OF THE OIG (OFFICE OF INSPECTOR GENERAL).
P885	THE USE OF THIS DRUG FOR THE INTENDED PURPOSE IS NOT COVERED BY COLORADO MEDICAID, CONSISTENT WITH COLORADO ADMINISTRATIVE CODE AND FEDERAL LAW.
P924	THE MEDICAL RECORDS SUBMITTED WITH THE CURRENT REQUEST CONFLICT OR DISAGREE WITH OUR MEDICAL RECORDS ON THIS CLIENT.
P950	INDEPENDENT NURSES, PLEASE NOTE PAYABLE SERVICES MAY NOT EXCEED 12 HOURS/DAY OR 60 HOURS/WEEK.
P951	SERVICES CAN ONLY BE AUTHORIZED THROUGH ONE YEAR FROM THE PRESCRIPTION DATE.
P952	LEAD INSPECTION IS A COVERED COLORADO MEDICAID SERVICE WHEN THE CHILD HAS BEEN SHOWN TO HAVE LEAD POISONING (E.G., CHILD HAS A BLOOD LEAD LEVEL > 19 UG/DL OR TWO CONSECUTIVE BLOOD LEAD LEVELS OF 15-19 UG/DL DONE AT LEAST 90 DAYS APART). THE INSPECTION MUS
P953	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P954	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P956	THE REQUEST CAN ONLY BE BACKDATED A MAXIMUM OF 14 DAYS FROM FIRST DATE RECEIVED BY COLORADO MEDICAID.
P957	COMPLETE PERIODONTAL CHARTING AT TIME OF SERVICE, AND SUBMIT CHARTING, COPY OF OPERATIVE REPORT, TOGETHER WITH A COPY OF THE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF), F-11035, TO PA UNIT ATTENTION DENTAL CONTSULTANT.
P958	NOTE THAT CODE D4341 HAS BEEN CHANGED. REFER TO THE DECISION NOTICE FOR AUTHORIZED QUANTITY.
P960	YOUR PA HAS BEEN APPROVED FOR 90 DAYS. THE 90 DAY APPROVAL DOES NOT IMPLY THE PA REQUEST MEETS PRIOR AUTHORIZATION CRITERIA. AFTER ADDITIONAL INFORMATION IS AVAILABLE IN INTERCHANGE, COLORADO MEDICAID WILL CREATE AN AMENDMENT REQUEST TO EXTEND THE PA FOR
P961	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P962	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
PA10	THE REQUESTED END DATE IS INVALID.
PA12	PLEASE FURNISH A WRITTEN DESCRIPTION OF THE CLIENTS DIAGNOSIS.
PA13	PROVIDE DIAGNOSES WITH DATES OF ONSET.
PA14	IDENTIFY PROBLEMS TO BE TREATED.
PA15	THE AUDIOLOGISTS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1), F-11020, AND PRIOR AUTHORIZATION REQUEST/HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2), F-11021.
PA16	THE PHYSICIANS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION/PHYSICIAN OTOLOGICAL REPORT (PA/POR), F-11019.
PA17	SUBMIT BRIEF HISTORY WITH REFERRAL INFORMATION, LIVING SITUATION, FUNCTIONAL STATUS, AND OTHER PERTINENT INFORMATION. WHAT CHANGE OF STATUS RESULTED IN REFERRAL AT THIS TIME?
PA18	PLEASE FURNISH THE CLIENTS HEIGHT AND WEIGHT.
PA19	PLEASE SUBMIT CLINICAL INFORMATION SUFFICIENT TO VERIFY THE NEED FOR THE REQUESTED SERVICE(S).

Denial Code	Long Description
PA20	PLEASE RESUBMIT WITH COMPLETE PERIODONTAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PA21	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL EDUCATIONAL PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA22	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL PROGRAM PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA23	REFER TO THE DURABLE MEDICAL EQUIPMENT INDEX FOR APPROPRIATE CODE AND DESCRIPTION. DO NOT USE AN "UNLISTED" CODE.
PA24	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUALIZED FAMILY SERVICE PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA25	INFORMATION ON THE REQUEST FORM IS ILLEGIBLE, AND THE REQUEST CANNOT BE PROCESSED.
PA26	RE-EVALUATE YOUR GOALS. EMPHASIS SHOULD BE ON FUNCTIONAL SELF-CARE. GOALS MUST BE RELATED TO FUNCTIONAL OUTCOME.
PA27	PLEASE CLARIFY THE NUMBER OF HOURS PER WEEK REQUESTED.
PA28	PLEASE CLARIFY THE NUMBER OF HOURS PER DAY REQUESTED.
PA29	PLEASE CLARIFY THE NUMBER OF VISITS PER DAY REQUESTED.
PA30	ATTACH SUPPORTIVE DOCUMENTATION; HOME EXERCISE PROGRAM AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA31	THE DIAGNOSIS CODE INDICATED ON THE REQUEST DOES NOT CORRESPOND TO THE DIAGNOSIS CODE DESCRIPTION.
PA32	PLEASE SUBMIT ADDITIONAL INFORMATION SUFFICIENT TO VERIFY APPROPRIATENESS AND NEED FOR TRANSPLANT.
PA33	PLEASE SUBMIT THE INITIAL AND PROGRESSIVE OBJECTIVE FINDINGS.
PA34	ATTACH SUPPORTIVE DOCUMENTATION, FACILITY PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA35	PLEASE SUBMIT THE CLIENTS ORIGINAL COMPLAINTS AND EXAMINATION FINDINGS.
PA36	ATTACH SUPPORTIVE DOCUMENTATION, IN-HOME AUTISM PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA37	PLEASE SUBMIT YOUR TREATMENT PLAN FOR THIS CLIENT.
PA38	ATTACH SUPPORTIVE DOCUMENTATION AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA39	INITIAL EVALUATIONS MUST BE PERFORMED BY AN OCCUPATIONAL THERAPIST REGISTERED (OTR), PER AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA) STANDARDS.
PA41	IDENTIFY THE PLACE OF SERVICE AND ITS EFFECT ON SUPPORTING THE DESIRED TREATMENT OUTCOME.
PA42	PLEASE INDICATE THE HOURS OF USE OF OXYGEN PER 24-HOUR PERIOD.
PA43	PROVIDE BASELINE DOCUMENTATION FOR THIS CLIENTS LIMITATIONS USING UNITS OF MEASUREMENT THAT ARE APPLIED CONSISTENTLY WHEN REPORTING STATUS.
PA44	IDENTIFY FUNCTIONAL LIMITATIONS AS THEY ARE RELATED TO IDENTIFIED CONDITIONS.
PA46	CORRELATE PLAN OF CARE TO REQUESTED PROCEDURE CODES.
PA47	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE FREQUENCY/DURATION REQUESTED.
PA48	PLEASE PROVIDE THE NAME AND CREDENTIALS OF THE RENDERING PROVIDER.
PA50	COLORADO MEDICAID RECORDS INDICATE THE CLIENT OWNS A WHEELCHAIR. DOCUMENT THE REASON AND NEED FOR REPLACEMENT AND COST TO REPAIR CURRENT WHEELCHAIR.
PA51	PLEASE DISTINGUISH PRIMARY AND SUPPORTIVE MODALITIES.
PA52	PLEASE SUBMIT A PROGRESS REPORT.
PA53	MULTIPLE FAMILY CLIENTS TREATMENT BY THE SAME PROVIDER REQUIRES FURTHER INFORMATION DOCUMENTING COORDINATION OF TREATMENT PLAN.
PA54	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE MINUTES REQUESTED.
PA55	MEDICAL NECESSITY OF TREATMENT REQUIRES ADDITIONAL DOCUMENTATION.
PA56	GIVEN AGE, DIAGNOSES, CURRENT LEVEL OF FUNCTION, PAST RESPONSE TO TREATMENT, AND LIVING SITUATION, EXPAND ON POTENTIAL FOR SIGNIFICANT FUNCTIONAL PROGRESS WITHIN THE NEXT SIX MONTHS. EMPHASIZE WHY PROGRESS IS EXPECTED WITH SERVICES AT THIS TIME.

Denial Code	Long Description
PA57	SUBMIT THE INITIAL FINDINGS. INCLUDE A COMPREHENSIVE EVALUATION.
PA58	SUBMIT PROGRESSIVE, OBJECTIVE FINDINGS. INCLUDE A PERTINENT RE-EVALUATION.
PA59	PLEASE SUPPLY INFORMATION REGARDING THE CLIENTS MEDICATION REQUIREMENTS, IF ANY.
PA60	PLEASE SPECIFY IF THE CLIENT IS IN AN EDUCATIONAL SETTING.
PA61	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA62	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
PA63	THE SKILLS OF A THERAPIST ARE PURPOSEFUL AND SKILLED INTERVENTIONS REQUIRED TO CONTINUALLY DESIGN, IMPLEMENT, REASSESS, MODIFY/GRADE, AND/OR DISCONTINUE A PLAN OF CARE IN A TIMELY MANNER, BASED ON THE COMPLEXITY OF THE CLIENTS MEDICAL CONDITION AND/OR CO
PA64	PLEASE SUBMIT A THERAPY PLAN OF CARE, INCLUDING A CURRENT, DATED EVALUATION.
PA65	A PLAN OF CARE SIGNED AND DATED BY THE PHYSICIAN IS REQUIRED.
PA66	THE SKILLS OF A THERAPIST ARE REQUIRED WHEN ONLY THE THERAPIST CAN SAFELY AND EFFECTIVELY DELIVER THE THERAPEUTIC PROCEDURES BECAUSE OF THEIR UNIQUE KNOWLEDGE, TRAINING, AND EXPERTISE. DESCRIBE THE REASON THAT SOMEONE OTHER THAN A THERAPIST CANNOT SAFELY
PA67	PLEASE SPECIFY IF THE CLIENTS WORK SITE DEMANDS GOOD BINAURAL HEARING.
PA68	DESCRIBE THE REASON, BASED ON THE CLIENTS COGNITIVE, PHYSICAL, COMMUNICATION, OR RESOURCE STATUS, THAT A HOME PROGRAM, EQUIPMENT, OR ENVIRONMENTAL ADAPTATIONS ALONE CANNOT MEET CLIENTS NEEDS.
PA69	PLEASE SPECIFY IF THE CLIENT HAS AN ACCOMPANYING DISABILITY THAT ADDS TO THE HEARING PROBLEM.
PA70	DISTINGUISH REQUESTED PROCEDURES AND GOALS FROM OTHER SERVICES THIS CLIENT RECEIVES. THEY MAY NOT BE DUPLICATIVE.
PA71	PLEASE INDICATE THE NUMBER OF DAYS REQUESTED.
PA73	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA74	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA75	PLEASE DOCUMENT CARRYOVER OF THE THERAPY PROGRAM TO NURSING.
PA76	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA79	PROVIDE EVIDENCE OF SIGNIFICANT FUNCTIONAL PROGRESS IN LAST SIX MONTHS.
PA84	THE GRANT DATE OF THIS REQUEST CANNOT BE PRIOR TO THE SIGNATURE DATE OF THE PRESCRIBING PHYSICIAN.
PA86	PROVIDE EVIDENCE OF SKILLS GAINED IN THERAPY CARRYING OVER TO OTHER SETTINGS WITHIN SIX MONTHS.
PA87	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE NUMBER OF SESSIONS REQUESTED.
PA88	THE REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL SCOPE OF PRACTICE.
PA89	PRIOR AUTHORIZATION IS NOT REQUIRED UNTIL LIMITATION OF SERVICE HAS BEEN REACHED.
PA91	PLEASE SUBMIT REQUIRED X-RAYS.
PA92	PLEASE PROVIDE AN EXPLANATION FOR THE MATERIAL SUBMITTED WITH THE REQUEST.
PA95	PLEASE DESCRIBE HOW THE PROVISION OF THIS SERVICE WOULD PREVENT INSTITUTIONALIZATION OF THE CLIENT.
PA96	COULD THE EXISTING DENTURE(S) BE RELINED OR REBASED? IF NOT, PLEASE EXPLAIN WHY NOT.
PA97	REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL STANDARDS OF PRACTICE.
PA98	PLEASE INDICATE IF THE CLIENT IS CURRENTLY BEING TUBE FED.
PB02	PLEASE PROVIDE THE REQUIRED DATED SIGNATURES ON THE ATTACHMENTS.
PB03	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING THE LOSS/DESTRUCTION/THEFT OF THE HEARING AID.
PB04	DESCRIBE THE CLIENTS ABILITY TO STAND OR AMBULATE SUFFICIENTLY TO ACCOMPLISH SELF-CARE ACTIVITIES.
PB07	PLEASE SUBMIT AN ORTHODONTIC STUDY MODEL OR DIAGNOSTIC CASTS.
PB09	PLEASE PROVIDE A PHOTOGRAPH OF THE INVOLVED AREA(S).

Denial Code	Long Description
PB10	PLEASE PROVIDE AN ESTIMATION (IN GRAMS) OF THE TOTAL AMOUNT OF TISSUE TO BE RESECTED.
PB11	PLEASE SUBMIT THE PLAN OF CARE FOR CO-TREATMENT.
PB12	FURNISH A DETAILED DESCRIPTION FOR THE PROCEDURE CODE REQUESTED.
PB13	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB15	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB18	PLEASE COMPLETE THE ATTACHED OUT-OF-STATE PROVIDER DATA SHEET, F-11001, AND RESUBMIT.
PB20	A SIGNED AND DATED PRESCRIPTION IS REQUIRED WITHIN THREE MONTHS OF RECEIPT BY COLORADO MEDICAID FOR INITIAL REQUESTS AND WITHIN 12 MONTHS OF RECEIPT BY COLORADO MEDICAID FOR SUBSEQUENT REQUESTS.
PB21	PLEASE COMPLETE THE APPROPRIATE PRIOR AUTHORIZATION ATTACHMENT. CONTACT PROVIDER SERVICES OR THE PRIOR AUTHORIZATION UNIT FOR ASSISTANCE.
PB23	PHYSICAL THERAPY ASSISTANT NOTES AND ALL FORMS SUBMITTED MUST BE COSIGNED BY A REGISTERED PHYSICAL THERAPIST.
PB31	ARE YOU REQUESTING A COMPLETE APPLIANCE, OR REPLACEMENT PARTS?
PB32	THE PROCEDURE CODE INDICATED ON THE REQUEST DOES NOT MATCH THE DESCRIPTION OF SERVICE; PLEASE CORRECT AND RESUBMIT.
PB35	THE SERVICE REQUESTED DOES NOT REQUIRE PRIOR AUTHORIZATION.
PB41	PLEASE FURNISH A CURRENT MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT, F-11090 (DATED WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID).
PB45	THE CERTIFICATION PERIOD ON THE PLAN OF CARE (POC) DOES NOT COVER THE REQUESTED GRANT/START DATE. PLEASE RESUBMIT YOUR REQUEST WITH A NEW POC.
PB49	A CERTIFIED OCCUPATIONAL THERAPY ASSISTANTS NOTES MUST BE COSIGNED BY AN OCCUPATIONAL THERAPIST REGISTERED.
PB51	ADDITIONAL INFORMATION IS REQUIRED ON PRIOR AUTHORIZATION TO ENABLE PRICING.
PB54	REQUESTED SERVICES DO NOT MATCH SERVICES ON THE PHYSICIANS ORDERS.
PB59	PLEASE PROVIDE AN INDIVIDUAL EDUCATIONAL PLAN (IEP), WHICH HAS BEEN SIGNED BY THE PROVIDER NO EARLIER THAN NINE MONTHS PRIOR TO RECEIPT AT COLORADO MEDICAID; OTHERWISE, DOCUMENT WHY NO IEP EXISTS.
PB65	PLEASE FURNISH THE ANTICIPATED TOTAL CHARGES FOR THIS REQUEST.
PB66	A PHOTOCOPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED; THE DATE MUST BE WITHIN SIX MONTHS OF RECEIPT BY COLORADO MEDICAID.
PB67	THE PRESCRIPTION DATE MUST INCLUDE MONTH, DAY, AND YEAR.
PB68	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID.
PB73	THE SERVICES IDENTIFIED ON THE PLAN OF CARE DO NOT APPEAR APPROPRIATE FOR THE PROCEDURE CODE(S) REQUESTED ON THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018.
PB74	THE CLIENT/PROVIDER DOES NOT HAVE RETROACTIVE ENROLLMENT.
PB75	THE REQUESTED START DATE IS MORE THAN 14 DAYS BEFORE OR 62 DAYS AFTER RECEIPT.
PB82	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
PB83	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A HOME HEALTH AIDE. PLEASE RESUBMIT AS A PERSONAL CARE WORKER OR PROVIDE ADDITIONAL DOCUMENTATION.
PB86	THE SERVICES REQUESTED ARE NOT BEING PROVIDED IN THE CLIENTS RESIDENCE. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL.
PB87	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A NURSE. PLEASE RESUBMIT AS A HOME HEALTH AIDE OR PROVIDE ADDITIONAL DOCUMENTATION.
PB92	PLEASE FURNISH THE CLIENTS COMPLETE ADDRESS.
PB94	IF THE CLIENT IS A RESIDENT OF A NURSING HOME, SUPPLY THE COMPLETE NAME AND ADDRESS OF THE NURSING HOME.
PB99	THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018, MUST BE SIGNED AND DATED.
PC01	PLEASE SUPPLY THE RENDERING PROVIDERS PROVIDER NUMBER.
PC03	THE DRUG ENFORCEMENT ADMINISTRATION NUMBER IS MISSING OR INVALID.
PC06	PLEASE DESCRIBE YOUR PROGRAM; INCLUDE ENTRY DATE, TERMINATION DATE, HOURS PER WEEK, AND NUMBER OF WEEKS OF PRIMARY INTENSIVE SERVICE REQUESTED.

Denial Code	Long Description
PC07	PLEASE DESCRIBE YOUR "AFTERCARE/FOLLOW-UP" PLANS FOR THIS CLIENT.
PC08	PLEASE SUPPLY DOCUMENTATION OF PREVIOUS SUBSTANCE ABUSE SERVICES WITH DATE(S) AND OUTCOME.
PC09	PLEASE DESCRIBE IN DETAIL THE TREATMENT OBJECTIVES/GOALS FOR THIS CLIENT.
PC10	PLEASE DESCRIBE THE FAMILY SITUATION/DYNAMICS. EXPLAIN HOW THE FAMILY WILL BE INCORPORATED INTO THE CLIENTS PLAN OF CARE.
PC12	PLEASE EXPLAIN IF YOUR SERVICE ENCOURAGES THE CLIENT TO ATTEND SELF-HELP GROUPS.
PC13	PLEASE SUPPLY A SPECIFIC SCHEDULE OF ACTIVITIES, INCLUDING DAY, TIME OF DAY, LENGTH OF SESSION, AND SERVICE TO BE RENDERED DURING THAT TIME.
PC15	PLEASE FURNISH DIAGNOSTIC RATIONALE.
PC17	PLEASE DOCUMENT IF THE CLIENT EVER RECEIVED SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT.
PC19	PLEASE FURNISH MORE EXTENSIVE AND IN-DEPTH HISTORICAL AND PSYCHOSOCIAL DATA.
PC20	PLEASE SUPPLY THE DATE THE CLIENT BECAME TOTALLY ENDENTULOUS.
PC23	PLEASE SUBMIT A PHYSICIANS STATEMENT REGARDING THE MEDICAL NECESSITY OF DENTURES FOR THIS CLIENT. THE PHYSICIANS STATEMENT MUST DOCUMENT THE MEDICAL NEED FOR DENTURES.
PC24	THE SERVICE REQUESTED WAS PREVIOUSLY AUTHORIZED. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT INDICATING THIS FACT IS REQUIRED.
PC25	PLEASE SUPPLY SUFFICIENT MITIGATING CIRCUMSTANCES TO WARRANT THE CONSTRUCTION OF NEW DENTURES(S).
PC26	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
PC28	PLEASE SUBMIT A PHYSICIANS STATEMENT INDICATING DENTURES ARE NECESSARY FOR THIS NURSING HOME CLIENT.
PC29	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING LOSS OR DESTRUCTION OF DENTURE(S). INCLUDE SIGNED STATEMENT FROM CLIENT OR FACILITY DIRECTOR REGARDING HOW, WHEN AND WHERE LOST.
PC30	PLEASE PROVIDE COMPLETE INTRAORAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PC31	PLEASE DESCRIBE ANY RELATED DEFORMITIES OF THE FEET.
PC34	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD WITH REQUESTED DME ITEM(S) AND DOCUMENT IF THE CLIENT CAN USE SAFELY AND INDEPENDENTLY.
PC35	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD AND DESCRIBE THE RESULTS AND EFFECTIVENESS OF THE SERVICE REQUESTED.
PC39	PLEASE INDICATE LITER FLOW PER MINUTE, HOURS OF USE PER 24 HOUR PERIOD, AND THE EXPECTED DURATION OF NEED.
PC40	THE ITEM DOES NOT REQUIRE PRIOR AUTHORIZATION UNTIL THE LIFE EXPECTANCY HAS BEEN REACHED.
PC41	PLEASE SUPPLY INFORMATION INDICATING THE NECESSITY OF POSITIONING THE CLIENT'S BODY IN MULTIPLE POSITIONS.
PC42	PLEASE INDICATE IF THE BED HEIGHT MUST BE CHANGED TO ALLOW FOR SAFE TRANSFER OR ADEQUATE BED CARE.
PC43	SUPPLY A PHYSICIANS STATEMENT INDICATING TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR UNIT HAS REDUCED PAIN, IMPROVED/INCREASED THE CLIENTS ACTIVITY LEVEL, AND/OR REDUCED CLIENTS USE OF PAIN MEDICATION.
PC44	A CURRENT AUTHORIZATION FOR THIS SERVICE IS ON FILE FOR ANOTHER PROVIDER. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT OF THAT FACT IS REQUIRED BY THE CLIENT OF FIRST PROVIDER.
PC59	DOCUMENT DECLINE OR PROGRESS IN SPECIFIC, MEASURABLE, OBJECTIVE TERMS.
PC60	DOCUMENT IF CLIENT HAS DEMONSTRATED A GOOD APPOINTMENT COMPLIANCE RECORD.
PC61	THE PHYSICIANS SIGNATURE DATE MUST NOT EXCEED 90 DAYS FROM THE DATE OF RECEIPT BY COLORADO MEDICAID.
PC62	REQUESTS FOR A CONTINUATION OF THERAPY SHOULD NOT BE SUBMITTED MORE THAN FOUR WEEKS PRIOR TO THE EXPIRATION DATE OF THE CURRENT AUTHORIZATION.
PC63	PLEASE FURNISH THE STYLE AND MANUFACTURER OF THE FRAME.
PC64	PLEASE FURNISH THE CLIENTS LENS FORMULA.
PC66	ALL REQUESTS FOR TINTS REQUIRE DOCUMENTATION OF THE VISUAL OR MEDICAL CONDITION RELATED TO PHOTOPHOBIA.

Denial Code	Long Description
PC67	PLEASE DOCUMENT THE REASON AND JUSTIFICATION FOR REPLACEMENT BEYOND THE FIRST LENS/FRAME.
PC68	DOCUMENT IF ALL REMAINING MAXILLARY AND/OR MANDIBULAR TEETH ARE DECAY-FREE, PROPERLY RESTORED, AND PERIODONTICALLY SOUND.
PC72	SUPPLY MORE DETAIL REGARDING PROGRESS (ATTACHMENT OF GOALS, ETC.). CORRELATE PROGRESS TO PREVIOUS GOALS AND IDENTIFIED LIMITATIONS.
PC77	PLEASE SUBMIT A PLAN OF CARE DESCRIBING THE SERVICES THAT WOULD BE PROVIDED.
PC78	PLEASE DOCUMENT SPECIFIC, MEASURABLE GOALS.
PC82	THE PRIOR AUTHORIZATION (PA) SYSTEM CAN PROCESS ONLY 26 DETAILS PER PA REQUEST. PLEASE RESUBMIT YOUR REQUEST WITH NO MORE THAN 26 DETAILS.
PC83	PLEASE SUPPLY A PHYSICIANS PRESCRIPTION DATED WITHIN ONE MONTH OF REQUESTED SUBSTANCE ABUSE DAY TREATMENT.
PC84	PLEASE PROVIDE INFORMATION INDICATING THIS CLIENT IS APPROPRIATELY DETOXIFIED FROM ALCOHOL AND/OR OTHER DRUGS.
PC85	PLEASE PROVIDE INFORMATION TO INDICATE THE CLIENTS ABILITY TO ABSTAIN FROM ALCOHOL OR DRUGS WHILE IN THE SUBSTANCE ABUSE DAY TREATMENT PROGRAM.
PC86	PLEASE INDICATE IF THIS CLIENT IS WILLING TO PARTICIPATE IN AFTERCARE OR CONTINUING CARE SERVICES.
PC87	PROVIDE MORE INFORMATION ON TREATMENT HISTORY; INCLUDE SERVICE PROVIDED, DATES, AND OUTCOME. PROVIDE DETAIL OF PREVIOUS TREATMENT.
PC88	PLEASE PROVIDE MORE RATIONALE FOR THE APPROPRIATENESS AND MEDICAL NECESSITY OF SUBSTANCE ABUSE DAY TREATMENT.
PC89	PROVIDE A TREATMENT PLAN THAT CONTAINS MEASURABLE GOALS AND OBJECTIVES CORRESPONDING TO THE IDENTIFIED DEFICIT.
PC91	PLEASE PROVIDE MORE INFORMATION ON FAMILY INVOLVEMENT TREATMENT.
PC92	PLEASE PROVIDE MORE HISTORY AND EXPLANATION ABOUT THE ISSUE OF ABSTINENCE FOR THIS CLIENT.
PC94	PLEASE PROVIDE THE ANTICIPATED BEGINNING DATE AND/OR THE ESTIMATED SUBSTANCE ABUSE DAY TREATMENT DISCHARGE DATE.
PC95	PLEASE SUPPLY JUSTIFICATION FOR BEGINNING CLIENT IN SERVICE PRIOR TO AUTHORIZATION BEING OBTAINED.
PC96	THE INITIAL THREE HOURS OF SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IN A CALENDAR YEAR DO NOT REQUIRE PRIOR AUTHORIZATION.
PC97	REIMBURSEMENT FOR INITIAL SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IS LIMITED TO THREE HOURS IN A CALENDAR YEAR AND DOES NOT REQUIRE PRIOR AUTHORIZATION.
PC98	THIS DRUG IS CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE BILL USING THE APPROPRIATE NATIONAL DRUG CODE (NDC) OR SUBMIT A COMPLETED DRUG ADDITION REQUEST FORM IF THE NDC IS NOT LISTED IN THE DRUG INDEX.
PC99	THIS DRUG IS NOT CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL, CURRENT ADMINISTRATIVE RULE, OR COLORADO DRUG INDEX FOR COVERAGE LIMITATIONS.
PD01	DOCUMENT THAT CLIENT HAS ACHIEVED GOOD ORAL HYGIENE, PERIODONTAL CASE TYPE 1 OR 2, AND IS MOTIVATED TO MAINTAIN SAME.
PD03	PLEASE PROVIDE AN ARTERIAL BLOOD GAS READING OR PULSE OXIMETRY RESULTS DONE ON ROOM AIR SIGNED AND DATED BY A MEDICAL DOCTOR. THIS SHOULD BE DONE WITHIN 60 DAYS OF REQUESTED SERVICE.
PD04	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 30 DAYS OF RECEIPT BY COLORADO MEDICAID.
PD07	SUBMIT A PHOTOCOPY OF A VALID PRESCRIPTION, ISSUED WITHIN THE PAST YEAR, OR COMPLETE SECTION B OF THE PRIOR AUTHORIZATION/DRUG ATTACHMENT (PA/DGA), F-11049.
PD10	BRAND MEDICALLY NECESSARY MUST BE IN THE PRESCRIBERS OWN HANDWRITING AND WRITTEN DIRECTLY ON THE PRESCRIPTION OR A SEPARATE ORDER ATTACHED TO THE ORIGINAL PRESCRIPTION.
PD12	COMPLETE DENTURES, PARTIAL DENTURES, DENTURE RELINES, AND FIXED PROSTHODONTIC SERVICES ARE NOT COVERED SERVICES FOR ADULTS FOR DATES OF SERVICE ON AND AFTER OCTOBER 1, 1995.
PD22	PLEASE COMPLETE ALL REQUIRED ELEMENTS ON THE PERSONAL CARE SCREENING TOOL (PCST), F-11133.

Denial Code	Long Description
PD24	THIS PRIOR AUTHORIZATION REQUEST IS UNABLE TO BE PROCESSED. PLEASE RESUBMIT WITH ADDITIONAL REQUIRED FORMS, INCLUDING THE ENTIRE PERSONAL CARE SCREENING TOOL (PCST), F-11133; PERSONAL CARE ADDENDUM, F-11136; AND SUPPORTING DOCUMENTATION, AS DIRECTED.
PD25	THERE IS A PERSONAL CARE SCREENING TOOL (PCST), F-11133, COMPLETED BY ANOTHER AGENCY. CONTACT THE AGENCY TO TRANSFER SCREEN.
PD26	THERE IS A LIMITED TERM CARE FUNCTIONAL SCREEN (LTC-FS) COMPLETED BY ANOTHER AGENCY. THE PERSONAL CARE SCREENING TOOL (PCST), F-11133, INFORMATION IS IN CONFLICT WITH LTC-FS.
PD27	ONLY ONE LEVEL OF FUNCTION MAY BE SELECTED FOR ALL ELEMENTS EXCEPT TOILETING. COLORADO MEDICAID IS UNABLE TO PROCESS THE PRIOR AUTHORIZATION REQUEST.
PD28	NO UNITS MAY BE REQUESTED USING THIS PRIOR AUTHORIZATION PROCESS. PLEASE SUBMIT WITH THE APPROPRIATE ATTACHMENTS FOR REQUESTING SPECIFIC PERSONAL CARE WORKER UNITS.
PD29	CLIENT IS NOT ELIGIBLE FOR THE REQUESTED SERVICE(S) AS OF THE REQUESTED START DATE.
PD30	NO TRAVEL TIME MAY BE AUTHORIZED WHEN NO PERSONAL CARE WORKER SERVICE IS AUTHORIZED.
PD32	PROVIDER NOT CERTIFIED TO RENDER THE SERVICE(S) REQUESTED.
PD34	BASED ON THE DOCUMENTATION SUBMITTED, THIS REQUEST CAN NOT BE PRIOR AUTHORIZED. REFER TO THE PA MESSAGES FROM THE CONSULTANT FOR COMPLETE EXPLANATION.
PD98	PLEASE DOCUMENT HOW AND WHEN EACH PREVIOUSLY AUTHORIZED PRO RE NATA VISIT WAS USED.

Oral, Enteral, Parenteral

Denial Code	Long Description
0201	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
0233	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0235	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0237	CLIENT IDENTIFICATION NUMBER DOES NOT MATCH CLIENTS FIRST NAME.
0238	THE CLIENT IDENTIFICATION NUMBER DOES NOT MATCH THE CLIENTS LAST NAME.
0242	SECONDARY DIAGNOSIS CODE IS INVALID.
0248	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0249	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0251	PROCEDURE CODE MODIFIER IN FIRST POSITION IS INVALID.
0252	THE PROCEDURE CODE MODIFIER IN SECOND POSITION IS INVALID FOR REQUESTED START DATE OR DATE OF RECEIPT.
0253	THE PROCEDURE CODE MODIFIER IN THIRD POSITION IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
0258	THE PRIMARY DIAGNOSIS CODE IS REQUIRED.
0272	THE PRIMARY DIAGNSOSIS CODE IS INVALID.
0400	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0853	HCPCS - ANNUAL UPDATE
0885	NEVER EVENTS MODIFIERS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
0886	NEVER EVENTS DIAGNOSIS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
1000	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
1002	RENDERING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1003	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1007	RENDERING PROVIDER ID IS NOT ON FILE.
1047	THE RENDERING PROVIDERS CERTIFICATION HAS BEEN CANCELLED.
1048	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1801	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.

Denial Code	Long Description
1804	A CERTIFIED SUBSTANCE ABUSE DAY TREATMENT PROVIDER MUST SUBMIT A SUBSTANCE ABUSE DAY TREATMENT PROCEDURE CODE.
1806	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
1808	THE BILLING PROVIDER DOES NOT HAVE THE REQUIRED CERTIFICATION ADDENDUM ON FILE.
1900	THE BILLING PROVIDERS TAXONOMY CODE IS INVALID.
1901	THE RENDERING PROVIDERS TAXONOMY CODE IS INVALID.
1927	A NATIONAL PROVIDER IDENTIFIER IS REQUIRED FOR THE BILLING PROVIDER.
1934	A NATIONAL PROVIDER INDENTIFIER IS REQUIRED FOR THE RENDERING PROVIDER.
1936	THE BILLING PROVIDER NUMBER IS INVALID.
1937	THE RENDERING PROVIDER NUMBER IS INVALID.
1960	INTERNAL PROCESSING IS REQUIRED.
1963	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.
1964	THE BILLING PROVIDER INDICATED IS NOT ALLOWABLE AS A BILLING PROVIDER.
1965	RENDERING PROVIDER NUMBER IS MISSING/INVALID FOR THIS PROCEDURE PROVIDER.
1974	PRESCRIBING/REFERRING/ORDERING PROVIDER INDICATED IS NOT CERTIFIED AS A PRESCRIBING/REFERRING/ORDERING PROVIDER.
1975	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
1976	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
2001	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2003	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2017	THE CLIENT IS ENROLLED IN A MEDICAID OR OTHER MANAGED CARE PROGRAM.
2037	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2603	CLIENT LOCKED-IN TO A PROVIDER OR ENROLLED IN A HOSPICE. CONTACT CLIENTS HOSPICE FOR PAYMENT OF SERVICES OR RESUBMIT WITH DOCUMENTATION OF UNRELATED NATURE OF CARE.
3324	THE MODIFIER HAS BEEN DISCONTINUED BY THE CENTERS OF MEDICARE AND MEDICAID SERVICES OR THE AMERICAN MEDICAL ASSOCIATION FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
3337	THE PROCEDURE CODE HAS BEEN TERMINATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AMERICAN MEDICAL ASSOCIATION, OR AMERICAN DENTAL ASSOCIATION FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT. RESUBMIT WITH VALID A PROCEDURE CODE.
3339	THE PROCEDURE BILLED IS NOT PAYABLE ACCORDING TO DEFICIT REDUCTION ACT (DEFRA) GUIDELINES.
3351	THE PROCEDURE IS NOT COVERED FOR CLIENTS WITH A NURSING HOME AUTHORIZATION ON THE REQUESTED START DATE OR DATE OF RECEIPT.
3353	THE PROCEDURE IS NOT A COVERED SERVICE FOR HOME AND COMMUNITY-BASED WAIVER CLIENTS.
4021	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4027	THE DIAGNOSIS CODE IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
4031	THE PROCEDURE SUBMITTED IS NOT APPROPRIATE FOR CLIENTS GENDER.
4032	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4034	THE PROCEDURE CODE HAS AN AGE RESTRICTION.
4036	THE PLACE OF SERVICE CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4040	THE PRIMARY DIAGNOSIS CODE IS NOT ON FILE.
4041	THE SECONDARY DIAGNOSIS IS NOT ON FILE.
4046	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4127	INTERNAL PROCESSING IS REQUIRED.
4131	INTERNAL PROCESSING IS REQUIRED.
4141	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4149	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4150	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4236	ETIOLOGY DIAGNOSIS CODE(S) (E-CODES) ARE INVALID AS THE PRIMARY DIAGNOSIS.
4244	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4245	THE FOURTH POSITION MODIFIER IS INVALID FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT.
4256	THE PROCEDURE CODE AND MODIFIER COMBINATION IS NOT PAYABLE FOR THE CLIENTS BENEFIT PLAN.
4257	THE MODIFIERS SUBMITTED ARE EITHER INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT OR THE MODIFIERS ARE MISSING.

Denial Code	Long Description
4311	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4315	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4316	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4371	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4372	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4711	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR CLIENTS AGE.
4714	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS AGE.
4731	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS DIAGNOSIS.
4742	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4743	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4744	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4745	DIAGNOSIS AND/OR PROCEDURE AND/OR PLACE OF SERVICE (POS) CODE IS NOT COVERED FOR EXPRESS ENROLLMENT CLIENTS.
4746	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4801	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4802	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
4821	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
4871	PLEASE REFER TO PA MESSAGES FOR RETURN INFORMATION.
4963	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS GENDER.
4990	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
7500	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
7509	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
P001	THE BILLING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THE SERVICES.
P002	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P003	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P005	THE PRIOR AUTHORIZATION CAN NOT BE END DATED. THE PRIOR AUTHORIZATION STATUS IS NOT APPROVED OR APPROVED WITH REVISIONS.
P006	PLEASE FURNISH THE PROCEDURE CODE AND CORRESPONDING DESCRIPTION.
P008	THE BILLING PROVIDER NUMBER IS INVALID.
P009	THE BILLING PROVIDER NUMBER IS INVALID.
P010	THE REQUESTED END DATE IS INVALID.
P011	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P012	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P013	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P014	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P015	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P016	THE REQUESTED START DATE IS MISSING OR INVALID.
P019	THE REQUESTED START DATE IS MISSING OR INVALID.
P020	THE RENDERING PROVIDER NUMBER IS INVALID.
P021	THE RENDERING PROVIDER NUMBER IS INVALID.
P022	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P023	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P024	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P026	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P027	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.

Denial Code	Long Description
P030	FIRST MODIFIER IS INVALID.
P031	FIRST MODIFIER IS INVALID.
P032	SECOND MODIFIER IS INVALID.
P033	SECOND MODIFIER IS INVALID.
P034	THIRD MODIFIER IS INVALID.
P035	THIRD MODIFIER IS INVALID.
P036	FOURTH MODIFIER IS INVALID.
P037	FOURTH MODIFIER IS INVALID.
P038	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P039	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P040	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P041	CLIENTS FIRST NAME IS MISSING.
P042	CLIENTS LAST NAME IS MISSING.
P043	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P044	BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES REQUESTED.
P045	FIRST MODIFIER IS INVALID.
P046	SECOND MODIFIER IS INVALID.
P047	THIRD MODIFIER IS INVALID.
P048	FOURTH MODIFIER IS INVALID.
P052	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P053	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P054	RENDERING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES FOR THE BENEFIT PLAN.
P055	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P061	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P062	THE CLIENT ID AND/OR NAME INDICATED ON THE PA REQUEST IS INCORRECT. THE CLIENT ID AND/OR NAME HAS BEEN UPDATED. PLEASE VERIFY THE ID AND/OR NAME IS CORRECT.
P064	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
P067	THE FREQUENCY OF HOURS REQUESTED ARE NOT APPROPRIATE FOR THIS CLIENT AND HAVE BEEN MODIFIED ACCORDINGLY.
P079	BILLING PROVIDER IS ON PAYMENT SUSPENSION DUE TO CREDIBLE ALLEGATION OF FRAUD.
P120	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAS BEEN REDUCED.
P121	THE SERVICE/ PROCEDURE REQUESTED IS NOT SUPPORTED BY SUBMITTED DOCUMENTATION.
P126	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
P128	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.
P138	SERVICE(S) DO NOT MEET COLORADO MEDICAID GUIDELINES.
P167	REQUESTED DOCUMENTATION HAS NOT BEEN SUBMITTED.
P178	THE SERVICE REQUESTED IS NOT MEDICALLY NECESSARY.
P179	THE MEDICAL NECESSITY FOR THIS SERVICE IS NOT SUPPORTED BY THE SUBMITTED DOCUMENTATION.
P233	THE DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE ADDITIONAL CARE.
P257	THIS CLIENTS FUNCTIONAL ASSESSMENT SCORES PLACE THIS CLIENT OUTSIDE ELIGIBILITY FOR DAY TREATMENT.
P274	OUR RECORDS INDICATE THIS CLIENT IS INVOLVED IN EFFECTIVE AND APPROPRIATE SERVICE ELSEWHERE.
P292	INTENSIVE REHABILITATION HOURS ARE NO LONGER APPROPRIATE AS INDICATED BY HISTORY, DIAGNOSIS, AND/ OR FUNCTIONAL ASSESSMENT SCORES.
P328	THE SERVICES REQUESTED INCLUDE NON-COVERED SERVICES, AND HOURS ARE REDUCED ACCORDINGLY.
P339	THE CLIENTS PAST HISTORY INDICATES REDUCED TREATMENT HOURS ARE WARRANTED.
P342	THE REQUEST DOES NOT MEET GENERALLY ACCEPTED CONDITIONS REQUIRING FLUORIDE TREATMENTS.

Denial Code	Long Description
P346	SERVICES EXCEED COLORADO MEDICAID LIMITATION AND DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE MEDICAL NECESSITY OF THE SERVICE.
P349	THE SERVICE REQUESTED WAS PERFORMED LESS THAN FIVE YEARS AGO.
P353	THE EXISTING APPLIANCE HAS NOT BEEN WORN FOR THREE YEARS.
P367	THE CLIENT HAS BEEN TOTALLY WITHOUT TEETH AND AN APPLIANCE FOR FIVE YEARS.
P392	THE CLIENT IS MISSING AN ANTERIOR TOOTH AND/OR HAS TWO OR MORE POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P405	THE SERVICE(S) REQUESTED COULD ADEQUATELY BE PERFORMED IN THE DENTAL OFFICE.
P406	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE OF GOOD PERIODONTAL HEALTH (AMERICAN ACADEMY OF PERIODONTOLOGY PERIODONTAL CLASSIFICATION OF TYPE I OR II).
P407	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE VISIBLE ON RADIOGRAPHS THAT AT LEAST 50 PERCENT OF THE CLINICAL CROWN IS INTACT.
P409	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING SIX OR MORE TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED, INCLUDING THIRD MOLARS.
P410	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING ONE OR MORE ANTERIOR TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED.
P411	DOCUMENTATION DOES NOT SUPPORT THE NEED FOR PERIODONTIC SERVICES. POCKETS ARE LESS THAN 4MM AND/OR GREATER THAN 6MM FOR CLIENT AND/OR THE CLIENT IS UNDER THE AGE OF 13.
P412	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA.
P413	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA. THIS PA HAS BEEN GRANTED AS APPROVED NOT APPROVED WITH REVISIONS. THE DURATION REQUESTED MAY HAVE BEEN REDUCED TO REFLECT COVERAGE LIMITATIONS, PRESCRIBER ORDERS, CONFLICTI
P417	THE SERVICE(S) REQUESTED COULD BE ADEQUATELY PERFORMED WITH LOCAL ANESTHESIA.
P437	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO POOR ORAL HYGIENE.
P444	THIS LINE ITEM IS A DUPLICATE OF ANOTHER LINE ITEM ON THIS PRIOR AUTHORIZATION (PA) REQUEST. PLEASE CORRECT.
P446	THIS IS A DUPLICATE OF AN EXISTING PRIOR AUTHORIZATION (PA) REQUEST. YOU MAY CONTACT PROVIDER SERVICES IF YOU REQUIRE ASSISTANCE. DUPLICATE PA REQUEST
P448	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO DECAY HISTORY.
P449	QUESTIONABLE LONG TERM PROGNOSIS DUE TO GUM AND BONE DISEASE.
P456	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO APPARENT ROOT INFECTION.
P457	OUR RECORDS INDICATE THIS CLIENT HAS EXCEEDED ESTABLISHED PROGRAM LIMITATIONS. COLORADO MEDICAID WILL NOT AUTHORIZE NEW DENTURES.
P458	DOCUMENTATION PROVIDED INDICATES A LESS ELABORATE PROCEDURE SHOULD BE CONSIDERED.
P502	RENTAL ONLY ALLOWED; MEDICAL NEED FOR PURCHASE HAS NOT BEEN DOCUMENTED.
P503	PURCHASE ONLY ALLOWED; MEDICAL NEED FOR RENTAL HAS NOT BEEN DOCUMENTED.
P504	OCCUPATIONAL THERAPY GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P505	THE SERVICE REQUESTED IS INCLUDED IN THE NURSING HOME RATE STRUCTURE.
P511	THIS NATIONAL DRUG CODE IS ONLY BILLABLE AS PART OF A COMPOUND DRUG.
P515	THE PRESENCE OF A HANDICAPPING MALOCCLUSION OR HANDICAPPING DENTOFACIAL DEFORMITY IS NOT SUPPORTED BY THE DOCUMENTATION SUBMITTED.
P521	THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVERED BY COLORADO MEDICAID.
P522	GASTRO-INTESTINAL SURGERY FOR THE PURPOSE OF WEIGHT CONTROL IS COVERED ONLY AS A LIFE THREATENING PROCEDURE.
P523	THE TREATMENT REQUEST IS NOT CONSISTENT WITH THE CLIENT'S DIAGNOSIS.
P524	PSYCHOTHERAPY PROVIDED IN THE CLIENTS HOME IS NOT A COVERED BENEFIT OF COLORADO MEDICAID.
P525	THE INFORMATION PROVIDED IS NOT CONSISTENT WITH THE INTENSITY OF SERVICES REQUESTED.
P526	INTENSIVE MULTIPLE MODALITY TREATMENT IS NOT CONSISTENT WITH THE INFORMATION PROVIDED.
P527	MULTIPLE PROVIDERS OF TREATMENT ARE NOT INDICATED FOR THIS CLIENT.
P528	THE DURATION OF TREATMENT SESSIONS EXCEED CURRENT COLORADO MEDICAID GUIDELINES.

Denial Code	Long Description
P534	DOCUMENTATION OF POOR PHYSICAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P535	OTHER PHYSICAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P536	THE PHYSICAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P537	USE OF PHYSICAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P538	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF A PHYSICAL THERAPIST.
P539	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS AND LIVING ARRANGEMENT.
P540	GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P541	THE PROCEDURE(S) REQUESTED ARE NOT MEDICAL IN NATURE.
P542	DOCUMENTATION OF POOR OCCUPATIONAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P543	DOCUMENTATION OF POOR SPEECH THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P544	OTHER OCCUPATIONAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P546	THE OCCUPATIONAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P547	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF PHYSICAL THERAPY.
P548	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P549	ACTIVITIES TO PROMOTE DIVERSION OR GENERAL MOTIVATION ARE NONCOVERED COLORADO MEDICAID SERVICES.
P550	REVISIONS OF THE REQUEST IS NECESSITATED BY THE CLIENTS MINIMAL PROGRESS.
P551	RESTORATIVE NURSING INVOLVEMENT COULD BE INCREASED.
P552	CLIENTS DEMONSTRATED RESPONSE TO CURRENT THERAPY DOES NOT WARRANT THE INTENSE FREQUENCY REQUESTED.
P553	MAINTENANCE IS TWO TIMES PER WEEK OR LESS.
P554	THE SPEECH THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P555	USE OF OCCUPATIONAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P556	USE OF SPEECH THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P557	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF AN OCCUPATIONAL THERAPIST.
P558	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
P559	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P560	THE MATERIALS/ SERVICES REQUESTED ARE PRINCIPALLY COSMETIC IN NATURE.
P561	THE LENS FORMULA DOES NOT JUSTIFY REPLACEMENT.
P562	THE CHANGE IN THE LENS FORMULA DOES NOT WARRANT MULTIPLE REPLACEMENTS.
P563	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P564	LENSES ONLY ARE APPROVED; PLEASE DISPENSE A CONTRACTED FRAME. THE NON-CONTRACTED FRAME IS NOT MEDICALLY JUSTIFIED.
P565	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P566	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P567	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF OCCUPATIONAL THERAPY.
P568	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF SPEECH THERAPY.
P569	LEVEL, INTENSITY, OR EXTENT OF SERVICE(S) REQUESTED HAS BEEN MODIFIED CONSISTENT WITH MEDICAL NEED AS DEFINED IN THE PLAN OF CARE.

Denial Code	Long Description
P570	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P571	THE SERVICE ASKED FOR IS NOT COVERED BY COLORADO MEDICAID AS THESE TASKS CAN BE DONE BY NURSES OR ACTIVITY STAFF.
P572	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P573	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.
P574	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P575	MEDICAL NEED FOR EQUIPMENT/ SUPPLY REQUESTED IS NOT SUPPORTED BY DOCUMENTATION SUBMITTED.
P576	OTHER SPEECH THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P577	DOCUMENTATION SUBMITTED IDENTIFIES THAT THE CLIENT HAS FEWER THAN TWO POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P582	LESS EXPENSIVE ALTERNATIVE SERVICES ARE AVAILABLE FOR THIS CLIENT.
P634	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P711	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING PERIODONTAL SCALING AND ROOT PLANNING.
P712	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING GINGIVECTOMY.
P754	AN APPROVED SUBSTANCE ABUSE DAY TREATMENT PROGRAM CANNOT EXCEED A SIX WEEK PERIOD.
P761	THE CLIENT DOES NOT APPEAR TO BE ABLE OR WILLING TO ABSTAIN FROM ALCOHOL/DRUG USAGE WHILE IN TREATMENT. THEREFORE, SUBSTANCE ABUSE DAY TREATMENT SERVICES ARE NOT APPROVED.
P764	THIS CLIENT HAS COMPLETED INTENSIVE SUBSTANCE ABUSE TREATMENT WITHIN THE PAST 12 MONTHS. THE DOCUMENTATION PROVIDED IS NOT ADEQUATE TO JUSTIFY ADDITIONAL INTENSIVE TREATMENT AT THIS TIME.
P785	A LESS THAN SIX-WEEK HEALING PERIOD HAS BEEN SPECIFIED FOR THIS PRIOR AUTHORIZATION. THEREFORE IT IS NOT NECESSARY TO WAIT THE FULL SIX WEEKS AFTER EXTRACTIONS BEFORE TAKING DENTURE IMPRESSIONS.
P818	SIX-WEEK HEALING TIME IS REQUIRED BETWEEN EDENTULATION AND FINAL IMPRESSIONS. PAYMENT FOR DENTURES WILL BE DENIED OR RECOUPED IF HEALING PERIOD IS NOT OBSERVED.
P849	COLORADO MEDICAID HAS DETERMINED THERE WERE (ARE) SEVERAL HOME HEALTH AGENCIES WILLING TO PROVIDE MEDICALLY NECESSARY SKILLED NURSING SERVICES TO THIS CLIENT.
P864	THE DOCUMENTATION YOU HAVE SUBMITTED DOES NOT MEET THE REQUIREMENTS OF COLORADO MEDICAID.
P873	THE MEDICAL NECESSITY FOR THE HOURS REQUESTED IS NOT SUPPORTED BY THE INFORMATION SUBMITTED.
P874	THE DOCUMENTATION SUBMITTED INDICATES THE TASKS SPECIFIED CAN BE COMPLETED DURING THE VISITS APPROVED.
P878	THE DOCUMENTATION SUBMITTED DOES NOT INDICATE THAT MEDICALLY ORIENTED TASKS ARE MEDICALLY NECESSARY; THEREFORE PERSONAL CARE SERVICES HAVE BEEN APPROVED.
P880	THE QUANTITY OF SERVICES AUTHORIZED FOR THIS CLIENTS PERSONAL CARE HAS BEEN AMENDED BASED ON INFORMATION RECEIVED FROM ONE OR MORE OF THESE SOURCES: THE CLIENT, THEIR PHYSICIAN, AND/OR THE IN-HOME VISIT BY STAFF OF THE OIG (OFFICE OF INSPECTOR GENERAL).
P885	THE USE OF THIS DRUG FOR THE INTENDED PURPOSE IS NOT COVERED BY COLORADO MEDICAID, CONSISTENT WITH COLORADO ADMINISTRATIVE CODE AND FEDERAL LAW.
P924	THE MEDICAL RECORDS SUBMITTED WITH THE CURRENT REQUEST CONFLICT OR DISAGREE WITH OUR MEDICAL RECORDS ON THIS CLIENT.
P950	INDEPENDENT NURSES, PLEASE NOTE PAYABLE SERVICES MAY NOT EXCEED 12 HOURS/DAY OR 60 HOURS/WEEK.
P951	SERVICES CAN ONLY BE AUTHORIZED THROUGH ONE YEAR FROM THE PRESCRIPTION DATE.
P952	LEAD INSPECTION IS A COVERED COLORADO MEDICAID SERVICE WHEN THE CHILD HAS BEEN SHOWN TO HAVE LEAD POISONING (E.G., CHILD HAS A BLOOD LEAD LEVEL > 19 UG/DL OR TWO CONSECUTIVE BLOOD LEAD LEVELS OF 15-19 UG/DL DONE AT LEAST 90 DAYS APART). THE INSPECTION MUS

Denial Code	Long Description
P953	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P954	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P956	THE REQUEST CAN ONLY BE BACKDATED A MAXIMUM OF 14 DAYS FROM FIRST DATE RECEIVED BY COLORADO MEDICAID.
P957	COMPLETE PERIODONTAL CHARTING AT TIME OF SERVICE, AND SUBMIT CHARTING, COPY OF OPERATIVE REPORT, TOGETHER WITH A COPY OF THE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF), F-11035, TO PA UNIT ATTENTION DENTAL CONTSULTANT.
P958	NOTE THAT CODE D4341 HAS BEEN CHANGED. REFER TO THE DECISION NOTICE FOR AUTHORIZED QUANTITY.
P960	YOUR PA HAS BEEN APPROVED FOR 90 DAYS. THE 90 DAY APPROVAL DOES NOT IMPLY THE PA REQUEST MEETS PRIOR AUTHORIZATION CRITERIA. AFTER ADDITIONAL INFORMATION IS AVAILABLE IN INTERCHANGE, COLORADO MEDICAID WILL CREATE AN AMENDMENT REQUEST TO EXTEND THE PA FOR
P961	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P962	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
PA10	THE REQUESTED END DATE IS INVALID.
PA12	PLEASE FURNISH A WRITTEN DESCRIPTION OF THE CLIENTS DIAGNOSIS.
PA13	PROVIDE DIAGNOSES WITH DATES OF ONSET.
PA14	IDENTIFY PROBLEMS TO BE TREATED.
PA15	THE AUDIOLOGISTS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1), F-11020, AND PRIOR AUTHORIZATION REQUEST/HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2), F-11021.
PA16	THE PHYSICIANS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION/PHYSICIAN OTOLOGICAL REPORT (PA/POR), F-11019.
PA17	SUBMIT BRIEF HISTORY WITH REFERRAL INFORMATION, LIVING SITUATION, FUNCTIONAL STATUS, AND OTHER PERTINENT INFORMATION. WHAT CHANGE OF STATUS RESULTED IN REFERRAL AT THIS TIME?
PA18	PLEASE FURNISH THE CLIENTS HEIGHT AND WEIGHT.
PA19	PLEASE SUBMIT CLINICAL INFORMATION SUFFICIENT TO VERIFY THE NEED FOR THE REQUESTED SERVICE(S).
PA20	PLEASE RESUBMIT WITH COMPLETE PERIODONTAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PA21	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL EDUCATIONAL PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA22	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL PROGRAM PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA23	REFER TO THE DURABLE MEDICAL EQUIPMENT INDEX FOR APPROPRIATE CODE AND DESCRIPTION. DO NOT USE AN "UNLISTED" CODE.
PA24	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUALIZED FAMILY SERVICE PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA25	INFORMATION ON THE REQUEST FORM IS ILLEGIBLE, AND THE REQUEST CANNOT BE PROCESSED.
PA26	RE-EVALUATE YOUR GOALS. EMPHASIS SHOULD BE ON FUNCTIONAL SELF-CARE. GOALS MUST BE RELATED TO FUNCTIONAL OUTCOME.
PA27	PLEASE CLARIFY THE NUMBER OF HOURS PER WEEK REQUESTED.
PA28	PLEASE CLARIFY THE NUMBER OF HOURS PER DAY REQUESTED.
PA29	PLEASE CLARIFY THE NUMBER OF VISITS PER DAY REQUESTED.
PA30	ATTACH SUPPORTIVE DOCUMENTATION; HOME EXERCISE PROGRAM AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA31	THE DIAGNOSIS CODE INDICATED ON THE REQUEST DOES NOT CORRESPOND TO THE DIAGNOSIS CODE DESCRIPTION.

Denial Code	Long Description
PA32	PLEASE SUBMIT ADDITIONAL INFORMATION SUFFICIENT TO VERIFY APPROPRIATENESS AND NEED FOR TRANSPLANT.
PA33	PLEASE SUBMIT THE INITIAL AND PROGRESSIVE OBJECTIVE FINDINGS.
PA34	ATTACH SUPPORTIVE DOCUMENTATION, FACILITY PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA35	PLEASE SUBMIT THE CLIENTS ORIGINAL COMPLAINTS AND EXAMINATION FINDINGS.
PA36	ATTACH SUPPORTIVE DOCUMENTATION, IN-HOME AUTISM PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA37	PLEASE SUBMIT YOUR TREATMENT PLAN FOR THIS CLIENT.
PA38	ATTACH SUPPORTIVE DOCUMENTATION AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA39	INITIAL EVALUATIONS MUST BE PERFORMED BY AN OCCUPATIONAL THERAPIST REGISTERED (OTR), PER AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA) STANDARDS.
PA41	IDENTIFY THE PLACE OF SERVICE AND ITS EFFECT ON SUPPORTING THE DESIRED TREATMENT OUTCOME.
PA42	PLEASE INDICATE THE HOURS OF USE OF OXYGEN PER 24-HOUR PERIOD.
PA43	PROVIDE BASELINE DOCUMENTATION FOR THIS CLIENTS LIMITATIONS USING UNITS OF MEASUREMENT THAT ARE APPLIED CONSISTENTLY WHEN REPORTING STATUS.
PA44	IDENTIFY FUNCTIONAL LIMITATIONS AS THEY ARE RELATED TO IDENTIFIED CONDITIONS.
PA46	CORRELATE PLAN OF CARE TO REQUESTED PROCEDURE CODES.
PA47	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE FREQUENCY/DURATION REQUESTED.
PA48	PLEASE PROVIDE THE NAME AND CREDENTIALS OF THE RENDERING PROVIDER.
PA50	COLORADO MEDICAID RECORDS INDICATE THE CLIENT OWNS A WHEELCHAIR. DOCUMENT THE REASON AND NEED FOR REPLACEMENT AND COST TO REPAIR CURRENT WHEELCHAIR.
PA51	PLEASE DISTINGUISH PRIMARY AND SUPPORTIVE MODALITIES.
PA52	PLEASE SUBMIT A PROGRESS REPORT.
PA53	MULTIPLE FAMILY CLIENTS TREATMENT BY THE SAME PROVIDER REQUIRES FURTHER INFORMATION DOCUMENTING COORDINATION OF TREATMENT PLAN.
PA54	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE MINUTES REQUESTED.
PA55	MEDICAL NECESSITY OF TREATMENT REQUIRES ADDITIONAL DOCUMENTATION.
PA56	GIVEN AGE, DIAGNOSES, CURRENT LEVEL OF FUNCTION, PAST RESPONSE TO TREATMENT, AND LIVING SITUATION, EXPAND ON POTENTIAL FOR SIGNIFICANT FUNCTIONAL PROGRESS WITHIN THE NEXT SIX MONTHS. EMPHASIZE WHY PROGRESS IS EXPECTED WITH SERVICES AT THIS TIME.
PA57	SUBMIT THE INITIAL FINDINGS. INCLUDE A COMPREHENSIVE EVALUATION.
PA58	SUBMIT PROGRESSIVE, OBJECTIVE FINDINGS. INCLUDE A PERTINENT RE-EVALUATION.
PA59	PLEASE SUPPLY INFORMATION REGARDING THE CLIENTS MEDICATION REQUIREMENTS, IF ANY.
PA60	PLEASE SPECIFY IF THE CLIENT IS IN AN EDUCATIONAL SETTING.
PA61	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA62	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
PA63	THE SKILLS OF A THERAPIST ARE PURPOSEFUL AND SKILLED INTERVENTIONS REQUIRED TO CONTINUALLY DESIGN, IMPLEMENT, REASSESS, MODIFY/GRADE, AND/OR DISCONTINUE A PLAN OF CARE IN A TIMELY MANNER, BASED ON THE COMPLEXITY OF THE CLIENTS MEDICAL CONDITION AND/OR CO
PA64	PLEASE SUBMIT A THERAPY PLAN OF CARE, INCLUDING A CURRENT, DATED EVALUATION.
PA65	A PLAN OF CARE SIGNED AND DATED BY THE PHYSICIAN IS REQUIRED.
PA66	THE SKILLS OF A THERAPIST ARE REQUIRED WHEN ONLY THE THERAPIST CAN SAFELY AND EFFECTIVELY DELIVER THE THERAPEUTIC PROCEDURES BECAUSE OF THEIR UNIQUE KNOWLEDGE, TRAINING, AND EXPERTISE. DESCRIBE THE REASON THAT SOMEONE OTHER THAN A THERAPIST CANNOT SAFELY
PA67	PLEASE SPECIFY IF THE CLIENTS WORK SITE DEMANDS GOOD BINAURAL HEARING.
PA68	DESCRIBE THE REASON, BASED ON THE CLIENTS COGNITIVE, PHYSICAL, COMMUNICATION, OR RESOURCE STATUS, THAT A HOME PROGRAM, EQUIPMENT, OR ENVIRONMENTAL ADAPTATIONS ALONE CANNOT MEET CLIENTS NEEDS.

Denial Code	Long Description
PA69	PLEASE SPECIFY IF THE CLIENT HAS AN ACCOMPANYING DISABILITY THAT ADDS TO THE HEARING PROBLEM.
PA70	DISTINGUISH REQUESTED PROCEDURES AND GOALS FROM OTHER SERVICES THIS CLIENT RECEIVES. THEY MAY NOT BE DUPLICATIVE.
PA71	PLEASE INDICATE THE NUMBER OF DAYS REQUESTED.
PA73	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA74	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA75	PLEASE DOCUMENT CARRYOVER OF THE THERAPY PROGRAM TO NURSING.
PA76	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA79	PROVIDE EVIDENCE OF SIGNIFICANT FUNCTIONAL PROGRESS IN LAST SIX MONTHS.
PA84	THE GRANT DATE OF THIS REQUEST CANNOT BE PRIOR TO THE SIGNATURE DATE OF THE PRESCRIBING PHYSICIAN.
PA86	PROVIDE EVIDENCE OF SKILLS GAINED IN THERAPY CARRYING OVER TO OTHER SETTINGS WITHIN SIX MONTHS.
PA87	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE NUMBER OF SESSIONS REQUESTED.
PA88	THE REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL SCOPE OF PRACTICE.
PA89	PRIOR AUTHORIZATION IS NOT REQUIRED UNTIL LIMITATION OF SERVICE HAS BEEN REACHED.
PA91	PLEASE SUBMIT REQUIRED X-RAYS.
PA92	PLEASE PROVIDE AN EXPLANATION FOR THE MATERIAL SUBMITTED WITH THE REQUEST.
PA95	PLEASE DESCRIBE HOW THE PROVISION OF THIS SERVICE WOULD PREVENT INSTITUTIONALIZATION OF THE CLIENT.
PA96	COULD THE EXISTING DENTURE(S) BE RELINED OR REBASED? IF NOT, PLEASE EXPLAIN WHY NOT.
PA97	REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL STANDARDS OF PRACTICE.
PA98	PLEASE INDICATE IF THE CLIENT IS CURRENTLY BEING TUBE FED.
PB02	PLEASE PROVIDE THE REQUIRED DATED SIGNATURES ON THE ATTACHMENTS.
PB03	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING THE LOSS/DESTRUCTION/THEFT OF THE HEARING AID.
PB04	DESCRIBE THE CLIENTS ABILITY TO STAND OR AMBULATE SUFFICIENTLY TO ACCOMPLISH SELF-CARE ACTIVITIES.
PB07	PLEASE SUBMIT AN ORTHODONTIC STUDY MODEL OR DIAGNOSTIC CASTS.
PB09	PLEASE PROVIDE A PHOTOGRAPH OF THE INVOLVED AREA(S).
PB10	PLEASE PROVIDE AN ESTIMATION (IN GRAMS) OF THE TOTAL AMOUNT OF TISSUE TO BE RESECTED.
PB11	PLEASE SUBMIT THE PLAN OF CARE FOR CO-TREATMENT.
PB12	FURNISH A DETAILED DESCRIPTION FOR THE PROCEDURE CODE REQUESTED.
PB13	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB15	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB18	PLEASE COMPLETE THE ATTACHED OUT-OF-STATE PROVIDER DATA SHEET, F-11001, AND RESUBMIT.
PB20	A SIGNED AND DATED PRESCRIPTION IS REQUIRED WITHIN THREE MONTHS OF RECEIPT BY COLORADO MEDICAID FOR INITIAL REQUESTS AND WITHIN 12 MONTHS OF RECEIPT BY COLORADO MEDICAID FOR SUBSEQUENT REQUESTS.
PB21	PLEASE COMPLETE THE APPROPRIATE PRIOR AUTHORIZATION ATTACHMENT. CONTACT PROVIDER SERVICES OR THE PRIOR AUTHORIZATION UNIT FOR ASSISTANCE.
PB23	PHYSICAL THERAPY ASSISTANT NOTES AND ALL FORMS SUBMITTED MUST BE COSIGNED BY A REGISTERED PHYSICAL THERAPIST.
PB31	ARE YOU REQUESTING A COMPLETE APPLIANCE, OR REPLACEMENT PARTS?
PB32	THE PROCEDURE CODE INDICATED ON THE REQUEST DOES NOT MATCH THE DESCRIPTION OF SERVICE; PLEASE CORRECT AND RESUBMIT.
PB35	THE SERVICE REQUESTED DOES NOT REQUIRE PRIOR AUTHORIZATION.
PB41	PLEASE FURNISH A CURRENT MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT, F-11090 (DATED WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID).

Denial Code	Long Description
PB45	THE CERTIFICATION PERIOD ON THE PLAN OF CARE (POC) DOES NOT COVER THE REQUESTED GRANT/START DATE. PLEASE RESUBMIT YOUR REQUEST WITH A NEW POC.
PB49	A CERTIFIED OCCUPATIONAL THERAPY ASSISTANTS NOTES MUST BE COSIGNED BY AN OCCUPATIONAL THERAPIST REGISTERED.
PB51	ADDITIONAL INFORMATION IS REQUIRED ON PRIOR AUTHORIZATION TO ENABLE PRICING.
PB54	REQUESTED SERVICES DO NOT MATCH SERVICES ON THE PHYSICIANS ORDERS.
PB59	PLEASE PROVIDE AN INDIVIDUAL EDUCATIONAL PLAN (IEP), WHICH HAS BEEN SIGNED BY THE PROVIDER NO EARLIER THAN NINE MONTHS PRIOR TO RECEIPT AT COLORADO MEDICAID; OTHERWISE, DOCUMENT WHY NO IEP EXISTS.
PB65	PLEASE FURNISH THE ANTICIPATED TOTAL CHARGES FOR THIS REQUEST.
PB66	A PHOTOCOPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED; THE DATE MUST BE WITHIN SIX MONTHS OF RECEIPT BY COLORADO MEDICAID.
PB67	THE PRESCRIPTION DATE MUST INCLUDE MONTH, DAY, AND YEAR.
PB68	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID.
PB73	THE SERVICES IDENTIFIED ON THE PLAN OF CARE DO NOT APPEAR APPROPRIATE FOR THE PROCEDURE CODE(S) REQUESTED ON THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018.
PB74	THE CLIENT/PROVIDER DOES NOT HAVE RETROACTIVE ENROLLMENT.
PB75	THE REQUESTED START DATE IS MORE THAN 14 DAYS BEFORE OR 62 DAYS AFTER RECEIPT.
PB82	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
PB83	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A HOME HEALTH AIDE. PLEASE RESUBMIT AS A PERSONAL CARE WORKER OR PROVIDE ADDITIONAL DOCUMENTATION.
PB86	THE SERVICES REQUESTED ARE NOT BEING PROVIDED IN THE CLIENTS RESIDENCE. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL.
PB87	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A NURSE. PLEASE RESUBMIT AS A HOME HEALTH AIDE OR PROVIDE ADDITIONAL DOCUMENTATION.
PB92	PLEASE FURNISH THE CLIENTS COMPLETE ADDRESS.
PB94	IF THE CLIENT IS A RESIDENT OF A NURSING HOME, SUPPLY THE COMPLETE NAME AND ADDRESS OF THE NURSING HOME.
PB99	THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018, MUST BE SIGNED AND DATED.
PC01	PLEASE SUPPLY THE RENDERING PROVIDERS PROVIDER NUMBER.
PC03	THE DRUG ENFORCEMENT ADMINISTRATION NUMBER IS MISSING OR INVALID.
PC06	PLEASE DESCRIBE YOUR PROGRAM; INCLUDE ENTRY DATE, TERMINATION DATE, HOURS PER WEEK, AND NUMBER OF WEEKS OF PRIMARY INTENSIVE SERVICE REQUESTED.
PC07	PLEASE DESCRIBE YOUR "AFTERCARE/FOLLOW-UP" PLANS FOR THIS CLIENT.
PC08	PLEASE SUPPLY DOCUMENTATION OF PREVIOUS SUBSTANCE ABUSE SERVICES WITH DATE(S) AND OUTCOME.
PC09	PLEASE DESCRIBE IN DETAIL THE TREATMENT OBJECTIVES/GOALS FOR THIS CLIENT.
PC10	PLEASE DESCRIBE THE FAMILY SITUATION/DYNAMICS. EXPLAIN HOW THE FAMILY WILL BE INCORPORATED INTO THE CLIENTS PLAN OF CARE.
PC12	PLEASE EXPLAIN IF YOUR SERVICE ENCOURAGES THE CLIENT TO ATTEND SELF-HELP GROUPS.
PC13	PLEASE SUPPLY A SPECIFIC SCHEDULE OF ACTIVITIES, INCLUDING DAY, TIME OF DAY, LENGTH OF SESSION, AND SERVICE TO BE RENDERED DURING THAT TIME.
PC15	PLEASE FURNISH DIAGNOSTIC RATIONALE.
PC17	PLEASE DOCUMENT IF THE CLIENT EVER RECEIVED SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT.
PC19	PLEASE FURNISH MORE EXTENSIVE AND IN-DEPTH HISTORICAL AND PSYCHOSOCIAL DATA.
PC20	PLEASE SUPPLY THE DATE THE CLIENT BECAME TOTALLY ENDENTULOUS.
PC23	PLEASE SUBMIT A PHYSICIANS STATEMENT REGARDING THE MEDICAL NECESSITY OF DENTURES FOR THIS CLIENT. THE PHYSICIANS STATEMENT MUST DOCUMENT THE MEDICAL NEED FOR DENTURES.
PC24	THE SERVICE REQUESTED WAS PREVIOUSLY AUTHORIZED. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT INDICATING THIS FACT IS REQUIRED.
PC25	PLEASE SUPPLY SUFFICIENT MITIGATING CIRCUMSTANCES TO WARRANT THE CONSTRUCTION OF NEW DENTURES(S).

Denial Code	Long Description
PC26	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
PC28	PLEASE SUBMIT A PHYSICIANS STATEMENT INDICATING DENTURES ARE NECESSARY FOR THIS NURSING HOME CLIENT.
PC29	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING LOSS OR DESTRUCTION OF DENTURE(S). INCLUDE SIGNED STATEMENT FROM CLIENT OR FACILITY DIRECTOR REGARDING HOW, WHEN AND WHERE LOST.
PC30	PLEASE PROVIDE COMPLETE INTRAORAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PC31	PLEASE DESCRIBE ANY RELATED DEFORMITIES OF THE FEET.
PC34	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD WITH REQUESTED DME ITEM(S) AND DOCUMENT IF THE CLIENT CAN USE SAFELY AND INDEPENDENTLY.
PC35	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD AND DESCRIBE THE RESULTS AND EFFECTIVENESS OF THE SERVICE REQUESTED.
PC39	PLEASE INDICATE LITER FLOW PER MINUTE, HOURS OF USE PER 24 HOUR PERIOD, AND THE EXPECTED DURATION OF NEED.
PC40	THE ITEM DOES NOT REQUIRE PRIOR AUTHORIZATION UNTIL THE LIFE EXPECTANCY HAS BEEN REACHED.
PC41	PLEASE SUPPLY INFORMATION INDICATING THE NECESSITY OF POSITIONING THE CLIENT'S BODY IN MULTIPLE POSITIONS.
PC42	PLEASE INDICATE IF THE BED HEIGHT MUST BE CHANGED TO ALLOW FOR SAFE TRANSFER OR ADEQUATE BED CARE.
PC43	SUPPLY A PHYSICIANS STATEMENT INDICATING TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR UNIT HAS REDUCED PAIN, IMPROVED/INCREASED THE CLIENTS ACTIVITY LEVEL, AND/OR REDUCED CLIENTS USE OF PAIN MEDICATION.
PC44	A CURRENT AUTHORIZATION FOR THIS SERVICE IS ON FILE FOR ANOTHER PROVIDER. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT OF THAT FACT IS REQUIRED BY THE CLIENT OF FIRST PROVIDER.
PC59	DOCUMENT DECLINE OR PROGRESS IN SPECIFIC, MEASURABLE, OBJECTIVE TERMS.
PC60	DOCUMENT IF CLIENT HAS DEMONSTRATED A GOOD APPOINTMENT COMPLIANCE RECORD.
PC61	THE PHYSICIANS SIGNATURE DATE MUST NOT EXCEED 90 DAYS FROM THE DATE OF RECEIPT BY COLORADO MEDICAID.
PC62	REQUESTS FOR A CONTINUATION OF THERAPY SHOULD NOT BE SUBMITTED MORE THAN FOUR WEEKS PRIOR TO THE EXPIRATION DATE OF THE CURRENT AUTHORIZATION.
PC63	PLEASE FURNISH THE STYLE AND MANUFACTURER OF THE FRAME.
PC64	PLEASE FURNISH THE CLIENTS LENS FORMULA.
PC66	ALL REQUESTS FOR TINTS REQUIRE DOCUMENTATION OF THE VISUAL OR MEDICAL CONDITION RELATED TO PHOTOPHOBIA.
PC67	PLEASE DOCUMENT THE REASON AND JUSTIFICATION FOR REPLACEMENT BEYOND THE FIRST LENS/FRAME.
PC68	DOCUMENT IF ALL REMAINING MAXILLARY AND/OR MANDIBULAR TEETH ARE DECAY-FREE, PROPERLY RESTORED, AND PERIODONTICALLY SOUND.
PC72	SUPPLY MORE DETAIL REGARDING PROGRESS (ATTACHMENT OF GOALS, ETC.). CORRELATE PROGRESS TO PREVIOUS GOALS AND IDENTIFIED LIMITATIONS.
PC77	PLEASE SUBMIT A PLAN OF CARE DESCRIBING THE SERVICES THAT WOULD BE PROVIDED.
PC78	PLEASE DOCUMENT SPECIFIC, MEASURABLE GOALS.
PC82	THE PRIOR AUTHORIZATION (PA) SYSTEM CAN PROCESS ONLY 26 DETAILS PER PA REQUEST. PLEASE RESUBMIT YOUR REQUEST WITH NO MORE THAN 26 DETAILS.
PC83	PLEASE SUPPLY A PHYSICIANS PRESCRIPTION DATED WITHIN ONE MONTH OF REQUESTED SUBSTANCE ABUSE DAY TREATMENT.
PC84	PLEASE PROVIDE INFORMATION INDICATING THIS CLIENT IS APPROPRIATELY DETOXIFIED FROM ALCOHOL AND/OR OTHER DRUGS.
PC85	PLEASE PROVIDE INFORMATION TO INDICATE THE CLIENTS ABILITY TO ABSTAIN FROM ALCOHOL OR DRUGS WHILE IN THE SUBSTANCE ABUSE DAY TREATMENT PROGRAM.
PC86	PLEASE INDICATE IF THIS CLIENT IS WILLING TO PARTICIPATE IN AFTERCARE OR CONTINUING CARE SERVICES.

Denial Code	Long Description
PC87	PROVIDE MORE INFORMATION ON TREATMENT HISTORY; INCLUDE SERVICE PROVIDED, DATES, AND OUTCOME. PROVIDE DETAIL OF PREVIOUS TREATMENT.
PC88	PLEASE PROVIDE MORE RATIONALE FOR THE APPROPRIATENESS AND MEDICAL NECESSITY OF SUBSTANCE ABUSE DAY TREATMENT.
PC89	PROVIDE A TREATMENT PLAN THAT CONTAINS MEASURABLE GOALS AND OBJECTIVES CORRESPONDING TO THE IDENTIFIED DEFICIT.
PC91	PLEASE PROVIDE MORE INFORMATION ON FAMILY INVOLVEMENT TREATMENT.
PC92	PLEASE PROVIDE MORE HISTORY AND EXPLANATION ABOUT THE ISSUE OF ABSTINENCE FOR THIS CLIENT.
PC94	PLEASE PROVIDE THE ANTICIPATED BEGINNING DATE AND/OR THE ESTIMATED SUBSTANCE ABUSE DAY TREATMENT DISCHARGE DATE.
PC95	PLEASE SUPPLY JUSTIFICATION FOR BEGINNING CLIENT IN SERVICE PRIOR TO AUTHORIZATION BEING OBTAINED.
PC96	THE INITIAL THREE HOURS OF SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IN A CALENDAR YEAR DO NOT REQUIRE PRIOR AUTHORIZATION.
PC97	REIMBURSEMENT FOR INITIAL SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IS LIMITED TO THREE HOURS IN A CALENDAR YEAR AND DOES NOT REQUIRE PRIOR AUTHORIZATION.
PC98	THIS DRUG IS CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE BILL USING THE APPROPRIATE NATIONAL DRUG CODE (NDC) OR SUBMIT A COMPLETED DRUG ADDITION REQUEST FORM IF THE NDC IS NOT LISTED IN THE DRUG INDEX.
PC99	THIS DRUG IS NOT CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL, CURRENT ADMINISTRATIVE RULE, OR COLORADO DRUG INDEX FOR COVERAGE LIMITATIONS.
PD01	DOCUMENT THAT CLIENT HAS ACHIEVED GOOD ORAL HYGIENE, PERIODONTAL CASE TYPE 1 OR 2, AND IS MOTIVATED TO MAINTAIN SAME.
PD03	PLEASE PROVIDE AN ARTERIAL BLOOD GAS READING OR PULSE OXIMETRY RESULTS DONE ON ROOM AIR SIGNED AND DATED BY A MEDICAL DOCTOR. THIS SHOULD BE DONE WITHIN 60 DAYS OF REQUESTED SERVICE.
PD04	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 30 DAYS OF RECEIPT BY COLORADO MEDICAID.
PD07	SUBMIT A PHOTOCOPY OF A VALID PRESCRIPTION, ISSUED WITHIN THE PAST YEAR, OR COMPLETE SECTION B OF THE PRIOR AUTHORIZATION/DRUG ATTACHMENT (PA/DGA), F-11049.
PD10	BRAND MEDICALLY NECESSARY MUST BE IN THE PRESCRIBERS OWN HANDWRITING AND WRITTEN DIRECTLY ON THE PRESCRIPTION OR A SEPARATE ORDER ATTACHED TO THE ORIGINAL PRESCRIPTION.
PD12	COMPLETE DENTURES, PARTIAL DENTURES, DENTURE RELINES, AND FIXED PROSTHODONTIC SERVICES ARE NOT COVERED SERVICES FOR ADULTS FOR DATES OF SERVICE ON AND AFTER OCTOBER 1, 1995.
PD22	PLEASE COMPLETE ALL REQUIRED ELEMENTS ON THE PERSONAL CARE SCREENING TOOL (PCST), F-11133.
PD24	THIS PRIOR AUTHORIZATION REQUEST IS UNABLE TO BE PROCESSED. PLEASE RESUBMIT WITH ADDITIONAL REQUIRED FORMS, INCLUDING THE ENTIRE PERSONAL CARE SCREENING TOOL (PCST), F-11133; PERSONAL CARE ADDENDUM, F-11136; AND SUPPORTING DOCUMENTATION, AS DIRECTED.
PD25	THERE IS A PERSONAL CARE SCREENING TOOL (PCST), F-11133, COMPLETED BY ANOTHER AGENCY. CONTACT THE AGENCY TO TRANSFER SCREEN.
PD26	THERE IS A LIMITED TERM CARE FUNCTIONAL SCREEN (LTC-FS) COMPLETED BY ANOTHER AGENCY. THE PERSONAL CARE SCREENING TOOL (PCST), F-11133, INFORMATION IS IN CONFLICT WITH LTC-FS.
PD27	ONLY ONE LEVEL OF FUNCTION MAY BE SELECTED FOR ALL ELEMENTS EXCEPT TOILETING. COLORADO MEDICAID IS UNABLE TO PROCESS THE PRIOR AUTHORIZATION REQUEST.
PD28	NO UNITS MAY BE REQUESTED USING THIS PRIOR AUTHORIZATION PROCESS. PLEASE SUBMIT WITH THE APPROPRIATE ATTACHMENTS FOR REQUESTING SPECIFIC PERSONAL CARE WORKER UNITS.
PD29	CLIENT IS NOT ELIGIBLE FOR THE REQUESTED SERVICE(S) AS OF THE REQUESTED START DATE.
PD30	NO TRAVEL TIME MAY BE AUTHORIZED WHEN NO PERSONAL CARE WORKER SERVICE IS AUTHORIZED.
PD32	PROVIDER NOT CERTIFIED TO RENDER THE SERVICE(S) REQUESTED.
PD34	BASED ON THE DOCUMENTATION SUBMITTED, THIS REQUEST CAN NOT BE PRIOR AUTHORIZED. REFER TO THE PA MESSAGES FROM THE CONSULTANT FOR COMPLETE EXPLANATION.
PD98	PLEASE DOCUMENT HOW AND WHEN EACH PREVIOUSLY AUTHORIZED PRO RE NATA VISIT WAS USED.

Orthodontics

Denial Code	Long Description
0201	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
0233	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0235	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0237	CLIENT IDENTIFICATION NUMBER DOES NOT MATCH CLIENTS FIRST NAME.
0238	THE CLIENT IDENTIFICATION NUMBER DOES NOT MATCH THE CLIENTS LAST NAME.
0248	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0249	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0251	PROCEDURE CODE MODIFIER IN FIRST POSITION IS INVALID.
0252	THE PROCEDURE CODE MODIFIER IN SECOND POSITION IS INVALID FOR REQUESTED START DATE OR DATE OF RECEIPT.
0253	THE PROCEDURE CODE MODIFIER IN THIRD POSITION IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
0261	THE TOOTH NUMBER OR LETTER IS INVALID.
0262	THE TOOTH NUMBER OR LETTER IS INVALID.
0400	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0450	THE AREA OF THE ORAL CAVITY INVALID.
0853	HCPCS - ANNUAL UPDATE
0885	NEVER EVENTS MODIFIERS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
0886	NEVER EVENTS DIAGNOSIS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
1000	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
1002	RENDERING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1003	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1007	RENDERING PROVIDER ID IS NOT ON FILE.
1047	THE RENDERING PROVIDERS CERTIFICATION HAS BEEN CANCELLED.
1048	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1801	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
1804	A CERTIFIED SUBSTANCE ABUSE DAY TREATMENT PROVIDER MUST SUBMIT A SUBSTANCE ABUSE DAY TREATMENT PROCEDURE CODE.
1806	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
1808	THE BILLING PROVIDER DOES NOT HAVE THE REQUIRED CERTIFICATION ADDENDUM ON FILE.
1900	THE BILLING PROVIDERS TAXONOMY CODE IS INVALID.
1901	THE RENDERING PROVIDERS TAXONOMY CODE IS INVALID.
1927	A NATIONAL PROVIDER IDENTIFIER IS REQUIRED FOR THE BILLING PROVIDER.
1934	A NATIONAL PROVIDER INDENTIFIER IS REQUIRED FOR THE RENDERING PROVIDER.
1936	THE BILLING PROVIDER NUMBER IS INVALID.
1937	THE RENDERING PROVIDER NUMBER IS INVALID.
1960	INTERNAL PROCESSING IS REQUIRED.
1963	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.
1964	THE BILLING PROVIDER INDICATED IS NOT ALLOWABLE AS A BILLING PROVIDER.
1965	RENDERING PROVIDER NUMBER IS MISSING/INVALID FOR THIS PROCEDURE PROVIDER.
1974	PRESCRIBING/REFERRING/ORDERING PROVIDER INDICATED IS NOT CERTIFIED AS A PRESCRIBING/REFERRING/ORDERING PROVIDER.
1975	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
1976	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
2001	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2003	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2004	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.

Denial Code	Long Description
2017	THE CLIENT IS ENROLLED IN A MEDICAID OR OTHER MANAGED CARE PROGRAM.
2037	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2603	CLIENT LOCKED-IN TO A PROVIDER OR ENROLLED IN A HOSPICE. CONTACT CLIENTS HOSPICE FOR PAYMENT OF SERVICES OR RESUBMIT WITH DOCUMENTATION OF UNRELATED NATURE OF CARE.
3324	THE MODIFIER HAS BEEN DISCONTINUED BY THE CENTERS OF MEDICARE AND MEDICAID SERVICES OR THE AMERICAN MEDICAL ASSOCIATION FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
3337	THE PROCEDURE CODE HAS BEEN TERMINATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AMERICAN MEDICAL ASSOCIATION, OR AMERICAN DENTAL ASSOCIATION FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT. RESUBMIT WITH VALID A PROCEDURE CODE.
4021	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4032	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4034	THE PROCEDURE CODE HAS AN AGE RESTRICTION.
4036	THE PLACE OF SERVICE CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4046	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4120	THE AREA OF ORAL CAVITY IS REQUIRED FOR THE PROCEDURE CODE.
4127	INTERNAL PROCESSING IS REQUIRED.
4131	INTERNAL PROCESSING IS REQUIRED.
4141	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4149	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4150	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4211	TOOTH NUMBER/LETTER NOT APPROPRIATE FOR PROCEDURE CODE.
4244	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4245	THE FOURTH POSITION MODIFIER IS INVALID FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT.
4256	THE PROCEDURE CODE AND MODIFIER COMBINATION IS NOT PAYABLE FOR THE CLIENTS BENEFIT PLAN.
4257	THE MODIFIERS SUBMITTED ARE EITHER INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT OR THE MODIFIERS ARE MISSING.
4371	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4714	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS AGE.
4731	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS DIAGNOSIS.
4801	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4821	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
4871	PLEASE REFER TO PA MESSAGES FOR RETURN INFORMATION.
4963	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS GENDER.
4990	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
7500	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
7509	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
P001	THE BILLING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THE SERVICES.
P003	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P005	THE PRIOR AUTHORIZATION CAN NOT BE END DATED. THE PRIOR AUTHORIZATION STATUS IS NOT APPROVED OR APPROVED WITH REVISIONS.
P006	PLEASE FURNISH THE PROCEDURE CODE AND CORRESPONDING DESCRIPTION.
P008	THE BILLING PROVIDER NUMBER IS INVALID.
P009	THE BILLING PROVIDER NUMBER IS INVALID.
P010	THE REQUESTED END DATE IS INVALID.
P011	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P012	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P013	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.

Denial Code	Long Description
P014	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P015	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P016	THE REQUESTED START DATE IS MISSING OR INVALID.
P019	THE REQUESTED START DATE IS MISSING OR INVALID.
P020	THE RENDERING PROVIDER NUMBER IS INVALID.
P021	THE RENDERING PROVIDER NUMBER IS INVALID.
P022	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P023	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P024	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P028	THE AREA OF THE ORAL CAVITY IS MISSING OR INVALID.
P029	THE AREA OF THE ORAL CAVITY IS MISSING OR INVALID.
P030	FIRST MODIFIER IS INVALID.
P031	FIRST MODIFIER IS INVALID.
P032	SECOND MODIFIER IS INVALID.
P033	SECOND MODIFIER IS INVALID.
P034	THIRD MODIFIER IS INVALID.
P035	THIRD MODIFIER IS INVALID.
P036	FOURTH MODIFIER IS INVALID.
P037	FOURTH MODIFIER IS INVALID.
P038	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P039	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P040	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P041	CLIENTS FIRST NAME IS MISSING.
P042	CLIENTS LAST NAME IS MISSING.
P043	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P044	BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES REQUESTED.
P045	FIRST MODIFIER IS INVALID.
P046	SECOND MODIFIER IS INVALID.
P047	THIRD MODIFIER IS INVALID.
P048	FOURTH MODIFIER IS INVALID.
P049	THE TOOTH IS MISSING OR INVALID.
P052	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P053	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P054	RENDERING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES FOR THE BENEFIT PLAN.
P055	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P059	THE TOOTH IS MISSING OR INVALID.
P061	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P062	THE CLIENT ID AND/OR NAME INDICATED ON THE PA REQUEST IS INCORRECT. THE CLIENT ID AND/OR NAME HAS BEEN UPDATED. PLEASE VERIFY THE ID AND/OR NAME IS CORRECT.
P064	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
P067	THE FREQUENCY OF HOURS REQUESTED ARE NOT APPROPRIATE FOR THIS CLIENT AND HAVE BEEN MODIFIED ACCORDINGLY.
P079	BILLING PROVIDER IS ON PAYMENT SUSPENSION DUE TO CREDIBLE ALLEGATION OF FRAUD.
P120	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAS BEEN REDUCED.
P121	THE SERVICE/ PROCEDURE REQUESTED IS NOT SUPPORTED BY SUBMITTED DOCUMENTATION.

Denial Code	Long Description
P126	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
P128	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.
P138	SERVICE(S) DO NOT MEET COLORADO MEDICAID GUIDELINES.
P167	REQUESTED DOCUMENTATION HAS NOT BEEN SUBMITTED.
P178	THE SERVICE REQUESTED IS NOT MEDICALLY NECESSARY.
P179	THE MEDICAL NECESSITY FOR THIS SERVICE IS NOT SUPPORTED BY THE SUBMITTED DOCUMENTATION.
P233	THE DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE ADDITIONAL CARE.
P257	THIS CLIENTS FUNCTIONAL ASSESSMENT SCORES PLACE THIS CLIENT OUTSIDE ELIGIBILITY FOR DAY TREATMENT.
P274	OUR RECORDS INDICATE THIS CLIENT IS INVOLVED IN EFFECTIVE AND APPROPRIATE SERVICE ELSEWHERE.
P292	INTENSIVE REHABILITATION HOURS ARE NO LONGER APPROPRIATE AS INDICATED BY HISTORY, DIAGNOSIS, AND/ OR FUNCTIONAL ASSESSMENT SCORES.
P328	THE SERVICES REQUESTED INCLUDE NON-COVERED SERVICES, AND HOURS ARE REDUCED ACCORDINGLY.
P339	THE CLIENTS PAST HISTORY INDICATES REDUCED TREATMENT HOURS ARE WARRANTED.
P342	THE REQUEST DOES NOT MEET GENERALLY ACCEPTED CONDITIONS REQUIRING FLUORIDE TREATMENTS.
P346	SERVICES EXCEED COLORADO MEDICAID LIMITATION AND DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE MEDICAL NECESSITY OF THE SERVICE.
P349	THE SERVICE REQUESTED WAS PERFORMED LESS THAN FIVE YEARS AGO.
P353	THE EXISTING APPLIANCE HAS NOT BEEN WORN FOR THREE YEARS.
P367	THE CLIENT HAS BEEN TOTALLY WITHOUT TEETH AND AN APPLIANCE FOR FIVE YEARS.
P392	THE CLIENT IS MISSING AN ANTERIOR TOOTH AND/OR HAS TWO OR MORE POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P405	THE SERVICE(S) REQUESTED COULD ADEQUATELY BE PERFORMED IN THE DENTAL OFFICE.
P406	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE OF GOOD PERIODONTAL HEALTH (AMERICAN ACADEMY OF PERIODONTOLOGY PERIODONTAL CLASSIFICATION OF TYPE I OR II).
P407	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE VISIBLE ON RADIOGRAPHS THAT AT LEAST 50 PERCENT OF THE CLINICAL CROWN IS INTACT.
P409	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING SIX OR MORE TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED, INCLUDING THIRD MOLARS.
P410	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING ONE OR MORE ANTERIOR TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED.
P411	DOCUMENTATION DOES NOT SUPPORT THE NEED FOR PERIODONTIC SERVICES. POCKETS ARE LESS THAN 4MM AND/OR GREATER THAN 6MM FOR CLIENT AND/OR THE CLIENT IS UNDER THE AGE OF 13.
P412	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA.
P413	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA. THIS PA HAS BEEN GRANTED AS APPROVED NOT APPROVED WITH REVISIONS. THE DURATION REQUESTED MAY HAVE BEEN REDUCED TO REFLECT COVERAGE LIMITATIONS, PRESCRIBER ORDERS, CONFLICTI
P417	THE SERVICE(S) REQUESTED COULD BE ADEQUATELY PERFORMED WITH LOCAL ANESTHESIA.
P437	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO POOR ORAL HYGIENE.
P444	THIS LINE ITEM IS A DUPLICATE OF ANOTHER LINE ITEM ON THIS PRIOR AUTHORIZATION (PA) REQUEST. PLEASE CORRECT.
P446	THIS IS A DUPLICATE OF AN EXISTING PRIOR AUTHORIZATION (PA) REQUEST. YOU MAY CONTACT PROVIDER SERVICES IF YOU REQUIRE ASSISTANCE. DUPLICATE PA REQUEST
P448	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO DECAY HISTORY.
P449	QUESTIONABLE LONG TERM PROGNOSIS DUE TO GUM AND BONE DISEASE.
P456	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO APPARENT ROOT INFECTION.
P457	OUR RECORDS INDICATE THIS CLIENT HAS EXCEEDED ESTABLISHED PROGRAM LIMITATIONS. COLORADO MEDICAID WILL NOT AUTHORIZE NEW DENTURES.
P458	DOCUMENTATION PROVIDED INDICATES A LESS ELABORATE PROCEDURE SHOULD BE CONSIDERED.
P502	RENTAL ONLY ALLOWED; MEDICAL NEED FOR PURCHASE HAS NOT BEEN DOCUMENTED.
P503	PURCHASE ONLY ALLOWED; MEDICAL NEED FOR RENTAL HAS NOT BEEN DOCUMENTED.
P504	OCCUPATIONAL THERAPY GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.

Denial Code	Long Description
P505	THE SERVICE REQUESTED IS INCLUDED IN THE NURSING HOME RATE STRUCTURE.
P511	THIS NATIONAL DRUG CODE IS ONLY BILLABLE AS PART OF A COMPOUND DRUG.
P515	THE PRESENCE OF A HANDICAPPING MALOCCLUSION OR HANDICAPPING DENTOFACIAL DEFORMITY IS NOT SUPPORTED BY THE DOCUMENTATION SUBMITTED.
P521	THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVERED BY COLORADO MEDICAID.
P522	GASTRO-INTESTINAL SURGERY FOR THE PURPOSE OF WEIGHT CONTROL IS COVERED ONLY AS A LIFE THREATENING PROCEDURE.
P523	THE TREATMENT REQUEST IS NOT CONSISTENT WITH THE CLIENT'S DIAGNOSIS.
P524	PSYCHOTHERAPY PROVIDED IN THE CLIENTS HOME IS NOT A COVERED BENEFIT OF COLORADO MEDICAID.
P525	THE INFORMATION PROVIDED IS NOT CONSISTENT WITH THE INTENSITY OF SERVICES REQUESTED.
P526	INTENSIVE MULTIPLE MODALITY TREATMENT IS NOT CONSISTENT WITH THE INFORMATION PROVIDED.
P527	MULTIPLE PROVIDERS OF TREATMENT ARE NOT INDICATED FOR THIS CLIENT.
P528	THE DURATION OF TREATMENT SESSIONS EXCEED CURRENT COLORADO MEDICAID GUIDELINES.
P534	DOCUMENTATION OF POOR PHYSICAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P535	OTHER PHYSICAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P536	THE PHYSICAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P537	USE OF PHYSICAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P538	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF A PHYSICAL THERAPIST.
P539	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS AND LIVING ARRANGEMENT.
P540	GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P541	THE PROCEDURE(S) REQUESTED ARE NOT MEDICAL IN NATURE.
P542	DOCUMENTATION OF POOR OCCUPATIONAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P543	DOCUMENTATION OF POOR SPEECH THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P544	OTHER OCCUPATIONAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P546	THE OCCUPATIONAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P547	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF PHYSICAL THERAPY.
P548	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P549	ACTIVITIES TO PROMOTE DIVERSION OR GENERAL MOTIVATION ARE NONCOVERED COLORADO MEDICAID SERVICES.
P550	REVISIONS OF THE REQUEST IS NECESSITATED BY THE CLIENTS MINIMAL PROGRESS.
P551	RESTORATIVE NURSING INVOLVEMENT COULD BE INCREASED.
P552	CLIENTS DEMONSTRATED RESPONSE TO CURRENT THERAPY DOES NOT WARRANT THE INTENSE FREQUENCY REQUESTED.
P553	MAINTENANCE IS TWO TIMES PER WEEK OR LESS.
P554	THE SPEECH THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P555	USE OF OCCUPATIONAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P556	USE OF SPEECH THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P557	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF AN OCCUPATIONAL THERAPIST.
P558	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
P559	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P560	THE MATERIALS/ SERVICES REQUESTED ARE PRINCIPALLY COSMETIC IN NATURE.

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P561	THE LENS FORMULA DOES NOT JUSTIFY REPLACEMENT.
P562	THE CHANGE IN THE LENS FORMULA DOES NOT WARRANT MULTIPLE REPLACEMENTS.
P563	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P564	LENSES ONLY ARE APPROVED; PLEASE DISPENSE A CONTRACTED FRAME. THE NON-CONTRACTED FRAME IS NOT MEDICALLY JUSTIFIED.
P565	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P566	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P567	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF OCCUPATIONAL THERAPY.
P568	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF SPEECH THERAPY.
P569	LEVEL, INTENSITY, OR EXTENT OF SERVICE(S) REQUESTED HAS BEEN MODIFIED CONSISTENT WITH MEDICAL NEED AS DEFINED IN THE PLAN OF CARE.
P570	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P571	THE SERVICE ASKED FOR IS NOT COVERED BY COLORADO MEDICAID AS THESE TASKS CAN BE DONE BY NURSES OR ACTIVITY STAFF.
P572	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P573	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.
P574	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P575	MEDICAL NEED FOR EQUIPMENT/ SUPPLY REQUESTED IS NOT SUPPORTED BY DOCUMENTATION SUBMITTED.
P576	OTHER SPEECH THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P577	DOCUMENTATION SUBMITTED IDENTIFIES THAT THE CLIENT HAS FEWER THAN TWO POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P582	LESS EXPENSIVE ALTERNATIVE SERVICES ARE AVAILABLE FOR THIS CLIENT.
P634	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P711	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING PERIODONTAL SCALING AND ROOT PLANNING.
P712	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING GINGIVECTOMY.
P754	AN APPROVED SUBSTANCE ABUSE DAY TREATMENT PROGRAM CANNOT EXCEED A SIX WEEK PERIOD.
P761	THE CLIENT DOES NOT APPEAR TO BE ABLE OR WILLING TO ABSTAIN FROM ALCOHOL/DRUG USAGE WHILE IN TREATMENT. THEREFORE, SUBSTANCE ABUSE DAY TREATMENT SERVICES ARE NOT APPROVED.
P764	THIS CLIENT HAS COMPLETED INTENSIVE SUBSTANCE ABUSE TREATMENT WITHIN THE PAST 12 MONTHS. THE DOCUMENTATION PROVIDED IS NOT ADEQUATE TO JUSTIFY ADDITIONAL INTENSIVE TREATMENT AT THIS TIME.
P785	A LESS THAN SIX-WEEK HEALING PERIOD HAS BEEN SPECIFIED FOR THIS PRIOR AUTHORIZATION. THEREFORE IT IS NOT NECESSARY TO WAIT THE FULL SIX WEEKS AFTER EXTRACTIONS BEFORE TAKING DENTURE IMPRESSIONS.
P818	SIX-WEEK HEALING TIME IS REQUIRED BETWEEN EDENTULATION AND FINAL IMPRESSIONS. PAYMENT FOR DENTURES WILL BE DENIED OR RECOUPED IF HEALING PERIOD IS NOT OBSERVED.
P849	COLORADO MEDICAID HAS DETERMINED THERE WERE (ARE) SEVERAL HOME HEALTH AGENCIES WILLING TO PROVIDE MEDICALLY NECESSARY SKILLED NURSING SERVICES TO THIS CLIENT.
P864	THE DOCUMENTATION YOU HAVE SUBMITTED DOES NOT MEET THE REQUIREMENTS OF COLORADO MEDICAID.
P873	THE MEDICAL NECESSITY FOR THE HOURS REQUESTED IS NOT SUPPORTED BY THE INFORMATION SUBMITTED.
P874	THE DOCUMENTATION SUBMITTED INDICATES THE TASKS SPECIFIED CAN BE COMPLETED DURING THE VISITS APPROVED.
P878	THE DOCUMENTATION SUBMITTED DOES NOT INDICATE THAT MEDICALLY ORIENTED TASKS ARE MEDICALLY NECESSARY; THEREFORE PERSONAL CARE SERVICES HAVE BEEN APPROVED.

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P880	THE QUANTITY OF SERVICES AUTHORIZED FOR THIS CLIENTS PERSONAL CARE HAS BEEN AMENDED BASED ON INFORMATION RECEIVED FROM ONE OR MORE OF THESE SOURCES: THE CLIENT, THEIR PHYSICIAN, AND/OR THE IN-HOME VISIT BY STAFF OF THE OIG (OFFICE OF INSPECTOR GENERAL).
P885	THE USE OF THIS DRUG FOR THE INTENDED PURPOSE IS NOT COVERED BY COLORADO MEDICAID, CONSISTENT WITH COLORADO ADMINISTRATIVE CODE AND FEDERAL LAW.
P924	THE MEDICAL RECORDS SUBMITTED WITH THE CURRENT REQUEST CONFLICT OR DISAGREE WITH OUR MEDICAL RECORDS ON THIS CLIENT.
P950	INDEPENDENT NURSES, PLEASE NOTE PAYABLE SERVICES MAY NOT EXCEED 12 HOURS/DAY OR 60 HOURS/WEEK.
P951	SERVICES CAN ONLY BE AUTHORIZED THROUGH ONE YEAR FROM THE PRESCRIPTION DATE.
P952	LEAD INSPECTION IS A COVERED COLORADO MEDICAID SERVICE WHEN THE CHILD HAS BEEN SHOWN TO HAVE LEAD POISONING (E.G., CHILD HAS A BLOOD LEAD LEVEL > 19 UG/DL OR TWO CONSECUTIVE BLOOD LEAD LEVELS OF 15-19 UG/DL DONE AT LEAST 90 DAYS APART). THE INSPECTION MUS
P953	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P954	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P956	THE REQUEST CAN ONLY BE BACKDATED A MAXIMUM OF 14 DAYS FROM FIRST DATE RECEIVED BY COLORADO MEDICAID.
P957	COMPLETE PERIODONTAL CHARTING AT TIME OF SERVICE, AND SUBMIT CHARTING, COPY OF OPERATIVE REPORT, TOGETHER WITH A COPY OF THE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF), F-11035, TO PA UNIT ATTENTION DENTAL CONTSULTANT.
P958	NOTE THAT CODE D4341 HAS BEEN CHANGED. REFER TO THE DECISION NOTICE FOR AUTHORIZED QUANTITY.
P960	YOUR PA HAS BEEN APPROVED FOR 90 DAYS. THE 90 DAY APPROVAL DOES NOT IMPLY THE PA REQUEST MEETS PRIOR AUTHORIZATION CRITERIA. AFTER ADDITIONAL INFORMATION IS AVAILABLE IN INTERCHANGE, COLORADO MEDICAID WILL CREATE AN AMENDMENT REQUEST TO EXTEND THE PA FOR
P961	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P962	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
PA10	THE REQUESTED END DATE IS INVALID.
PA12	PLEASE FURNISH A WRITTEN DESCRIPTION OF THE CLIENTS DIAGNOSIS.
PA13	PROVIDE DIAGNOSES WITH DATES OF ONSET.
PA14	IDENTIFY PROBLEMS TO BE TREATED.
PA15	THE AUDIOLOGISTS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1), F-11020, AND PRIOR AUTHORIZATION REQUEST/HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2), F-11021.
PA16	THE PHYSICIANS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION/PHYSICIAN OTOLOGICAL REPORT (PA/POR), F-11019.
PA17	SUBMIT BRIEF HISTORY WITH REFERRAL INFORMATION, LIVING SITUATION, FUNCTIONAL STATUS, AND OTHER PERTINENT INFORMATION. WHAT CHANGE OF STATUS RESULTED IN REFERRAL AT THIS TIME?
PA18	PLEASE FURNISH THE CLIENTS HEIGHT AND WEIGHT.
PA19	PLEASE SUBMIT CLINICAL INFORMATION SUFFICIENT TO VERIFY THE NEED FOR THE REQUESTED SERVICE(S).
PA20	PLEASE RESUBMIT WITH COMPLETE PERIODONTAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PA21	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL EDUCATIONAL PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA22	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL PROGRAM PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA23	REFER TO THE DURABLE MEDICAL EQUIPMENT INDEX FOR APPROPRIATE CODE AND DESCRIPTION. DO NOT USE AN "UNLISTED" CODE.

Denial Code	Long Description
PA24	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUALIZED FAMILY SERVICE PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA25	INFORMATION ON THE REQUEST FORM IS ILLEGIBLE, AND THE REQUEST CANNOT BE PROCESSED.
PA26	RE-EVALUATE YOUR GOALS. EMPHASIS SHOULD BE ON FUNCTIONAL SELF-CARE. GOALS MUST BE RELATED TO FUNCTIONAL OUTCOME.
PA27	PLEASE CLARIFY THE NUMBER OF HOURS PER WEEK REQUESTED.
PA28	PLEASE CLARIFY THE NUMBER OF HOURS PER DAY REQUESTED.
PA29	PLEASE CLARIFY THE NUMBER OF VISITS PER DAY REQUESTED.
PA30	ATTACH SUPPORTIVE DOCUMENTATION; HOME EXERCISE PROGRAM AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA31	THE DIAGNOSIS CODE INDICATED ON THE REQUEST DOES NOT CORRESPOND TO THE DIAGNOSIS CODE DESCRIPTION.
PA32	PLEASE SUBMIT ADDITIONAL INFORMATION SUFFICIENT TO VERIFY APPROPRIATENESS AND NEED FOR TRANSPLANT.
PA33	PLEASE SUBMIT THE INITIAL AND PROGRESSIVE OBJECTIVE FINDINGS.
PA34	ATTACH SUPPORTIVE DOCUMENTATION, FACILITY PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA35	PLEASE SUBMIT THE CLIENTS ORIGINAL COMPLAINTS AND EXAMINATION FINDINGS.
PA36	ATTACH SUPPORTIVE DOCUMENTATION, IN-HOME AUTISM PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA37	PLEASE SUBMIT YOUR TREATMENT PLAN FOR THIS CLIENT.
PA38	ATTACH SUPPORTIVE DOCUMENTATION AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA39	INITIAL EVALUATIONS MUST BE PERFORMED BY AN OCCUPATIONAL THERAPIST REGISTERED (OTR), PER AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA) STANDARDS.
PA41	IDENTIFY THE PLACE OF SERVICE AND ITS EFFECT ON SUPPORTING THE DESIRED TREATMENT OUTCOME.
PA42	PLEASE INDICATE THE HOURS OF USE OF OXYGEN PER 24-HOUR PERIOD.
PA43	PROVIDE BASELINE DOCUMENTATION FOR THIS CLIENTS LIMITATIONS USING UNITS OF MEASUREMENT THAT ARE APPLIED CONSISTENTLY WHEN REPORTING STATUS.
PA44	IDENTIFY FUNCTIONAL LIMITATIONS AS THEY ARE RELATED TO IDENTIFIED CONDITIONS.
PA46	CORRELATE PLAN OF CARE TO REQUESTED PROCEDURE CODES.
PA47	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE FREQUENCY/DURATION REQUESTED.
PA48	PLEASE PROVIDE THE NAME AND CREDENTIALS OF THE RENDERING PROVIDER.
PA50	COLORADO MEDICAID RECORDS INDICATE THE CLIENT OWNS A WHEELCHAIR. DOCUMENT THE REASON AND NEED FOR REPLACEMENT AND COST TO REPAIR CURRENT WHEELCHAIR.
PA51	PLEASE DISTINGUISH PRIMARY AND SUPPORTIVE MODALITIES.
PA52	PLEASE SUBMIT A PROGRESS REPORT.
PA53	MULTIPLE FAMILY CLIENTS TREATMENT BY THE SAME PROVIDER REQUIRES FURTHER INFORMATION DOCUMENTING COORDINATION OF TREATMENT PLAN.
PA54	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE MINUTES REQUESTED.
PA55	MEDICAL NECESSITY OF TREATMENT REQUIRES ADDITIONAL DOCUMENTATION.
PA56	GIVEN AGE, DIAGNOSES, CURRENT LEVEL OF FUNCTION, PAST RESPONSE TO TREATMENT, AND LIVING SITUATION, EXPAND ON POTENTIAL FOR SIGNIFICANT FUNCTIONAL PROGRESS WITHIN THE NEXT SIX MONTHS. EMPHASIZE WHY PROGRESS IS EXPECTED WITH SERVICES AT THIS TIME.
PA57	SUBMIT THE INITIAL FINDINGS. INCLUDE A COMPREHENSIVE EVALUATION.
PA58	SUBMIT PROGRESSIVE, OBJECTIVE FINDINGS. INCLUDE A PERTINENT RE-EVALUATION.
PA59	PLEASE SUPPLY INFORMATION REGARDING THE CLIENTS MEDICATION REQUIREMENTS, IF ANY.
PA60	PLEASE SPECIFY IF THE CLIENT IS IN AN EDUCATIONAL SETTING.
PA61	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA62	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.

Denial Code	Long Description
PA63	THE SKILLS OF A THERAPIST ARE PURPOSEFUL AND SKILLED INTERVENTIONS REQUIRED TO CONTINUALLY DESIGN, IMPLEMENT, REASSESS, MODIFY/GRADE, AND/OR DISCONTINUE A PLAN OF CARE IN A TIMELY MANNER, BASED ON THE COMPLEXITY OF THE CLIENTS MEDICAL CONDITION AND/OR CO
PA64	PLEASE SUBMIT A THERAPY PLAN OF CARE, INCLUDING A CURRENT, DATED EVALUATION.
PA65	A PLAN OF CARE SIGNED AND DATED BY THE PHYSICIAN IS REQUIRED.
PA66	THE SKILLS OF A THERAPIST ARE REQUIRED WHEN ONLY THE THERAPIST CAN SAFELY AND EFFECTIVELY DELIVER THE THERAPEUTIC PROCEDURES BECAUSE OF THEIR UNIQUE KNOWLEDGE, TRAINING, AND EXPERTISE. DESCRIBE THE REASON THAT SOMEONE OTHER THAN A THERAPIST CANNOT SAFELY
PA67	PLEASE SPECIFY IF THE CLIENTS WORK SITE DEMANDS GOOD BINAURAL HEARING.
PA68	DESCRIBE THE REASON, BASED ON THE CLIENTS COGNITIVE, PHYSICAL, COMMUNICATION, OR RESOURCE STATUS, THAT A HOME PROGRAM, EQUIPMENT, OR ENVIRONMENTAL ADAPTATIONS ALONE CANNOT MEET CLIENTS NEEDS.
PA69	PLEASE SPECIFY IF THE CLIENT HAS AN ACCOMPANYING DISABILITY THAT ADDS TO THE HEARING PROBLEM.
PA70	DISTINGUISH REQUESTED PROCEDURES AND GOALS FROM OTHER SERVICES THIS CLIENT RECEIVES. THEY MAY NOT BE DUPLICATIVE.
PA71	PLEASE INDICATE THE NUMBER OF DAYS REQUESTED.
PA73	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA74	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA75	PLEASE DOCUMENT CARRYOVER OF THE THERAPY PROGRAM TO NURSING.
PA76	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA79	PROVIDE EVIDENCE OF SIGNIFICANT FUNCTIONAL PROGRESS IN LAST SIX MONTHS.
PA84	THE GRANT DATE OF THIS REQUEST CANNOT BE PRIOR TO THE SIGNATURE DATE OF THE PRESCRIBING PHYSICIAN.
PA86	PROVIDE EVIDENCE OF SKILLS GAINED IN THERAPY CARRYING OVER TO OTHER SETTINGS WITHIN SIX MONTHS.
PA87	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE NUMBER OF SESSIONS REQUESTED.
PA88	THE REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL SCOPE OF PRACTICE.
PA89	PRIOR AUTHORIZATION IS NOT REQUIRED UNTIL LIMITATION OF SERVICE HAS BEEN REACHED.
PA91	PLEASE SUBMIT REQUIRED X-RAYS.
PA92	PLEASE PROVIDE AN EXPLANATION FOR THE MATERIAL SUBMITTED WITH THE REQUEST.
PA95	PLEASE DESCRIBE HOW THE PROVISION OF THIS SERVICE WOULD PREVENT INSTITUTIONALIZATION OF THE CLIENT.
PA96	COULD THE EXISTING DENTURE(S) BE RELINED OR REBASED? IF NOT, PLEASE EXPLAIN WHY NOT.
PA97	REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL STANDARDS OF PRACTICE.
PA98	PLEASE INDICATE IF THE CLIENT IS CURRENTLY BEING TUBE FED.
PB02	PLEASE PROVIDE THE REQUIRED DATED SIGNATURES ON THE ATTACHMENTS.
PB03	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING THE LOSS/DESTRUCTION/THEFT OF THE HEARING AID.
PB04	DESCRIBE THE CLIENTS ABILITY TO STAND OR AMBULATE SUFFICIENTLY TO ACCOMPLISH SELF-CARE ACTIVITIES.
PB07	PLEASE SUBMIT AN ORTHODONTIC STUDY MODEL OR DIAGNOSTIC CASTS.
PB09	PLEASE PROVIDE A PHOTOGRAPH OF THE INVOLVED AREA(S).
PB10	PLEASE PROVIDE AN ESTIMATION (IN GRAMS) OF THE TOTAL AMOUNT OF TISSUE TO BE RESECTED.
PB11	PLEASE SUBMIT THE PLAN OF CARE FOR CO-TREATMENT.
PB12	FURNISH A DETAILED DESCRIPTION FOR THE PROCEDURE CODE REQUESTED.
PB13	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB15	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB18	PLEASE COMPLETE THE ATTACHED OUT-OF-STATE PROVIDER DATA SHEET, F-11001, AND RESUBMIT.

Denial Code	Long Description
PB20	A SIGNED AND DATED PRESCRIPTION IS REQUIRED WITHIN THREE MONTHS OF RECEIPT BY COLORADO MEDICAID FOR INITIAL REQUESTS AND WITHIN 12 MONTHS OF RECEIPT BY COLORADO MEDICAID FOR SUBSEQUENT REQUESTS.
PB21	PLEASE COMPLETE THE APPROPRIATE PRIOR AUTHORIZATION ATTACHMENT. CONTACT PROVIDER SERVICES OR THE PRIOR AUTHORIZATION UNIT FOR ASSISTANCE.
PB23	PHYSICAL THERAPY ASSISTANT NOTES AND ALL FORMS SUBMITTED MUST BE COSIGNED BY A REGISTERED PHYSICAL THERAPIST.
PB31	ARE YOU REQUESTING A COMPLETE APPLIANCE, OR REPLACEMENT PARTS?
PB32	THE PROCEDURE CODE INDICATED ON THE REQUEST DOES NOT MATCH THE DESCRIPTION OF SERVICE; PLEASE CORRECT AND RESUBMIT.
PB35	THE SERVICE REQUESTED DOES NOT REQUIRE PRIOR AUTHORIZATION.
PB41	PLEASE FURNISH A CURRENT MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT, F-11090 (DATED WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID).
PB45	THE CERTIFICATION PERIOD ON THE PLAN OF CARE (POC) DOES NOT COVER THE REQUESTED GRANT/START DATE. PLEASE RESUBMIT YOUR REQUEST WITH A NEW POC.
PB49	A CERTIFIED OCCUPATIONAL THERAPY ASSISTANTS NOTES MUST BE COSIGNED BY AN OCCUPATIONAL THERAPIST REGISTERED.
PB51	ADDITIONAL INFORMATION IS REQUIRED ON PRIOR AUTHORIZATION TO ENABLE PRICING.
PB54	REQUESTED SERVICES DO NOT MATCH SERVICES ON THE PHYSICIANS ORDERS.
PB59	PLEASE PROVIDE AN INDIVIDUAL EDUCATIONAL PLAN (IEP), WHICH HAS BEEN SIGNED BY THE PROVIDER NO EARLIER THAN NINE MONTHS PRIOR TO RECEIPT AT COLORADO MEDICAID; OTHERWISE, DOCUMENT WHY NO IEP EXISTS.
PB65	PLEASE FURNISH THE ANTICIPATED TOTAL CHARGES FOR THIS REQUEST.
PB66	A PHOTOCOPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED; THE DATE MUST BE WITHIN SIX MONTHS OF RECEIPT BY COLORADO MEDICAID.
PB67	THE PRESCRIPTION DATE MUST INCLUDE MONTH, DAY, AND YEAR.
PB68	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID.
PB73	THE SERVICES IDENTIFIED ON THE PLAN OF CARE DO NOT APPEAR APPROPRIATE FOR THE PROCEDURE CODE(S) REQUESTED ON THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018.
PB74	THE CLIENT/PROVIDER DOES NOT HAVE RETROACTIVE ENROLLMENT.
PB75	THE REQUESTED START DATE IS MORE THAN 14 DAYS BEFORE OR 62 DAYS AFTER RECEIPT.
PB82	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
PB83	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A HOME HEALTH AIDE. PLEASE RESUBMIT AS A PERSONAL CARE WORKER OR PROVIDE ADDITIONAL DOCUMENTATION.
PB86	THE SERVICES REQUESTED ARE NOT BEING PROVIDED IN THE CLIENTS RESIDENCE. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL.
PB87	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A NURSE. PLEASE RESUBMIT AS A HOME HEALTH AIDE OR PROVIDE ADDITIONAL DOCUMENTATION.
PB92	PLEASE FURNISH THE CLIENTS COMPLETE ADDRESS.
PB94	IF THE CLIENT IS A RESIDENT OF A NURSING HOME, SUPPLY THE COMPLETE NAME AND ADDRESS OF THE NURSING HOME.
PB99	THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018, MUST BE SIGNED AND DATED.
PC01	PLEASE SUPPLY THE RENDERING PROVIDERS PROVIDER NUMBER.
PC03	THE DRUG ENFORCEMENT ADMINISTRATION NUMBER IS MISSING OR INVALID.
PC06	PLEASE DESCRIBE YOUR PROGRAM; INCLUDE ENTRY DATE, TERMINATION DATE, HOURS PER WEEK, AND NUMBER OF WEEKS OF PRIMARY INTENSIVE SERVICE REQUESTED.
PC07	PLEASE DESCRIBE YOUR "AFTERCARE/FOLLOW-UP" PLANS FOR THIS CLIENT.
PC08	PLEASE SUPPLY DOCUMENTATION OF PREVIOUS SUBSTANCE ABUSE SERVICES WITH DATE(S) AND OUTCOME.
PC09	PLEASE DESCRIBE IN DETAIL THE TREATMENT OBJECTIVES/GOALS FOR THIS CLIENT.
PC10	PLEASE DESCRIBE THE FAMILY SITUATION/DYNAMICS. EXPLAIN HOW THE FAMILY WILL BE INCORPORATED INTO THE CLIENTS PLAN OF CARE.
PC12	PLEASE EXPLAIN IF YOUR SERVICE ENCOURAGES THE CLIENT TO ATTEND SELF-HELP GROUPS.

Denial Code	Long Description
PC13	PLEASE SUPPLY A SPECIFIC SCHEDULE OF ACTIVITIES, INCLUDING DAY, TIME OF DAY, LENGTH OF SESSION, AND SERVICE TO BE RENDERED DURING THAT TIME.
PC15	PLEASE FURNISH DIAGNOSTIC RATIONALE.
PC17	PLEASE DOCUMENT IF THE CLIENT EVER RECEIVED SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT.
PC19	PLEASE FURNISH MORE EXTENSIVE AND IN-DEPTH HISTORICAL AND PSYCHOSOCIAL DATA.
PC20	PLEASE SUPPLY THE DATE THE CLIENT BECAME TOTALLY ENDENTULOUS.
PC23	PLEASE SUBMIT A PHYSICIANS STATEMENT REGARDING THE MEDICAL NECESSITY OF DENTURES FOR THIS CLIENT. THE PHYSICIANS STATEMENT MUST DOCUMENT THE MEDICAL NEED FOR DENTURES.
PC24	THE SERVICE REQUESTED WAS PREVIOUSLY AUTHORIZED. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT INDICATING THIS FACT IS REQUIRED.
PC25	PLEASE SUPPLY SUFFICIENT MITIGATING CIRCUMSTANCES TO WARRANT THE CONSTRUCTION OF NEW DENTURES(S).
PC26	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
PC28	PLEASE SUBMIT A PHYSICIANS STATEMENT INDICATING DENTURES ARE NECESSARY FOR THIS NURSING HOME CLIENT.
PC29	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING LOSS OR DESTRUCTION OF DENTURE(S). INCLUDE SIGNED STATEMENT FROM CLIENT OR FACILITY DIRECTOR REGARDING HOW, WHEN AND WHERE LOST.
PC30	PLEASE PROVIDE COMPLETE INTRAORAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PC31	PLEASE DESCRIBE ANY RELATED DEFORMITIES OF THE FEET.
PC34	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD WITH REQUESTED DME ITEM(S) AND DOCUMENT IF THE CLIENT CAN USE SAFELY AND INDEPENDENTLY.
PC35	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD AND DESCRIBE THE RESULTS AND EFFECTIVENESS OF THE SERVICE REQUESTED.
PC39	PLEASE INDICATE LITER FLOW PER MINUTE, HOURS OF USE PER 24 HOUR PERIOD, AND THE EXPECTED DURATION OF NEED.
PC40	THE ITEM DOES NOT REQUIRE PRIOR AUTHORIZATION UNTIL THE LIFE EXPECTANCY HAS BEEN REACHED.
PC41	PLEASE SUPPLY INFORMATION INDICATING THE NECESSITY OF POSITIONING THE CLIENT'S BODY IN MULTIPLE POSITIONS.
PC42	PLEASE INDICATE IF THE BED HEIGHT MUST BE CHANGED TO ALLOW FOR SAFE TRANSFER OR ADEQUATE BED CARE.
PC43	SUPPLY A PHYSICIANS STATEMENT INDICATING TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR UNIT HAS REDUCED PAIN, IMPROVED/INCREASED THE CLIENTS ACTIVITY LEVEL, AND/OR REDUCED CLIENTS USE OF PAIN MEDICATION.
PC44	A CURRENT AUTHORIZATION FOR THIS SERVICE IS ON FILE FOR ANOTHER PROVIDER. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT OF THAT FACT IS REQUIRED BY THE CLIENT OF FIRST PROVIDER.
PC59	DOCUMENT DECLINE OR PROGRESS IN SPECIFIC, MEASURABLE, OBJECTIVE TERMS.
PC60	DOCUMENT IF CLIENT HAS DEMONSTRATED A GOOD APPOINTMENT COMPLIANCE RECORD.
PC61	THE PHYSICIANS SIGNATURE DATE MUST NOT EXCEED 90 DAYS FROM THE DATE OF RECEIPT BY COLORADO MEDICAID.
PC62	REQUESTS FOR A CONTINUATION OF THERAPY SHOULD NOT BE SUBMITTED MORE THAN FOUR WEEKS PRIOR TO THE EXPIRATION DATE OF THE CURRENT AUTHORIZATION.
PC63	PLEASE FURNISH THE STYLE AND MANUFACTURER OF THE FRAME.
PC64	PLEASE FURNISH THE CLIENTS LENS FORMULA.
PC66	ALL REQUESTS FOR TINTS REQUIRE DOCUMENTATION OF THE VISUAL OR MEDICAL CONDITION RELATED TO PHOTOPHOBIA.
PC67	PLEASE DOCUMENT THE REASON AND JUSTIFICATION FOR REPLACEMENT BEYOND THE FIRST LENS/FRAME.
PC68	DOCUMENT IF ALL REMAINING MAXILLARY AND/OR MANDIBULAR TEETH ARE DECAY-FREE, PROPERLY RESTORED, AND PERIODONTICALLY SOUND.
PC72	SUPPLY MORE DETAIL REGARDING PROGRESS (ATTACHMENT OF GOALS, ETC.). CORRELATE PROGRESS TO PREVIOUS GOALS AND IDENTIFIED LIMITATIONS.
PC77	PLEASE SUBMIT A PLAN OF CARE DESCRIBING THE SERVICES THAT WOULD BE PROVIDED.

Denial Code	Long Description
PC78	PLEASE DOCUMENT SPECIFIC, MEASURABLE GOALS.
PC82	THE PRIOR AUTHORIZATION (PA) SYSTEM CAN PROCESS ONLY 26 DETAILS PER PA REQUEST. PLEASE RESUBMIT YOUR REQUEST WITH NO MORE THAN 26 DETAILS.
PC83	PLEASE SUPPLY A PHYSICIANS PRESCRIPTION DATED WITHIN ONE MONTH OF REQUESTED SUBSTANCE ABUSE DAY TREATMENT.
PC84	PLEASE PROVIDE INFORMATION INDICATING THIS CLIENT IS APPROPRIATELY DETOXIFIED FROM ALCOHOL AND/OR OTHER DRUGS.
PC85	PLEASE PROVIDE INFORMATION TO INDICATE THE CLIENTS ABILITY TO ABSTAIN FROM ALCOHOL OR DRUGS WHILE IN THE SUBSTANCE ABUSE DAY TREATMENT PROGRAM.
PC86	PLEASE INDICATE IF THIS CLIENT IS WILLING TO PARTICIPATE IN AFTERCARE OR CONTINUING CARE SERVICES.
PC87	PROVIDE MORE INFORMATION ON TREATMENT HISTORY; INCLUDE SERVICE PROVIDED, DATES, AND OUTCOME. PROVIDE DETAIL OF PREVIOUS TREATMENT.
PC88	PLEASE PROVIDE MORE RATIONALE FOR THE APPROPRIATENESS AND MEDICAL NECESSITY OF SUBSTANCE ABUSE DAY TREATMENT.
PC89	PROVIDE A TREATMENT PLAN THAT CONTAINS MEASURABLE GOALS AND OBJECTIVES CORRESPONDING TO THE IDENTIFIED DEFICIT.
PC91	PLEASE PROVIDE MORE INFORMATION ON FAMILY INVOLVEMENT TREATMENT.
PC92	PLEASE PROVIDE MORE HISTORY AND EXPLANATION ABOUT THE ISSUE OF ABSTINENCE FOR THIS CLIENT.
PC94	PLEASE PROVIDE THE ANTICIPATED BEGINNING DATE AND/OR THE ESTIMATED SUBSTANCE ABUSE DAY TREATMENT DISCHARGE DATE.
PC95	PLEASE SUPPLY JUSTIFICATION FOR BEGINNING CLIENT IN SERVICE PRIOR TO AUTHORIZATION BEING OBTAINED.
PC96	THE INITIAL THREE HOURS OF SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IN A CALENDAR YEAR DO NOT REQUIRE PRIOR AUTHORIZATION.
PC97	REIMBURSEMENT FOR INITIAL SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IS LIMITED TO THREE HOURS IN A CALENDAR YEAR AND DOES NOT REQUIRE PRIOR AUTHORIZATION.
PC98	THIS DRUG IS CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE BILL USING THE APPROPRIATE NATIONAL DRUG CODE (NDC) OR SUBMIT A COMPLETED DRUG ADDITION REQUEST FORM IF THE NDC IS NOT LISTED IN THE DRUG INDEX.
PC99	THIS DRUG IS NOT CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL, CURRENT ADMINISTRATIVE RULE, OR COLORADO DRUG INDEX FOR COVERAGE LIMITATIONS.
PD01	DOCUMENT THAT CLIENT HAS ACHIEVED GOOD ORAL HYGIENE, PERIODONTAL CASE TYPE 1 OR 2, AND IS MOTIVATED TO MAINTAIN SAME.
PD03	PLEASE PROVIDE AN ARTERIAL BLOOD GAS READING OR PULSE OXIMETRY RESULTS DONE ON ROOM AIR SIGNED AND DATED BY A MEDICAL DOCTOR. THIS SHOULD BE DONE WITHIN 60 DAYS OF REQUESTED SERVICE.
PD04	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 30 DAYS OF RECEIPT BY COLORADO MEDICAID.
PD07	SUBMIT A PHOTOCOPY OF A VALID PRESCRIPTION, ISSUED WITHIN THE PAST YEAR, OR COMPLETE SECTION B OF THE PRIOR AUTHORIZATION/DRUG ATTACHMENT (PA/DGA), F-11049.
PD10	BRAND MEDICALLY NECESSARY MUST BE IN THE PRESCRIBERS OWN HANDWRITING AND WRITTEN DIRECTLY ON THE PRESCRIPTION OR A SEPARATE ORDER ATTACHED TO THE ORIGINAL PRESCRIPTION.
PD12	COMPLETE DENTURES, PARTIAL DENTURES, DENTURE RELINES, AND FIXED PROSTHODONTIC SERVICES ARE NOT COVERED SERVICES FOR ADULTS FOR DATES OF SERVICE ON AND AFTER OCTOBER 1, 1995.
PD22	PLEASE COMPLETE ALL REQUIRED ELEMENTS ON THE PERSONAL CARE SCREENING TOOL (PCST), F-11133.
PD24	THIS PRIOR AUTHORIZATION REQUEST IS UNABLE TO BE PROCESSED. PLEASE RESUBMIT WITH ADDITIONAL REQUIRED FORMS, INCLUDING THE ENTIRE PERSONAL CARE SCREENING TOOL (PCST), F-11133; PERSONAL CARE ADDENDUM, F-11136; AND SUPPORTING DOCUMENTATION, AS DIRECTED.
PD25	THERE IS A PERSONAL CARE SCREENING TOOL (PCST), F-11133, COMPLETED BY ANOTHER AGENCY. CONTACT THE AGENCY TO TRANSFER SCREEN.

Denial Code	Long Description
PD26	THERE IS A LIMITED TERM CARE FUNCTIONAL SCREEN (LTC-FS) COMPLETED BY ANOTHER AGENCY. THE PERSONAL CARE SCREENING TOOL (PCST), F-11133, INFORMATION IS IN CONFLICT WITH LTC-FS.
PD27	ONLY ONE LEVEL OF FUNCTION MAY BE SELECTED FOR ALL ELEMENTS EXCEPT TOILETING. COLORADO MEDICAID IS UNABLE TO PROCESS THE PRIOR AUTHORIZATION REQUEST.
PD28	NO UNITS MAY BE REQUESTED USING THIS PRIOR AUTHORIZATION PROCESS. PLEASE SUBMIT WITH THE APPROPRIATE ATTACHMENTS FOR REQUESTING SPECIFIC PERSONAL CARE WORKER UNITS.
PD29	CLIENT IS NOT ELIGIBLE FOR THE REQUESTED SERVICE(S) AS OF THE REQUESTED START DATE.
PD30	NO TRAVEL TIME MAY BE AUTHORIZED WHEN NO PERSONAL CARE WORKER SERVICE IS AUTHORIZED.
PD32	PROVIDER NOT CERTIFIED TO RENDER THE SERVICE(S) REQUESTED.
PD34	BASED ON THE DOCUMENTATION SUBMITTED, THIS REQUEST CAN NOT BE PRIOR AUTHORIZED. REFER TO THE PA MESSAGES FROM THE CONSULTANT FOR COMPLETE EXPLANATION.
PD98	PLEASE DOCUMENT HOW AND WHEN EACH PREVIOUSLY AUTHORIZED PRO RE NATA VISIT WAS USED.

Other

Denial Code	Long Description
0201	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
0233	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0235	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0237	CLIENT IDENTIFICATION NUMBER DOES NOT MATCH CLIENTS FIRST NAME.
0238	THE CLIENT IDENTIFICATION NUMBER DOES NOT MATCH THE CLIENTS LAST NAME.
0242	SECONDARY DIAGNOSIS CODE IS INVALID.
0248	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0249	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0251	PROCEDURE CODE MODIFIER IN FIRST POSITION IS INVALID.
0252	THE PROCEDURE CODE MODIFIER IN SECOND POSITION IS INVALID FOR REQUESTED START DATE OR DATE OF RECEIPT.
0253	THE PROCEDURE CODE MODIFIER IN THIRD POSITION IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
0258	THE PRIMARY DIAGNOSIS CODE IS REQUIRED.
0272	THE PRIMARY DIAGNSOSIS CODE IS INVALID.
0339	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0340	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0400	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0853	HCPCS - ANNUAL UPDATE
0885	NEVER EVENTS MODIFIERS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
0886	NEVER EVENTS DIAGNOSIS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
1000	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
1002	RENDERING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1003	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1007	RENDERING PROVIDER ID IS NOT ON FILE.
1024	THE LEVEL OF CARE DOES NOT AGREE WITH THE CLIENT FILE.
1047	THE RENDERING PROVIDERS CERTIFICATION HAS BEEN CANCELLED.
1048	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1801	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
1804	A CERTIFIED SUBSTANCE ABUSE DAY TREATMENT PROVIDER MUST SUBMIT A SUBSTANCE ABUSE DAY TREATMENT PROCEDURE CODE.
1806	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.

Denial Code	Long Description
1808	THE BILLING PROVIDER DOES NOT HAVE THE REQUIRED CERTIFICATION ADDENDUM ON FILE.
1900	THE BILLING PROVIDERS TAXONOMY CODE IS INVALID.
1901	THE RENDERING PROVIDERS TAXONOMY CODE IS INVALID.
1927	A NATIONAL PROVIDER IDENTIFIER IS REQUIRED FOR THE BILLING PROVIDER.
1934	A NATIONAL PROVIDER INDENTIFIER IS REQUIRED FOR THE RENDERING PROVIDER.
1936	THE BILLING PROVIDER NUMBER IS INVALID.
1937	THE RENDERING PROVIDER NUMBER IS INVALID.
1960	INTERNAL PROCESSING IS REQUIRED.
1963	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.
1964	THE BILLING PROVIDER INDICATED IS NOT ALLOWABLE AS A BILLING PROVIDER.
1965	RENDERING PROVIDER NUMBER IS MISSING/INVALID FOR THIS PROCEDURE PROVIDER.
1974	PRESCRIBING/REFERRING/ORDERING PROVIDER INDICATED IS NOT CERTIFIED AS A PRESCRIBING/REFERRING/ORDERING PROVIDER.
1975	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
1976	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
2001	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2003	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2017	THE CLIENT IS ENROLLED IN A MEDICAID OR OTHER MANAGED CARE PROGRAM.
2037	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2043	THIS SERVICE IS NOT COVERED. THE CLIENT IS IN A DIVESTMENT PENALTY PERIOD.
2603	CLIENT LOCKED-IN TO A PROVIDER OR ENROLLED IN A HOSPICE. CONTACT CLIENTS HOSPICE FOR PAYMENT OF SERVICES OR RESUBMIT WITH DOCUMENTATION OF UNRELATED NATURE OF CARE.
3324	THE MODIFIER HAS BEEN DISCONTINUED BY THE CENTERS OF MEDICARE AND MEDICAID SERVICES OR THE AMERICAN MEDICAL ASSOCIATION FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
3337	THE PROCEDURE CODE HAS BEEN TERMINATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AMERICAN MEDICAL ASSOCIATION, OR AMERICAN DENTAL ASSOCIATION FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT. RESUBMIT WITH VALID A PROCEDURE CODE.
3339	THE PROCEDURE BILLED IS NOT PAYABLE ACCORDING TO DEFICIT REDUCTION ACT (DEFRA) GUIDELINES.
3351	THE PROCEDURE IS NOT COVERED FOR CLIENTS WITH A NURSING HOME AUTHORIZATION ON THE REQUESTED START DATE OR DATE OF RECEIPT.
3353	THE PROCEDURE IS NOT A COVERED SERVICE FOR HOME AND COMMUNITY-BASED WAIVER CLIENTS.
4021	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4027	THE DIAGNOSIS CODE IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
4031	THE PROCEDURE SUBMITTED IS NOT APPROPRIATE FOR CLIENTS GENDER.
4032	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4034	THE PROCEDURE CODE HAS AN AGE RESTRICTION.
4036	THE PLACE OF SERVICE CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4040	THE PRIMARY DIAGNOSIS CODE IS NOT ON FILE.
4041	THE SECONDARY DIAGNOSIS IS NOT ON FILE.
4046	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4059	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4077	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4127	INTERNAL PROCESSING IS REQUIRED.
4131	INTERNAL PROCESSING IS REQUIRED.
4141	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4149	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4150	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4151	THE PROVIDER IS NOT AUTHORIZED TO PERFORM THE PROCEDURE.
4227	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4236	ETIOLOGY DIAGNOSIS CODE(S) (E-CODES) ARE INVALID AS THE PRIMARY DIAGNOSIS.
4244	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4245	THE FOURTH POSITION MODIFIER IS INVALID FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT.
4256	THE PROCEDURE CODE AND MODIFIER COMBINATION IS NOT PAYABLE FOR THE CLIENTS BENEFIT PLAN.

Denial Code	Long Description
4257	THE MODIFIERS SUBMITTED ARE EITHER INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT OR THE MODIFIERS ARE MISSING.
4315	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4316	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4321	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4322	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4371	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4372	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4374	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4714	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS AGE.
4731	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS DIAGNOSIS.
4733	DIAGNOSIS AND/OR PROCEDURE AND/OR PLACE OF SERVICE (POS) CODE IS NOT COVERED FOR EXPRESS ENROLLMENT CLIENTS.
4742	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4743	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4744	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4745	DIAGNOSIS AND/OR PROCEDURE AND/OR PLACE OF SERVICE (POS) CODE IS NOT COVERED FOR EXPRESS ENROLLMENT CLIENTS.
4746	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4801	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4802	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
4804	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4821	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
4871	PLEASE REFER TO PA MESSAGES FOR RETURN INFORMATION.
4874	PLEASE REFER TO PA MESSAGES FOR RETURN INFORMATION.
4963	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS GENDER.
4975	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4990	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
7500	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
7509	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
P001	THE BILLING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THE SERVICES.
P002	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P003	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P005	THE PRIOR AUTHORIZATION CAN NOT BE END DATED. THE PRIOR AUTHORIZATION STATUS IS NOT APPROVED OR APPROVED WITH REVISIONS.
P006	PLEASE FURNISH THE PROCEDURE CODE AND CORRESPONDING DESCRIPTION.
P008	THE BILLING PROVIDER NUMBER IS INVALID.
P009	THE BILLING PROVIDER NUMBER IS INVALID.
P010	THE REQUESTED END DATE IS INVALID.
P011	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P012	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P013	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P014	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.

Denial Code	Long Description
P015	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P016	THE REQUESTED START DATE IS MISSING OR INVALID.
P019	THE REQUESTED START DATE IS MISSING OR INVALID.
P020	THE RENDERING PROVIDER NUMBER IS INVALID.
P021	THE RENDERING PROVIDER NUMBER IS INVALID.
P022	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P023	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P024	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P026	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P027	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P030	FIRST MODIFIER IS INVALID.
P031	FIRST MODIFIER IS INVALID.
P032	SECOND MODIFIER IS INVALID.
P033	SECOND MODIFIER IS INVALID.
P034	THIRD MODIFIER IS INVALID.
P035	THIRD MODIFIER IS INVALID.
P036	FOURTH MODIFIER IS INVALID.
P037	FOURTH MODIFIER IS INVALID.
P038	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P039	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P040	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P041	CLIENTS FIRST NAME IS MISSING.
P042	CLIENTS LAST NAME IS MISSING.
P043	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P044	BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES REQUESTED.
P045	FIRST MODIFIER IS INVALID.
P046	SECOND MODIFIER IS INVALID.
P047	THIRD MODIFIER IS INVALID.
P048	FOURTH MODIFIER IS INVALID.
P052	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P053	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P054	RENDERING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES FOR THE BENEFIT PLAN.
P055	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P061	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P062	THE CLIENT ID AND/OR NAME INDICATED ON THE PA REQUEST IS INCORRECT. THE CLIENT ID AND/OR NAME HAS BEEN UPDATED. PLEASE VERIFY THE ID AND/OR NAME IS CORRECT.
P064	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
P067	THE FREQUENCY OF HOURS REQUESTED ARE NOT APPROPRIATE FOR THIS CLIENT AND HAVE BEEN MODIFIED ACCORDINGLY.
P079	BILLING PROVIDER IS ON PAYMENT SUSPENSION DUE TO CREDIBLE ALLEGATION OF FRAUD.
P120	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAS BEEN REDUCED.
P121	THE SERVICE/ PROCEDURE REQUESTED IS NOT SUPPORTED BY SUBMITTED DOCUMENTATION.
P126	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
P128	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.
P138	SERVICE(S) DO NOT MEET COLORADO MEDICAID GUIDELINES.
P167	REQUESTED DOCUMENTATION HAS NOT BEEN SUBMITTED.

Denial Code	Long Description
P178	THE SERVICE REQUESTED IS NOT MEDICALLY NECESSARY.
P179	THE MEDICAL NECESSITY FOR THIS SERVICE IS NOT SUPPORTED BY THE SUBMITTED DOCUMENTATION.
P233	THE DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE ADDITIONAL CARE.
P257	THIS CLIENTS FUNCTIONAL ASSESSMENT SCORES PLACE THIS CLIENT OUTSIDE ELIGIBILITY FOR DAY TREATMENT.
P274	OUR RECORDS INDICATE THIS CLIENT IS INVOLVED IN EFFECTIVE AND APPROPRIATE SERVICE ELSEWHERE.
P292	INTENSIVE REHABILITATION HOURS ARE NO LONGER APPROPRIATE AS INDICATED BY HISTORY, DIAGNOSIS, AND/ OR FUNCTIONAL ASSESSMENT SCORES.
P328	THE SERVICES REQUESTED INCLUDE NON-COVERED SERVICES, AND HOURS ARE REDUCED ACCORDINGLY.
P339	THE CLIENTS PAST HISTORY INDICATES REDUCED TREATMENT HOURS ARE WARRANTED.
P342	THE REQUEST DOES NOT MEET GENERALLY ACCEPTED CONDITIONS REQUIRING FLUORIDE TREATMENTS.
P346	SERVICES EXCEED COLORADO MEDICAID LIMITATION AND DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE MEDICAL NECESSITY OF THE SERVICE.
P349	THE SERVICE REQUESTED WAS PERFORMED LESS THAN FIVE YEARS AGO.
P353	THE EXISTING APPLIANCE HAS NOT BEEN WORN FOR THREE YEARS.
P367	THE CLIENT HAS BEEN TOTALLY WITHOUT TEETH AND AN APPLIANCE FOR FIVE YEARS.
P392	THE CLIENT IS MISSING AN ANTERIOR TOOTH AND/OR HAS TWO OR MORE POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P405	THE SERVICE(S) REQUESTED COULD ADEQUATELY BE PERFORMED IN THE DENTAL OFFICE.
P406	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE OF GOOD PERIODONTAL HEALTH (AMERICAN ACADEMY OF PERIODONTOLOGY PERIODONTAL CLASSIFICATION OF TYPE I OR II).
P407	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE VISIBLE ON RADIOGRAPHS THAT AT LEAST 50 PERCENT OF THE CLINICAL CROWN IS INTACT.
P409	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING SIX OR MORE TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED, INCLUDING THIRD MOLARS.
P410	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING ONE OR MORE ANTERIOR TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED.
P411	DOCUMENTATION DOES NOT SUPPORT THE NEED FOR PERIODONTIC SERVICES. POCKETS ARE LESS THAN 4MM AND/OR GREATER THAN 6MM FOR CLIENT AND/OR THE CLIENT IS UNDER THE AGE OF 13.
P412	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA.
P413	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA. THIS PA HAS BEEN GRANTED AS APPROVED NOT APPROVED WITH REVISIONS. THE DURATION REQUESTED MAY HAVE BEEN REDUCED TO REFLECT COVERAGE LIMITATIONS, PRESCRIBER ORDERS, CONFLICTI
P417	THE SERVICE(S) REQUESTED COULD BE ADEQUATELY PERFORMED WITH LOCAL ANESTHESIA.
P437	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO POOR ORAL HYGIENE.
P444	THIS LINE ITEM IS A DUPLICATE OF ANOTHER LINE ITEM ON THIS PRIOR AUTHORIZATION (PA) REQUEST. PLEASE CORRECT.
P446	THIS IS A DUPLICATE OF AN EXISTING PRIOR AUTHORIZATION (PA) REQUEST. YOU MAY CONTACT PROVIDER SERVICES IF YOU REQUIRE ASSISTANCE. DUPLICATE PA REQUEST
P448	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO DECAY HISTORY.
P449	QUESTIONABLE LONG TERM PROGNOSIS DUE TO GUM AND BONE DISEASE.
P456	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO APPARENT ROOT INFECTION.
P457	OUR RECORDS INDICATE THIS CLIENT HAS EXCEEDED ESTABLISHED PROGRAM LIMITATIONS. COLORADO MEDICAID WILL NOT AUTHORIZE NEW DENTURES.
P458	DOCUMENTATION PROVIDED INDICATES A LESS ELABORATE PROCEDURE SHOULD BE CONSIDERED.
P502	RENTAL ONLY ALLOWED; MEDICAL NEED FOR PURCHASE HAS NOT BEEN DOCUMENTED.
P503	PURCHASE ONLY ALLOWED; MEDICAL NEED FOR RENTAL HAS NOT BEEN DOCUMENTED.
P504	OCCUPATIONAL THERAPY GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P505	THE SERVICE REQUESTED IS INCLUDED IN THE NURSING HOME RATE STRUCTURE.
P511	THIS NATIONAL DRUG CODE IS ONLY BILLABLE AS PART OF A COMPOUND DRUG.
P515	THE PRESENCE OF A HANDICAPPING MALOCCLUSION OR HANDICAPPING DENTOFACIAL DEFORMITY IS NOT SUPPORTED BY THE DOCUMENTATION SUBMITTED.

Denial Code	Long Description
P521	THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVERED BY COLORADO MEDICAID.
P522	GASTRO-INTESTINAL SURGERY FOR THE PURPOSE OF WEIGHT CONTROL IS COVERED ONLY AS A LIFE THREATENING PROCEDURE.
P523	THE TREATMENT REQUEST IS NOT CONSISTENT WITH THE CLIENT'S DIAGNOSIS.
P524	PSYCHOTHERAPY PROVIDED IN THE CLIENTS HOME IS NOT A COVERED BENEFIT OF COLORADO MEDICAID.
P525	THE INFORMATION PROVIDED IS NOT CONSISTENT WITH THE INTENSITY OF SERVICES REQUESTED.
P526	INTENSIVE MULTIPLE MODALITY TREATMENT IS NOT CONSISTENT WITH THE INFORMATION PROVIDED.
P527	MULTIPLE PROVIDERS OF TREATMENT ARE NOT INDICATED FOR THIS CLIENT.
P528	THE DURATION OF TREATMENT SESSIONS EXCEED CURRENT COLORADO MEDICAID GUIDELINES.
P534	DOCUMENTATION OF POOR PHYSICAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P535	OTHER PHYSICAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P536	THE PHYSICAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P537	USE OF PHYSICAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P538	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF A PHYSICAL THERAPIST.
P539	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS AND LIVING ARRANGEMENT.
P540	GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P541	THE PROCEDURE(S) REQUESTED ARE NOT MEDICAL IN NATURE.
P542	DOCUMENTATION OF POOR OCCUPATIONAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P543	DOCUMENTATION OF POOR SPEECH THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P544	OTHER OCCUPATIONAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P546	THE OCCUPATIONAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P547	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF PHYSICAL THERAPY.
P548	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P549	ACTIVITIES TO PROMOTE DIVERSION OR GENERAL MOTIVATION ARE NONCOVERED COLORADO MEDICAID SERVICES.
P550	REVISIONS OF THE REQUEST IS NECESSITATED BY THE CLIENTS MINIMAL PROGRESS.
P551	RESTORATIVE NURSING INVOLVEMENT COULD BE INCREASED.
P552	CLIENTS DEMONSTRATED RESPONSE TO CURRENT THERAPY DOES NOT WARRANT THE INTENSE FREQUENCY REQUESTED.
P553	MAINTENANCE IS TWO TIMES PER WEEK OR LESS.
P554	THE SPEECH THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P555	USE OF OCCUPATIONAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P556	USE OF SPEECH THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P557	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF AN OCCUPATIONAL THERAPIST.
P558	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
P559	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P560	THE MATERIALS/ SERVICES REQUESTED ARE PRINCIPALLY COSMETIC IN NATURE.
P561	THE LENS FORMULA DOES NOT JUSTIFY REPLACEMENT.
P562	THE CHANGE IN THE LENS FORMULA DOES NOT WARRANT MULTIPLE REPLACEMENTS.
P563	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.

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P564	LENSES ONLY ARE APPROVED; PLEASE DISPENSE A CONTRACTED FRAME. THE NON-CONTRACTED FRAME IS NOT MEDICALLY JUSTIFIED.
P565	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P566	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P567	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF OCCUPATIONAL THERAPY.
P568	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF SPEECH THERAPY.
P569	LEVEL, INTENSITY, OR EXTENT OF SERVICE(S) REQUESTED HAS BEEN MODIFIED CONSISTENT WITH MEDICAL NEED AS DEFINED IN THE PLAN OF CARE.
P570	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P571	THE SERVICE ASKED FOR IS NOT COVERED BY COLORADO MEDICAID AS THESE TASKS CAN BE DONE BY NURSES OR ACTIVITY STAFF.
P572	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P573	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.
P574	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P575	MEDICAL NEED FOR EQUIPMENT/ SUPPLY REQUESTED IS NOT SUPPORTED BY DOCUMENTATION SUBMITTED.
P576	OTHER SPEECH THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P577	DOCUMENTATION SUBMITTED IDENTIFIES THAT THE CLIENT HAS FEWER THAN TWO POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P582	LESS EXPENSIVE ALTERNATIVE SERVICES ARE AVAILABLE FOR THIS CLIENT.
P634	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P711	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING PERIODONTAL SCALING AND ROOT PLANNING.
P712	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING GINGIVECTOMY.
P754	AN APPROVED SUBSTANCE ABUSE DAY TREATMENT PROGRAM CANNOT EXCEED A SIX WEEK PERIOD.
P761	THE CLIENT DOES NOT APPEAR TO BE ABLE OR WILLING TO ABSTAIN FROM ALCOHOL/DRUG USAGE WHILE IN TREATMENT. THEREFORE, SUBSTANCE ABUSE DAY TREATMENT SERVICES ARE NOT APPROVED.
P764	THIS CLIENT HAS COMPLETED INTENSIVE SUBSTANCE ABUSE TREATMENT WITHIN THE PAST 12 MONTHS. THE DOCUMENTATION PROVIDED IS NOT ADEQUATE TO JUSTIFY ADDITIONAL INTENSIVE TREATMENT AT THIS TIME.
P785	A LESS THAN SIX-WEEK HEALING PERIOD HAS BEEN SPECIFIED FOR THIS PRIOR AUTHORIZATION. THEREFORE IT IS NOT NECESSARY TO WAIT THE FULL SIX WEEKS AFTER EXTRACTIONS BEFORE TAKING DENTURE IMPRESSIONS.
P818	SIX-WEEK HEALING TIME IS REQUIRED BETWEEN EDENTULATION AND FINAL IMPRESSIONS. PAYMENT FOR DENTURES WILL BE DENIED OR RECOUPED IF HEALING PERIOD IS NOT OBSERVED.
P849	COLORADO MEDICAID HAS DETERMINED THERE WERE (ARE) SEVERAL HOME HEALTH AGENCIES WILLING TO PROVIDE MEDICALLY NECESSARY SKILLED NURSING SERVICES TO THIS CLIENT.
P864	THE DOCUMENTATION YOU HAVE SUBMITTED DOES NOT MEET THE REQUIREMENTS OF COLORADO MEDICAID.
P873	THE MEDICAL NECESSITY FOR THE HOURS REQUESTED IS NOT SUPPORTED BY THE INFORMATION SUBMITTED.
P874	THE DOCUMENTATION SUBMITTED INDICATES THE TASKS SPECIFIED CAN BE COMPLETED DURING THE VISITS APPROVED.
P878	THE DOCUMENTATION SUBMITTED DOES NOT INDICATE THAT MEDICALLY ORIENTED TASKS ARE MEDICALLY NECESSARY; THEREFORE PERSONAL CARE SERVICES HAVE BEEN APPROVED.
P880	THE QUANTITY OF SERVICES AUTHORIZED FOR THIS CLIENTS PERSONAL CARE HAS BEEN AMENDED BASED ON INFORMATION RECEIVED FROM ONE OR MORE OF THESE SOURCES: THE CLIENT, THEIR PHYSICIAN, AND/OR THE IN-HOME VISIT BY STAFF OF THE OIG (OFFICE OF INSPECTOR GENERAL).

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P885	THE USE OF THIS DRUG FOR THE INTENDED PURPOSE IS NOT COVERED BY COLORADO MEDICAID, CONSISTENT WITH COLORADO ADMINISTRATIVE CODE AND FEDERAL LAW.
P924	THE MEDICAL RECORDS SUBMITTED WITH THE CURRENT REQUEST CONFLICT OR DISAGREE WITH OUR MEDICAL RECORDS ON THIS CLIENT.
P950	INDEPENDENT NURSES, PLEASE NOTE PAYABLE SERVICES MAY NOT EXCEED 12 HOURS/DAY OR 60 HOURS/WEEK.
P951	SERVICES CAN ONLY BE AUTHORIZED THROUGH ONE YEAR FROM THE PRESCRIPTION DATE.
P952	LEAD INSPECTION IS A COVERED COLORADO MEDICAID SERVICE WHEN THE CHILD HAS BEEN SHOWN TO HAVE LEAD POISONING (E.G., CHILD HAS A BLOOD LEAD LEVEL > 19 UG/DL OR TWO CONSECUTIVE BLOOD LEAD LEVELS OF 15-19 UG/DL DONE AT LEAST 90 DAYS APART). THE INSPECTION MUS
P953	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P954	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P956	THE REQUEST CAN ONLY BE BACKDATED A MAXIMUM OF 14 DAYS FROM FIRST DATE RECEIVED BY COLORADO MEDICAID.
P957	COMPLETE PERIODONTAL CHARTING AT TIME OF SERVICE, AND SUBMIT CHARTING, COPY OF OPERATIVE REPORT, TOGETHER WITH A COPY OF THE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF), F-11035, TO PA UNIT ATTENTION DENTAL CONTSULTANT.
P958	NOTE THAT CODE D4341 HAS BEEN CHANGED. REFER TO THE DECISION NOTICE FOR AUTHORIZED QUANTITY.
P960	YOUR PA HAS BEEN APPROVED FOR 90 DAYS. THE 90 DAY APPROVAL DOES NOT IMPLY THE PA REQUEST MEETS PRIOR AUTHORIZATION CRITERIA. AFTER ADDITIONAL INFORMATION IS AVAILABLE IN INTERCHANGE, COLORADO MEDICAID WILL CREATE AN AMENDMENT REQUEST TO EXTEND THE PA FOR
P961	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P962	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
PA10	THE REQUESTED END DATE IS INVALID.
PA12	PLEASE FURNISH A WRITTEN DESCRIPTION OF THE CLIENTS DIAGNOSIS.
PA13	PROVIDE DIAGNOSES WITH DATES OF ONSET.
PA14	IDENTIFY PROBLEMS TO BE TREATED.
PA15	THE AUDIOLOGISTS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1), F-11020, AND PRIOR AUTHORIZATION REQUEST/HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2), F-11021.
PA16	THE PHYSICIANS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION/PHYSICIAN OTOLOGICAL REPORT (PA/POR), F-11019.
PA17	SUBMIT BRIEF HISTORY WITH REFERRAL INFORMATION, LIVING SITUATION, FUNCTIONAL STATUS, AND OTHER PERTINENT INFORMATION. WHAT CHANGE OF STATUS RESULTED IN REFERRAL AT THIS TIME?
PA18	PLEASE FURNISH THE CLIENTS HEIGHT AND WEIGHT.
PA19	PLEASE SUBMIT CLINICAL INFORMATION SUFFICIENT TO VERIFY THE NEED FOR THE REQUESTED SERVICE(S).
PA20	PLEASE RESUBMIT WITH COMPLETE PERIODONTAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PA21	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL EDUCATIONAL PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA22	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL PROGRAM PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA23	REFER TO THE DURABLE MEDICAL EQUIPMENT INDEX FOR APPROPRIATE CODE AND DESCRIPTION. DO NOT USE AN "UNLISTED" CODE.
PA24	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUALIZED FAMILY SERVICE PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA25	INFORMATION ON THE REQUEST FORM IS ILLEGIBLE, AND THE REQUEST CANNOT BE PROCESSED.

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PA26	RE-EVALUATE YOUR GOALS. EMPHASIS SHOULD BE ON FUNCTIONAL SELF-CARE. GOALS MUST BE RELATED TO FUNCTIONAL OUTCOME.
PA27	PLEASE CLARIFY THE NUMBER OF HOURS PER WEEK REQUESTED.
PA28	PLEASE CLARIFY THE NUMBER OF HOURS PER DAY REQUESTED.
PA29	PLEASE CLARIFY THE NUMBER OF VISITS PER DAY REQUESTED.
PA30	ATTACH SUPPORTIVE DOCUMENTATION; HOME EXERCISE PROGRAM AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA31	THE DIAGNOSIS CODE INDICATED ON THE REQUEST DOES NOT CORRESPOND TO THE DIAGNOSIS CODE DESCRIPTION.
PA32	PLEASE SUBMIT ADDITIONAL INFORMATION SUFFICIENT TO VERIFY APPROPRIATENESS AND NEED FOR TRANSPLANT.
PA33	PLEASE SUBMIT THE INITIAL AND PROGRESSIVE OBJECTIVE FINDINGS.
PA34	ATTACH SUPPORTIVE DOCUMENTATION, FACILITY PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA35	PLEASE SUBMIT THE CLIENTS ORIGINAL COMPLAINTS AND EXAMINATION FINDINGS.
PA36	ATTACH SUPPORTIVE DOCUMENTATION, IN-HOME AUTISM PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA37	PLEASE SUBMIT YOUR TREATMENT PLAN FOR THIS CLIENT.
PA38	ATTACH SUPPORTIVE DOCUMENTATION AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA39	INITIAL EVALUATIONS MUST BE PERFORMED BY AN OCCUPATIONAL THERAPIST REGISTERED (OTR), PER AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA) STANDARDS.
PA41	IDENTIFY THE PLACE OF SERVICE AND ITS EFFECT ON SUPPORTING THE DESIRED TREATMENT OUTCOME.
PA42	PLEASE INDICATE THE HOURS OF USE OF OXYGEN PER 24-HOUR PERIOD.
PA43	PROVIDE BASELINE DOCUMENTATION FOR THIS CLIENTS LIMITATIONS USING UNITS OF MEASUREMENT THAT ARE APPLIED CONSISTENTLY WHEN REPORTING STATUS.
PA44	IDENTIFY FUNCTIONAL LIMITATIONS AS THEY ARE RELATED TO IDENTIFIED CONDITIONS.
PA46	CORRELATE PLAN OF CARE TO REQUESTED PROCEDURE CODES.
PA47	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE FREQUENCY/DURATION REQUESTED.
PA48	PLEASE PROVIDE THE NAME AND CREDENTIALS OF THE RENDERING PROVIDER.
PA50	COLORADO MEDICAID RECORDS INDICATE THE CLIENT OWNS A WHEELCHAIR. DOCUMENT THE REASON AND NEED FOR REPLACEMENT AND COST TO REPAIR CURRENT WHEELCHAIR.
PA51	PLEASE DISTINGUISH PRIMARY AND SUPPORTIVE MODALITIES.
PA52	PLEASE SUBMIT A PROGRESS REPORT.
PA53	MULTIPLE FAMILY CLIENTS TREATMENT BY THE SAME PROVIDER REQUIRES FURTHER INFORMATION DOCUMENTING COORDINATION OF TREATMENT PLAN.
PA54	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE MINUTES REQUESTED.
PA55	MEDICAL NECESSITY OF TREATMENT REQUIRES ADDITIONAL DOCUMENTATION.
PA56	GIVEN AGE, DIAGNOSES, CURRENT LEVEL OF FUNCTION, PAST RESPONSE TO TREATMENT, AND LIVING SITUATION, EXPAND ON POTENTIAL FOR SIGNIFICANT FUNCTIONAL PROGRESS WITHIN THE NEXT SIX MONTHS. EMPHASIZE WHY PROGRESS IS EXPECTED WITH SERVICES AT THIS TIME.
PA57	SUBMIT THE INITIAL FINDINGS. INCLUDE A COMPREHENSIVE EVALUATION.
PA58	SUBMIT PROGRESSIVE, OBJECTIVE FINDINGS. INCLUDE A PERTINENT RE-EVALUATION.
PA59	PLEASE SUPPLY INFORMATION REGARDING THE CLIENTS MEDICATION REQUIREMENTS, IF ANY.
PA60	PLEASE SPECIFY IF THE CLIENT IS IN AN EDUCATIONAL SETTING.
PA61	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA62	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
PA63	THE SKILLS OF A THERAPIST ARE PURPOSEFUL AND SKILLED INTERVENTIONS REQUIRED TO CONTINUALLY DESIGN, IMPLEMENT, REASSESS, MODIFY/GRADE, AND/OR DISCONTINUE A PLAN OF CARE IN A TIMELY MANNER, BASED ON THE COMPLEXITY OF THE CLIENTS MEDICAL CONDITION AND/OR CO

Denial Code	Long Description
PA64	PLEASE SUBMIT A THERAPY PLAN OF CARE, INCLUDING A CURRENT, DATED EVALUATION.
PA65	A PLAN OF CARE SIGNED AND DATED BY THE PHYSICIAN IS REQUIRED.
PA66	THE SKILLS OF A THERAPIST ARE REQUIRED WHEN ONLY THE THERAPIST CAN SAFELY AND EFFECTIVELY DELIVER THE THERAPEUTIC PROCEDURES BECAUSE OF THEIR UNIQUE KNOWLEDGE, TRAINING, AND EXPERTISE. DESCRIBE THE REASON THAT SOMEONE OTHER THAN A THERAPIST CANNOT SAFELY
PA67	PLEASE SPECIFY IF THE CLIENTS WORK SITE DEMANDS GOOD BINAURAL HEARING.
PA68	DESCRIBE THE REASON, BASED ON THE CLIENTS COGNITIVE, PHYSICAL, COMMUNICATION, OR RESOURCE STATUS, THAT A HOME PROGRAM, EQUIPMENT, OR ENVIRONMENTAL ADAPTATIONS ALONE CANNOT MEET CLIENTS NEEDS.
PA69	PLEASE SPECIFY IF THE CLIENT HAS AN ACCOMPANYING DISABILITY THAT ADDS TO THE HEARING PROBLEM.
PA70	DISTINGUISH REQUESTED PROCEDURES AND GOALS FROM OTHER SERVICES THIS CLIENT RECEIVES. THEY MAY NOT BE DUPLICATIVE.
PA71	PLEASE INDICATE THE NUMBER OF DAYS REQUESTED.
PA73	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA74	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA75	PLEASE DOCUMENT CARRYOVER OF THE THERAPY PROGRAM TO NURSING.
PA76	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA79	PROVIDE EVIDENCE OF SIGNIFICANT FUNCTIONAL PROGRESS IN LAST SIX MONTHS.
PA84	THE GRANT DATE OF THIS REQUEST CANNOT BE PRIOR TO THE SIGNATURE DATE OF THE PRESCRIBING PHYSICIAN.
PA86	PROVIDE EVIDENCE OF SKILLS GAINED IN THERAPY CARRYING OVER TO OTHER SETTINGS WITHIN SIX MONTHS.
PA87	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE NUMBER OF SESSIONS REQUESTED.
PA88	THE REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL SCOPE OF PRACTICE.
PA89	PRIOR AUTHORIZATION IS NOT REQUIRED UNTIL LIMITATION OF SERVICE HAS BEEN REACHED.
PA91	PLEASE SUBMIT REQUIRED X-RAYS.
PA92	PLEASE PROVIDE AN EXPLANATION FOR THE MATERIAL SUBMITTED WITH THE REQUEST.
PA95	PLEASE DESCRIBE HOW THE PROVISION OF THIS SERVICE WOULD PREVENT INSTITUTIONALIZATION OF THE CLIENT.
PA96	COULD THE EXISTING DENTURE(S) BE RELINED OR REBASED? IF NOT, PLEASE EXPLAIN WHY NOT.
PA97	REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL STANDARDS OF PRACTICE.
PA98	PLEASE INDICATE IF THE CLIENT IS CURRENTLY BEING TUBE FED.
PB02	PLEASE PROVIDE THE REQUIRED DATED SIGNATURES ON THE ATTACHMENTS.
PB03	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING THE LOSS/DESTRUCTION/THEFT OF THE HEARING AID.
PB04	DESCRIBE THE CLIENTS ABILITY TO STAND OR AMBULATE SUFFICIENTLY TO ACCOMPLISH SELF-CARE ACTIVITIES.
PB07	PLEASE SUBMIT AN ORTHODONTIC STUDY MODEL OR DIAGNOSTIC CASTS.
PB09	PLEASE PROVIDE A PHOTOGRAPH OF THE INVOLVED AREA(S).
PB10	PLEASE PROVIDE AN ESTIMATION (IN GRAMS) OF THE TOTAL AMOUNT OF TISSUE TO BE RESECTED.
PB11	PLEASE SUBMIT THE PLAN OF CARE FOR CO-TREATMENT.
PB12	FURNISH A DETAILED DESCRIPTION FOR THE PROCEDURE CODE REQUESTED.
PB13	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB15	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB18	PLEASE COMPLETE THE ATTACHED OUT-OF-STATE PROVIDER DATA SHEET, F-11001, AND RESUBMIT.
PB20	A SIGNED AND DATED PRESCRIPTION IS REQUIRED WITHIN THREE MONTHS OF RECEIPT BY COLORADO MEDICAID FOR INITIAL REQUESTS AND WITHIN 12 MONTHS OF RECEIPT BY COLORADO MEDICAID FOR SUBSEQUENT REQUESTS.
PB21	PLEASE COMPLETE THE APPROPRIATE PRIOR AUTHORIZATION ATTACHMENT. CONTACT PROVIDER SERVICES OR THE PRIOR AUTHORIZATION UNIT FOR ASSISTANCE.

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PB23	PHYSICAL THERAPY ASSISTANT NOTES AND ALL FORMS SUBMITTED MUST BE COSIGNED BY A REGISTERED PHYSICAL THERAPIST.
PB31	ARE YOU REQUESTING A COMPLETE APPLIANCE, OR REPLACEMENT PARTS?
PB32	THE PROCEDURE CODE INDICATED ON THE REQUEST DOES NOT MATCH THE DESCRIPTION OF SERVICE; PLEASE CORRECT AND RESUBMIT.
PB35	THE SERVICE REQUESTED DOES NOT REQUIRE PRIOR AUTHORIZATION.
PB41	PLEASE FURNISH A CURRENT MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT, F-11090 (DATED WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID).
PB45	THE CERTIFICATION PERIOD ON THE PLAN OF CARE (POC) DOES NOT COVER THE REQUESTED GRANT/START DATE. PLEASE RESUBMIT YOUR REQUEST WITH A NEW POC.
PB49	A CERTIFIED OCCUPATIONAL THERAPY ASSISTANTS NOTES MUST BE COSIGNED BY AN OCCUPATIONAL THERAPIST REGISTERED.
PB51	ADDITIONAL INFORMATION IS REQUIRED ON PRIOR AUTHORIZATION TO ENABLE PRICING.
PB54	REQUESTED SERVICES DO NOT MATCH SERVICES ON THE PHYSICIANS ORDERS.
PB59	PLEASE PROVIDE AN INDIVIDUAL EDUCATIONAL PLAN (IEP), WHICH HAS BEEN SIGNED BY THE PROVIDER NO EARLIER THAN NINE MONTHS PRIOR TO RECEIPT AT COLORADO MEDICAID; OTHERWISE, DOCUMENT WHY NO IEP EXISTS.
PB65	PLEASE FURNISH THE ANTICIPATED TOTAL CHARGES FOR THIS REQUEST.
PB66	A PHOTOCOPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED; THE DATE MUST BE WITHIN SIX MONTHS OF RECEIPT BY COLORADO MEDICAID.
PB67	THE PRESCRIPTION DATE MUST INCLUDE MONTH, DAY, AND YEAR.
PB68	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID.
PB73	THE SERVICES IDENTIFIED ON THE PLAN OF CARE DO NOT APPEAR APPROPRIATE FOR THE PROCEDURE CODE(S) REQUESTED ON THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018.
PB74	THE CLIENT/PROVIDER DOES NOT HAVE RETROACTIVE ENROLLMENT.
PB75	THE REQUESTED START DATE IS MORE THAN 14 DAYS BEFORE OR 62 DAYS AFTER RECEIPT.
PB82	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
PB83	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A HOME HEALTH AIDE. PLEASE RESUBMIT AS A PERSONAL CARE WORKER OR PROVIDE ADDITIONAL DOCUMENTATION.
PB86	THE SERVICES REQUESTED ARE NOT BEING PROVIDED IN THE CLIENTS RESIDENCE. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL.
PB87	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A NURSE. PLEASE RESUBMIT AS A HOME HEALTH AIDE OR PROVIDE ADDITIONAL DOCUMENTATION.
PB92	PLEASE FURNISH THE CLIENTS COMPLETE ADDRESS.
PB94	IF THE CLIENT IS A RESIDENT OF A NURSING HOME, SUPPLY THE COMPLETE NAME AND ADDRESS OF THE NURSING HOME.
PB99	THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018, MUST BE SIGNED AND DATED.
PC01	PLEASE SUPPLY THE RENDERING PROVIDERS PROVIDER NUMBER.
PC03	THE DRUG ENFORCEMENT ADMINISTRATION NUMBER IS MISSING OR INVALID.
PC06	PLEASE DESCRIBE YOUR PROGRAM; INCLUDE ENTRY DATE, TERMINATION DATE, HOURS PER WEEK, AND NUMBER OF WEEKS OF PRIMARY INTENSIVE SERVICE REQUESTED.
PC07	PLEASE DESCRIBE YOUR "AFTERCARE/FOLLOW-UP" PLANS FOR THIS CLIENT.
PC08	PLEASE SUPPLY DOCUMENTATION OF PREVIOUS SUBSTANCE ABUSE SERVICES WITH DATE(S) AND OUTCOME.
PC09	PLEASE DESCRIBE IN DETAIL THE TREATMENT OBJECTIVES/GOALS FOR THIS CLIENT.
PC10	PLEASE DESCRIBE THE FAMILY SITUATION/DYNAMICS. EXPLAIN HOW THE FAMILY WILL BE INCORPORATED INTO THE CLIENTS PLAN OF CARE.
PC12	PLEASE EXPLAIN IF YOUR SERVICE ENCOURAGES THE CLIENT TO ATTEND SELF-HELP GROUPS.
PC13	PLEASE SUPPLY A SPECIFIC SCHEDULE OF ACTIVITIES, INCLUDING DAY, TIME OF DAY, LENGTH OF SESSION, AND SERVICE TO BE RENDERED DURING THAT TIME.
PC15	PLEASE FURNISH DIAGNOSTIC RATIONALE.
PC17	PLEASE DOCUMENT IF THE CLIENT EVER RECEIVED SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT.
PC19	PLEASE FURNISH MORE EXTENSIVE AND IN-DEPTH HISTORICAL AND PSYCHOSOCIAL DATA.

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PC20	PLEASE SUPPLY THE DATE THE CLIENT BECAME TOTALLY ENDENTULOUS.
PC23	PLEASE SUBMIT A PHYSICIANS STATEMENT REGARDING THE MEDICAL NECESSITY OF DENTURES FOR THIS CLIENT. THE PHYSICIANS STATEMENT MUST DOCUMENT THE MEDICAL NEED FOR DENTURES.
PC24	THE SERVICE REQUESTED WAS PREVIOUSLY AUTHORIZED. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT INDICATING THIS FACT IS REQUIRED.
PC25	PLEASE SUPPLY SUFFICIENT MITIGATING CIRCUMSTANCES TO WARRANT THE CONSTRUCTION OF NEW DENTURES(S).
PC26	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
PC28	PLEASE SUBMIT A PHYSICIANS STATEMENT INDICATING DENTURES ARE NECESSARY FOR THIS NURSING HOME CLIENT.
PC29	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING LOSS OR DESTRUCTION OF DENTURE(S). INCLUDE SIGNED STATEMENT FROM CLIENT OR FACILITY DIRECTOR REGARDING HOW, WHEN AND WHERE LOST.
PC30	PLEASE PROVIDE COMPLETE INTRAORAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PC31	PLEASE DESCRIBE ANY RELATED DEFORMITIES OF THE FEET.
PC34	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD WITH REQUESTED DME ITEM(S) AND DOCUMENT IF THE CLIENT CAN USE SAFELY AND INDEPENDENTLY.
PC35	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD AND DESCRIBE THE RESULTS AND EFFECTIVENESS OF THE SERVICE REQUESTED.
PC39	PLEASE INDICATE LITER FLOW PER MINUTE, HOURS OF USE PER 24 HOUR PERIOD, AND THE EXPECTED DURATION OF NEED.
PC40	THE ITEM DOES NOT REQUIRE PRIOR AUTHORIZATION UNTIL THE LIFE EXPECTANCY HAS BEEN REACHED.
PC41	PLEASE SUPPLY INFORMATION INDICATING THE NECESSITY OF POSITIONING THE CLIENT'S BODY IN MULTIPLE POSITIONS.
PC42	PLEASE INDICATE IF THE BED HEIGHT MUST BE CHANGED TO ALLOW FOR SAFE TRANSFER OR ADEQUATE BED CARE.
PC43	SUPPLY A PHYSICIANS STATEMENT INDICATING TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR UNIT HAS REDUCED PAIN, IMPROVED/INCREASED THE CLIENTS ACTIVITY LEVEL, AND/OR REDUCED CLIENTS USE OF PAIN MEDICATION.
PC44	A CURRENT AUTHORIZATION FOR THIS SERVICE IS ON FILE FOR ANOTHER PROVIDER. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT OF THAT FACT IS REQUIRED BY THE CLIENT OF FIRST PROVIDER.
PC59	DOCUMENT DECLINE OR PROGRESS IN SPECIFIC, MEASURABLE, OBJECTIVE TERMS.
PC60	DOCUMENT IF CLIENT HAS DEMONSTRATED A GOOD APPOINTMENT COMPLIANCE RECORD.
PC61	THE PHYSICIANS SIGNATURE DATE MUST NOT EXCEED 90 DAYS FROM THE DATE OF RECEIPT BY COLORADO MEDICAID.
PC62	REQUESTS FOR A CONTINUATION OF THERAPY SHOULD NOT BE SUBMITTED MORE THAN FOUR WEEKS PRIOR TO THE EXPIRATION DATE OF THE CURRENT AUTHORIZATION.
PC63	PLEASE FURNISH THE STYLE AND MANUFACTURER OF THE FRAME.
PC64	PLEASE FURNISH THE CLIENTS LENS FORMULA.
PC66	ALL REQUESTS FOR TINTS REQUIRE DOCUMENTATION OF THE VISUAL OR MEDICAL CONDITION RELATED TO PHOTOPHOBIA.
PC67	PLEASE DOCUMENT THE REASON AND JUSTIFICATION FOR REPLACEMENT BEYOND THE FIRST LENS/FRAME.
PC68	DOCUMENT IF ALL REMAINING MAXILLARY AND/OR MANDIBULAR TEETH ARE DECAY-FREE, PROPERLY RESTORED, AND PERIODONTICALLY SOUND.
PC72	SUPPLY MORE DETAIL REGARDING PROGRESS (ATTACHMENT OF GOALS, ETC.). CORRELATE PROGRESS TO PREVIOUS GOALS AND IDENTIFIED LIMITATIONS.
PC77	PLEASE SUBMIT A PLAN OF CARE DESCRIBING THE SERVICES THAT WOULD BE PROVIDED.
PC78	PLEASE DOCUMENT SPECIFIC, MEASURABLE GOALS.
PC82	THE PRIOR AUTHORIZATION (PA) SYSTEM CAN PROCESS ONLY 26 DETAILS PER PA REQUEST. PLEASE RESUBMIT YOUR REQUEST WITH NO MORE THAN 26 DETAILS.
PC83	PLEASE SUPPLY A PHYSICIANS PRESCRIPTION DATED WITHIN ONE MONTH OF REQUESTED SUBSTANCE ABUSE DAY TREATMENT.

Denial Code	Long Description
PC84	PLEASE PROVIDE INFORMATION INDICATING THIS CLIENT IS APPROPRIATELY DETOXIFIED FROM ALCOHOL AND/OR OTHER DRUGS.
PC85	PLEASE PROVIDE INFORMATION TO INDICATE THE CLIENTS ABILITY TO ABSTAIN FROM ALCOHOL OR DRUGS WHILE IN THE SUBSTANCE ABUSE DAY TREATMENT PROGRAM.
PC86	PLEASE INDICATE IF THIS CLIENT IS WILLING TO PARTICIPATE IN AFTERCARE OR CONTINUING CARE SERVICES.
PC87	PROVIDE MORE INFORMATION ON TREATMENT HISTORY; INCLUDE SERVICE PROVIDED, DATES, AND OUTCOME. PROVIDE DETAIL OF PREVIOUS TREATMENT.
PC88	PLEASE PROVIDE MORE RATIONALE FOR THE APPROPRIATENESS AND MEDICAL NECESSITY OF SUBSTANCE ABUSE DAY TREATMENT.
PC89	PROVIDE A TREATMENT PLAN THAT CONTAINS MEASURABLE GOALS AND OBJECTIVES CORRESPONDING TO THE IDENTIFIED DEFICIT.
PC91	PLEASE PROVIDE MORE INFORMATION ON FAMILY INVOLVEMENT TREATMENT.
PC92	PLEASE PROVIDE MORE HISTORY AND EXPLANATION ABOUT THE ISSUE OF ABSTINENCE FOR THIS CLIENT.
PC94	PLEASE PROVIDE THE ANTICIPATED BEGINNING DATE AND/OR THE ESTIMATED SUBSTANCE ABUSE DAY TREATMENT DISCHARGE DATE.
PC95	PLEASE SUPPLY JUSTIFICATION FOR BEGINNING CLIENT IN SERVICE PRIOR TO AUTHORIZATION BEING OBTAINED.
PC96	THE INITIAL THREE HOURS OF SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IN A CALENDAR YEAR DO NOT REQUIRE PRIOR AUTHORIZATION.
PC97	REIMBURSEMENT FOR INITIAL SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IS LIMITED TO THREE HOURS IN A CALENDAR YEAR AND DOES NOT REQUIRE PRIOR AUTHORIZATION.
PC98	THIS DRUG IS CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE BILL USING THE APPROPRIATE NATIONAL DRUG CODE (NDC) OR SUBMIT A COMPLETED DRUG ADDITION REQUEST FORM IF THE NDC IS NOT LISTED IN THE DRUG INDEX.
PC99	THIS DRUG IS NOT CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL, CURRENT ADMINISTRATIVE RULE, OR COLORADO DRUG INDEX FOR COVERAGE LIMITATIONS.
PD01	DOCUMENT THAT CLIENT HAS ACHIEVED GOOD ORAL HYGIENE, PERIODONTAL CASE TYPE 1 OR 2, AND IS MOTIVATED TO MAINTAIN SAME.
PD03	PLEASE PROVIDE AN ARTERIAL BLOOD GAS READING OR PULSE OXIMETRY RESULTS DONE ON ROOM AIR SIGNED AND DATED BY A MEDICAL DOCTOR. THIS SHOULD BE DONE WITHIN 60 DAYS OF REQUESTED SERVICE.
PD04	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 30 DAYS OF RECEIPT BY COLORADO MEDICAID.
PD07	SUBMIT A PHOTOCOPY OF A VALID PRESCRIPTION, ISSUED WITHIN THE PAST YEAR, OR COMPLETE SECTION B OF THE PRIOR AUTHORIZATION/DRUG ATTACHMENT (PA/DGA), F-11049.
PD10	BRAND MEDICALLY NECESSARY MUST BE IN THE PRESCRIBERS OWN HANDWRITING AND WRITTEN DIRECTLY ON THE PRESCRIPTION OR A SEPARATE ORDER ATTACHED TO THE ORIGINAL PRESCRIPTION.
PD12	COMPLETE DENTURES, PARTIAL DENTURES, DENTURE RELINES, AND FIXED PROSTHODONTIC SERVICES ARE NOT COVERED SERVICES FOR ADULTS FOR DATES OF SERVICE ON AND AFTER OCTOBER 1, 1995.
PD22	PLEASE COMPLETE ALL REQUIRED ELEMENTS ON THE PERSONAL CARE SCREENING TOOL (PCST), F-11133.
PD24	THIS PRIOR AUTHORIZATION REQUEST IS UNABLE TO BE PROCESSED. PLEASE RESUBMIT WITH ADDITIONAL REQUIRED FORMS, INCLUDING THE ENTIRE PERSONAL CARE SCREENING TOOL (PCST), F-11133; PERSONAL CARE ADDENDUM, F-11136; AND SUPPORTING DOCUMENTATION, AS DIRECTED.
PD25	THERE IS A PERSONAL CARE SCREENING TOOL (PCST), F-11133, COMPLETED BY ANOTHER AGENCY. CONTACT THE AGENCY TO TRANSFER SCREEN.
PD26	THERE IS A LIMITED TERM CARE FUNCTIONAL SCREEN (LTC-FS) COMPLETED BY ANOTHER AGENCY. THE PERSONAL CARE SCREENING TOOL (PCST), F-11133, INFORMATION IS IN CONFLICT WITH LTC-FS.
PD27	ONLY ONE LEVEL OF FUNCTION MAY BE SELECTED FOR ALL ELEMENTS EXCEPT TOILETING. COLORADO MEDICAID IS UNABLE TO PROCESS THE PRIOR AUTHORIZATION REQUEST.
PD28	NO UNITS MAY BE REQUESTED USING THIS PRIOR AUTHORIZATION PROCESS. PLEASE SUBMIT WITH THE APPROPRIATE ATTACHMENTS FOR REQUESTING SPECIFIC PERSONAL CARE WORKER UNITS.

Denial Code	Long Description
PD29	CLIENT IS NOT ELIGIBLE FOR THE REQUESTED SERVICE(S) AS OF THE REQUESTED START DATE.
PD30	NO TRAVEL TIME MAY BE AUTHORIZED WHEN NO PERSONAL CARE WORKER SERVICE IS AUTHORIZED.
PD32	PROVIDER NOT CERTIFIED TO RENDER THE SERVICE(S) REQUESTED.
PD34	BASED ON THE DOCUMENTATION SUBMITTED, THIS REQUEST CAN NOT BE PRIOR AUTHORIZED. REFER TO THE PA MESSAGES FROM THE CONSULTANT FOR COMPLETE EXPLANATION.
PD98	PLEASE DOCUMENT HOW AND WHEN EACH PREVIOUSLY AUTHORIZED PRO RE NATA VISIT WAS USED.

Pharmacy Benefit Management System (PBMS) Pharmacy

Denial Code	Long Description
0201	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
0205	PRESCRIBER ID IS REQUIRED.
0218	THE NATIONAL DRUG CODE IS REQUIRED.
0219	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0220	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0233	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0235	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0237	CLIENT IDENTIFICATION NUMBER DOES NOT MATCH CLIENTS FIRST NAME.
0238	THE CLIENT IDENTIFICATION NUMBER DOES NOT MATCH THE CLIENTS LAST NAME.
0242	SECONDARY DIAGNOSIS CODE IS INVALID.
0248	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0249	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0251	PROCEDURE CODE MODIFIER IN FIRST POSITION IS INVALID.
0252	THE PROCEDURE CODE MODIFIER IN SECOND POSITION IS INVALID FOR REQUESTED START DATE OR DATE OF RECEIPT.
0253	THE PROCEDURE CODE MODIFIER IN THIRD POSITION IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
0258	THE PRIMARY DIAGNOSIS CODE IS REQUIRED.
0272	THE PRIMARY DIAGNSOSIS CODE IS INVALID.
0400	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0820	THE PATIENT LOCATION IS INVALID.
0834	THE PRESCRIBING PROVIDER ID IS INVALID FOR THE NATIONAL DRUG CODE SUBMITTED.
0853	HCPCS - ANNUAL UPDATE
0867	NDC IS OBSOLETE FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
0879	THE PLACE OF SERVICE (POS) IS MISSING OR THE POS IS INVALID.
0885	NEVER EVENTS MODIFIERS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
0886	NEVER EVENTS DIAGNOSIS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
1000	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
1001	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1002	RENDERING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1003	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1007	RENDERING PROVIDER ID IS NOT ON FILE.
1016	A FEDERAL DRUG REBATE AGREEMENT IS NOT ON FILE. THIS DRUG CODE IS NOT A BENEFIT.
1047	THE RENDERING PROVIDERS CERTIFICATION HAS BEEN CANCELLED.
1048	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1049	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1801	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.

Denial Code	Long Description
1804	A CERTIFIED SUBSTANCE ABUSE DAY TREATMENT PROVIDER MUST SUBMIT A SUBSTANCE ABUSE DAY TREATMENT PROCEDURE CODE.
1805	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
1806	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
1808	THE BILLING PROVIDER DOES NOT HAVE THE REQUIRED CERTIFICATION ADDENDUM ON FILE.
1900	THE BILLING PROVIDERS TAXONOMY CODE IS INVALID.
1901	THE RENDERING PROVIDERS TAXONOMY CODE IS INVALID.
1927	A NATIONAL PROVIDER IDENTIFIER IS REQUIRED FOR THE BILLING PROVIDER.
1934	A NATIONAL PROVIDER INDENTIFIER IS REQUIRED FOR THE RENDERING PROVIDER.
1936	THE BILLING PROVIDER NUMBER IS INVALID.
1937	THE RENDERING PROVIDER NUMBER IS INVALID.
1960	INTERNAL PROCESSING IS REQUIRED.
1963	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.
1964	THE BILLING PROVIDER INDICATED IS NOT ALLOWABLE AS A BILLING PROVIDER.
1965	RENDERING PROVIDER NUMBER IS MISSING/INVALID FOR THIS PROCEDURE PROVIDER.
1974	PRESCRIBING/REFERRING/ORDERING PROVIDER INDICATED IS NOT CERTIFIED AS A PRESCRIBING/REFERRING/ORDERING PROVIDER.
1975	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
1976	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
2001	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2002	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2003	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2017	THE CLIENT IS ENROLLED IN A MEDICAID OR OTHER MANAGED CARE PROGRAM.
2037	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2603	CLIENT LOCKED-IN TO A PROVIDER OR ENROLLED IN A HOSPICE. CONTACT CLIENTS HOSPICE FOR PAYMENT OF SERVICES OR RESUBMIT WITH DOCUMENTATION OF UNRELATED NATURE OF CARE.
3324	THE MODIFIER HAS BEEN DISCONTINUED BY THE CENTERS OF MEDICARE AND MEDICAID SERVICES OR THE AMERICAN MEDICAL ASSOCIATION FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
3337	THE PROCEDURE CODE HAS BEEN TERMINATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AMERICAN MEDICAL ASSOCIATION, OR AMERICAN DENTAL ASSOCIATION FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT. RESUBMIT WITH VALID A PROCEDURE CODE.
3339	THE PROCEDURE BILLED IS NOT PAYABLE ACCORDING TO DEFICIT REDUCTION ACT (DEFRA) GUIDELINES.
3351	THE PROCEDURE IS NOT COVERED FOR CLIENTS WITH A NURSING HOME AUTHORIZATION ON THE REQUESTED START DATE OR DATE OF RECEIPT.
3353	THE PROCEDURE IS NOT A COVERED SERVICE FOR HOME AND COMMUNITY-BASED WAIVER CLIENTS.
3850	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
3874	THE NATIONAL DRUG CODE HAS DIAGNOSIS RESTRICTIONS.
3876	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4002	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICE ON THE REQUESTED START DATE OR DATE OF RECEIPT.
4004	THE NATIONAL DRUG CODE IS REQUIRED.
4007	THE NATIONAL DRUG CODE HAS BEEN TERMINATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
4021	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4023	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS GENDER.
4027	THE DIAGNOSIS CODE IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
4031	THE PROCEDURE SUBMITTED IS NOT APPROPRIATE FOR CLIENTS GENDER.
4032	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4034	THE PROCEDURE CODE HAS AN AGE RESTRICTION.
4036	THE PLACE OF SERVICE CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4040	THE PRIMARY DIAGNOSIS CODE IS NOT ON FILE.

Denial Code	Long Description
4041	THE SECONDARY DIAGNOSIS IS NOT ON FILE.
4046	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4127	INTERNAL PROCESSING IS REQUIRED.
4131	INTERNAL PROCESSING IS REQUIRED.
4138	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
4141	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4149	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4150	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4236	ETIOLOGY DIAGNOSIS CODE(S) (E-CODES) ARE INVALID AS THE PRIMARY DIAGNOSIS.
4244	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4245	THE FOURTH POSITION MODIFIER IS INVALID FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT.
4256	THE PROCEDURE CODE AND MODIFIER COMBINATION IS NOT PAYABLE FOR THE CLIENTS BENEFIT PLAN.
4257	THE MODIFIERS SUBMITTED ARE EITHER INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT OR THE MODIFIERS ARE MISSING.
4311	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4315	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4316	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4347	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4371	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4372	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4711	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR CLIENTS AGE.
4713	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS AGE.
4714	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS AGE.
4731	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS DIAGNOSIS.
4742	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4743	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4744	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4745	DIAGNOSIS AND/OR PROCEDURE AND/OR PLACE OF SERVICE (POS) CODE IS NOT COVERED FOR EXPRESS ENROLLMENT CLIENTS.
4746	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4775	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4801	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4802	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
4803	THE NATIONAL DRUG CODE SUBMITTED IS NOT VALID.
4821	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
4963	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS GENDER.
4965	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4990	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
7500	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
7509	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
P001	THE BILLING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THE SERVICES.
P002	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P003	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P006	PLEASE FURNISH THE PROCEDURE CODE AND CORRESPONDING DESCRIPTION.
P007	THE PATIENT LOCATION IS REQUIRED.
P008	THE BILLING PROVIDER NUMBER IS INVALID.
P009	THE BILLING PROVIDER NUMBER IS INVALID.
P010	THE REQUESTED END DATE IS INVALID.

Denial Code	Long Description
P011	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P012	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P013	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P014	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P015	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P016	THE REQUESTED START DATE IS MISSING OR INVALID.
P019	THE REQUESTED START DATE IS MISSING OR INVALID.
P020	THE RENDERING PROVIDER NUMBER IS INVALID.
P022	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P023	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P024	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P026	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P027	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P030	FIRST MODIFIER IS INVALID.
P031	FIRST MODIFIER IS INVALID.
P032	SECOND MODIFIER IS INVALID.
P033	SECOND MODIFIER IS INVALID.
P034	THIRD MODIFIER IS INVALID.
P035	THIRD MODIFIER IS INVALID.
P036	FOURTH MODIFIER IS INVALID.
P037	FOURTH MODIFIER IS INVALID.
P038	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P039	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P040	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P041	CLIENTS FIRST NAME IS MISSING.
P042	CLIENTS LAST NAME IS MISSING.
P043	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P044	BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES REQUESTED.
P045	FIRST MODIFIER IS INVALID.
P046	SECOND MODIFIER IS INVALID.
P047	THIRD MODIFIER IS INVALID.
P048	FOURTH MODIFIER IS INVALID.
P052	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P053	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P054	RENDERING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES FOR THE BENEFIT PLAN.
P055	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P056	PLEASE FURNISH THE NATIONAL DRUG CODE AND CORRESPONDING DESCRIPTION.
P060	THE PATIENT LOCATION IS MISSING OR INVALID.
P061	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P062	THE CLIENT ID AND/OR NAME INDICATED ON THE PA REQUEST IS INCORRECT. THE CLIENT ID AND/OR NAME HAS BEEN UPDATED. PLEASE VERIFY THE ID AND/OR NAME IS CORRECT.
P064	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
P067	THE FREQUENCY OF HOURS REQUESTED ARE NOT APPROPRIATE FOR THIS CLIENT AND HAVE BEEN MODIFIED ACCORDINGLY.
P079	BILLING PROVIDER IS ON PAYMENT SUSPENSION DUE TO CREDIBLE ALLEGATION OF FRAUD.

Denial Code	Long Description
P120	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAS BEEN REDUCED.
P121	THE SERVICE/ PROCEDURE REQUESTED IS NOT SUPPORTED BY SUBMITTED DOCUMENTATION.
P126	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
P128	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.
P138	SERVICE(S) DO NOT MEET COLORADO MEDICAID GUIDELINES.
P167	REQUESTED DOCUMENTATION HAS NOT BEEN SUBMITTED.
P178	THE SERVICE REQUESTED IS NOT MEDICALLY NECESSARY.
P179	THE MEDICAL NECESSITY FOR THIS SERVICE IS NOT SUPPORTED BY THE SUBMITTED DOCUMENTATION.
P233	THE DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE ADDITIONAL CARE.
P257	THIS CLIENTS FUNCTIONAL ASSESSMENT SCORES PLACE THIS CLIENT OUTSIDE ELIGIBILITY FOR DAY TREATMENT.
P274	OUR RECORDS INDICATE THIS CLIENT IS INVOLVED IN EFFECTIVE AND APPROPRIATE SERVICE ELSEWHERE.
P292	INTENSIVE REHABILITATION HOURS ARE NO LONGER APPROPRIATE AS INDICATED BY HISTORY, DIAGNOSIS, AND/ OR FUNCTIONAL ASSESSMENT SCORES.
P328	THE SERVICES REQUESTED INCLUDE NON-COVERED SERVICES, AND HOURS ARE REDUCED ACCORDINGLY.
P339	THE CLIENTS PAST HISTORY INDICATES REDUCED TREATMENT HOURS ARE WARRANTED.
P342	THE REQUEST DOES NOT MEET GENERALLY ACCEPTED CONDITIONS REQUIRING FLUORIDE TREATMENTS.
P346	SERVICES EXCEED COLORADO MEDICAID LIMITATION AND DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE MEDICAL NECESSITY OF THE SERVICE.
P349	THE SERVICE REQUESTED WAS PERFORMED LESS THAN FIVE YEARS AGO.
P353	THE EXISTING APPLIANCE HAS NOT BEEN WORN FOR THREE YEARS.
P367	THE CLIENT HAS BEEN TOTALLY WITHOUT TEETH AND AN APPLIANCE FOR FIVE YEARS.
P392	THE CLIENT IS MISSING AN ANTERIOR TOOTH AND/OR HAS TWO OR MORE POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P405	THE SERVICE(S) REQUESTED COULD ADEQUATELY BE PERFORMED IN THE DENTAL OFFICE.
P406	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE OF GOOD PERIODONTAL HEALTH (AMERICAN ACADEMY OF PERIODONTOLOGY PERIODONTAL CLASSIFICATION OF TYPE I OR II).
P407	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE VISIBLE ON RADIOGRAPHS THAT AT LEAST 50 PERCENT OF THE CLINICAL CROWN IS INTACT.
P409	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING SIX OR MORE TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED, INCLUDING THIRD MOLARS.
P410	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING ONE OR MORE ANTERIOR TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED.
P411	DOCUMENTATION DOES NOT SUPPORT THE NEED FOR PERIODONTIC SERVICES. POCKETS ARE LESS THAN 4MM AND/OR GREATER THAN 6MM FOR CLIENT AND/OR THE CLIENT IS UNDER THE AGE OF 13.
P412	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA.
P413	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA. THIS PA HAS BEEN GRANTED AS APPROVED NOT APPROVED WITH REVISIONS. THE DURATION REQUESTED MAY HAVE BEEN REDUCED TO REFLECT COVERAGE LIMITATIONS, PRESCRIBER ORDERS, CONFLICTI
P417	THE SERVICE(S) REQUESTED COULD BE ADEQUATELY PERFORMED WITH LOCAL ANESTHESIA.
P420	THE PRIOR AUTHORIZATION REQUEST FOR ENTERAL NUTRITION SUBMITTED ON THE COLORADO MEDICAID PORTAL HAS BEEN APPROVED.
P437	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO POOR ORAL HYGIENE.
P444	THIS LINE ITEM IS A DUPLICATE OF ANOTHER LINE ITEM ON THIS PRIOR AUTHORIZATION (PA) REQUEST. PLEASE CORRECT.
P446	THIS IS A DUPLICATE OF AN EXISTING PRIOR AUTHORIZATION (PA) REQUEST. YOU MAY CONTACT PROVIDER SERVICES IF YOU REQUIRE ASSISTANCE. DUPLICATE PA REQUEST
P448	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO DECAY HISTORY.
P449	QUESTIONABLE LONG TERM PROGNOSIS DUE TO GUM AND BONE DISEASE.
P456	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO APPARENT ROOT INFECTION.
P457	OUR RECORDS INDICATE THIS CLIENT HAS EXCEEDED ESTABLISHED PROGRAM LIMITATIONS. COLORADO MEDICAID WILL NOT AUTHORIZE NEW DENTURES.

Denial Code	Long Description
P458	DOCUMENTATION PROVIDED INDICATES A LESS ELABORATE PROCEDURE SHOULD BE CONSIDERED.
P502	RENTAL ONLY ALLOWED; MEDICAL NEED FOR PURCHASE HAS NOT BEEN DOCUMENTED.
P503	PURCHASE ONLY ALLOWED; MEDICAL NEED FOR RENTAL HAS NOT BEEN DOCUMENTED.
P504	OCCUPATIONAL THERAPY GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P505	THE SERVICE REQUESTED IS INCLUDED IN THE NURSING HOME RATE STRUCTURE.
P511	THIS NATIONAL DRUG CODE IS ONLY BILLABLE AS PART OF A COMPOUND DRUG.
P515	THE PRESENCE OF A HANDICAPPING MALOCCLUSION OR HANDICAPPING DENTOFACIAL DEFORMITY IS NOT SUPPORTED BY THE DOCUMENTATION SUBMITTED.
P521	THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVERED BY COLORADO MEDICAID.
P522	GASTRO-INTESTINAL SURGERY FOR THE PURPOSE OF WEIGHT CONTROL IS COVERED ONLY AS A LIFE THREATENING PROCEDURE.
P523	THE TREATMENT REQUEST IS NOT CONSISTENT WITH THE CLIENT'S DIAGNOSIS.
P524	PSYCHOTHERAPY PROVIDED IN THE CLIENTS HOME IS NOT A COVERED BENEFIT OF COLORADO MEDICAID.
P525	THE INFORMATION PROVIDED IS NOT CONSISTENT WITH THE INTENSITY OF SERVICES REQUESTED.
P526	INTENSIVE MULTIPLE MODALITY TREATMENT IS NOT CONSISTENT WITH THE INFORMATION PROVIDED.
P527	MULTIPLE PROVIDERS OF TREATMENT ARE NOT INDICATED FOR THIS CLIENT.
P528	THE DURATION OF TREATMENT SESSIONS EXCEED CURRENT COLORADO MEDICAID GUIDELINES.
P534	DOCUMENTATION OF POOR PHYSICAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P535	OTHER PHYSICAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P536	THE PHYSICAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P537	USE OF PHYSICAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P538	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF A PHYSICAL THERAPIST.
P539	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS AND LIVING ARRANGEMENT.
P540	GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P541	THE PROCEDURE(S) REQUESTED ARE NOT MEDICAL IN NATURE.
P542	DOCUMENTATION OF POOR OCCUPATIONAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P543	DOCUMENTATION OF POOR SPEECH THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P544	OTHER OCCUPATIONAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P546	THE OCCUPATIONAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P547	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF PHYSICAL THERAPY.
P548	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P549	ACTIVITIES TO PROMOTE DIVERSION OR GENERAL MOTIVATION ARE NONCOVERED COLORADO MEDICAID SERVICES.
P550	REVISIONS OF THE REQUEST IS NECESSITATED BY THE CLIENTS MINIMAL PROGRESS.
P551	RESTORATIVE NURSING INVOLVEMENT COULD BE INCREASED.
P552	CLIENTS DEMONSTRATED RESPONSE TO CURRENT THERAPY DOES NOT WARRANT THE INTENSE FREQUENCY REQUESTED.
P553	MAINTENANCE IS TWO TIMES PER WEEK OR LESS.
P554	THE SPEECH THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P555	USE OF OCCUPATIONAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P556	USE OF SPEECH THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.

Denial Code	Long Description
P557	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF AN OCCUPATIONAL THERAPIST.
P558	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
P559	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P560	THE MATERIALS/ SERVICES REQUESTED ARE PRINCIPALLY COSMETIC IN NATURE.
P561	THE LENS FORMULA DOES NOT JUSTIFY REPLACEMENT.
P562	THE CHANGE IN THE LENS FORMULA DOES NOT WARRANT MULTIPLE REPLACEMENTS.
P563	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P564	LENSES ONLY ARE APPROVED; PLEASE DISPENSE A CONTRACTED FRAME. THE NON-CONTRACTED FRAME IS NOT MEDICALLY JUSTIFIED.
P565	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P566	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P567	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF OCCUPATIONAL THERAPY.
P568	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF SPEECH THERAPY.
P569	LEVEL, INTENSITY, OR EXTENT OF SERVICE(S) REQUESTED HAS BEEN MODIFIED CONSISTENT WITH MEDICAL NEED AS DEFINED IN THE PLAN OF CARE.
P570	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P571	THE SERVICE ASKED FOR IS NOT COVERED BY COLORADO MEDICAID AS THESE TASKS CAN BE DONE BY NURSES OR ACTIVITY STAFF.
P572	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P573	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.
P574	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P575	MEDICAL NEED FOR EQUIPMENT/ SUPPLY REQUESTED IS NOT SUPPORTED BY DOCUMENTATION SUBMITTED.
P576	OTHER SPEECH THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P577	DOCUMENTATION SUBMITTED IDENTIFIES THAT THE CLIENT HAS FEWER THAN TWO POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P582	LESS EXPENSIVE ALTERNATIVE SERVICES ARE AVAILABLE FOR THIS CLIENT.
P634	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P711	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING PERIODONTAL SCALING AND ROOT PLANNING.
P712	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING GINGIVECTOMY.
P754	AN APPROVED SUBSTANCE ABUSE DAY TREATMENT PROGRAM CANNOT EXCEED A SIX WEEK PERIOD.
P761	THE CLIENT DOES NOT APPEAR TO BE ABLE OR WILLING TO ABSTAIN FROM ALCOHOL/DRUG USAGE WHILE IN TREATMENT. THEREFORE, SUBSTANCE ABUSE DAY TREATMENT SERVICES ARE NOT APPROVED.
P764	THIS CLIENT HAS COMPLETED INTENSIVE SUBSTANCE ABUSE TREATMENT WITHIN THE PAST 12 MONTHS. THE DOCUMENTATION PROVIDED IS NOT ADEQUATE TO JUSTIFY ADDITIONAL INTENSIVE TREATMENT AT THIS TIME.
P785	A LESS THAN SIX-WEEK HEALING PERIOD HAS BEEN SPECIFIED FOR THIS PRIOR AUTHORIZATION. THEREFORE IT IS NOT NECESSARY TO WAIT THE FULL SIX WEEKS AFTER EXTRACTIONS BEFORE TAKING DENTURE IMPRESSIONS.
P818	SIX-WEEK HEALING TIME IS REQUIRED BETWEEN EDENTULATION AND FINAL IMPRESSIONS. PAYMENT FOR DENTURES WILL BE DENIED OR RECOUPED IF HEALING PERIOD IS NOT OBSERVED.
P849	COLORADO MEDICAID HAS DETERMINED THERE WERE (ARE) SEVERAL HOME HEALTH AGENCIES WILLING TO PROVIDE MEDICALLY NECESSARY SKILLED NURSING SERVICES TO THIS CLIENT.
P864	THE DOCUMENTATION YOU HAVE SUBMITTED DOES NOT MEET THE REQUIREMENTS OF COLORADO MEDICAID.
P873	THE MEDICAL NECESSITY FOR THE HOURS REQUESTED IS NOT SUPPORTED BY THE INFORMATION SUBMITTED.

Denial Code	Long Description
P874	THE DOCUMENTATION SUBMITTED INDICATES THE TASKS SPECIFIED CAN BE COMPLETED DURING THE VISITS APPROVED.
P878	THE DOCUMENTATION SUBMITTED DOES NOT INDICATE THAT MEDICALLY ORIENTED TASKS ARE MEDICALLY NECESSARY; THEREFORE PERSONAL CARE SERVICES HAVE BEEN APPROVED.
P880	THE QUANTITY OF SERVICES AUTHORIZED FOR THIS CLIENTS PERSONAL CARE HAS BEEN AMENDED BASED ON INFORMATION RECEIVED FROM ONE OR MORE OF THESE SOURCES: THE CLIENT, THEIR PHYSICIAN, AND/OR THE IN-HOME VISIT BY STAFF OF THE OIG (OFFICE OF INSPECTOR GENERAL).
P885	THE USE OF THIS DRUG FOR THE INTENDED PURPOSE IS NOT COVERED BY COLORADO MEDICAID, CONSISTENT WITH COLORADO ADMINISTRATIVE CODE AND FEDERAL LAW.
P924	THE MEDICAL RECORDS SUBMITTED WITH THE CURRENT REQUEST CONFLICT OR DISAGREE WITH OUR MEDICAL RECORDS ON THIS CLIENT.
P950	INDEPENDENT NURSES, PLEASE NOTE PAYABLE SERVICES MAY NOT EXCEED 12 HOURS/DAY OR 60 HOURS/WEEK.
P951	SERVICES CAN ONLY BE AUTHORIZED THROUGH ONE YEAR FROM THE PRESCRIPTION DATE.
P952	LEAD INSPECTION IS A COVERED COLORADO MEDICAID SERVICE WHEN THE CHILD HAS BEEN SHOWN TO HAVE LEAD POISONING (E.G., CHILD HAS A BLOOD LEAD LEVEL > 19 UG/DL OR TWO CONSECUTIVE BLOOD LEAD LEVELS OF 15-19 UG/DL DONE AT LEAST 90 DAYS APART). THE INSPECTION MUS
P953	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P954	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P956	THE REQUEST CAN ONLY BE BACKDATED A MAXIMUM OF 14 DAYS FROM FIRST DATE RECEIVED BY COLORADO MEDICAID.
P957	COMPLETE PERIODONTAL CHARTING AT TIME OF SERVICE, AND SUBMIT CHARTING, COPY OF OPERATIVE REPORT, TOGETHER WITH A COPY OF THE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF), F-11035, TO PA UNIT ATTENTION DENTAL CONTSULTANT.
P958	NOTE THAT CODE D4341 HAS BEEN CHANGED. REFER TO THE DECISION NOTICE FOR AUTHORIZED QUANTITY.
P960	YOUR PA HAS BEEN APPROVED FOR 90 DAYS. THE 90 DAY APPROVAL DOES NOT IMPLY THE PA REQUEST MEETS PRIOR AUTHORIZATION CRITERIA. AFTER ADDITIONAL INFORMATION IS AVAILABLE IN INTERCHANGE, COLORADO MEDICAID WILL CREATE AN AMENDMENT REQUEST TO EXTEND THE PA FOR
P961	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P962	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P967	PA POLICY BYPASS NAMENDA
P987	ANTIPSYCHOTIC ATTESTATION IS REQUIRED WHEN MORE THAN ONE ANTIPSYCHOTIC DRUG IS PRESCRIBED FOR A CLIENT 16 YEARS OF AGE OR YOUNGER. EACH ANTIPSYCHOTIC DRUG MUST BE ENTERED IN THE ATTESTATION PROCESS. ANTIPSYCHOTIC ATTESTATION AUTHORIZATIONS CANNOT BE AMEN
P988	THE PRIOR AUTHORIZATION FOR THIS DRUG HAS BEEN APPROVED AT THE ACTIVE INGREDIENT LEVEL INSTEAD OF THE DRUG STRENGTH AND DOSAGE FORM LEVEL. ADDITIONAL PAS ARE NOT NEEDED FOR A DIFFERENT STRENGTH OF THIS SAME DRUG.
PA10	THE REQUESTED END DATE IS INVALID.
PA12	PLEASE FURNISH A WRITTEN DESCRIPTION OF THE CLIENTS DIAGNOSIS.
PA13	PROVIDE DIAGNOSES WITH DATES OF ONSET.
PA14	IDENTIFY PROBLEMS TO BE TREATED.
PA15	THE AUDIOLOGISTS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1), F-11020, AND PRIOR AUTHORIZATION REQUEST/HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2), F-11021.
PA16	THE PHYSICIANS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION/PHYSICIAN OTOLOGICAL REPORT (PA/POR), F-11019.
PA17	SUBMIT BRIEF HISTORY WITH REFERRAL INFORMATION, LIVING SITUATION, FUNCTIONAL STATUS, AND OTHER PERTINENT INFORMATION. WHAT CHANGE OF STATUS RESULTED IN REFERRAL AT THIS TIME?

Denial Code	Long Description
PA18	PLEASE FURNISH THE CLIENTS HEIGHT AND WEIGHT.
PA19	PLEASE SUBMIT CLINICAL INFORMATION SUFFICIENT TO VERIFY THE NEED FOR THE REQUESTED SERVICE(S).
PA20	PLEASE RESUBMIT WITH COMPLETE PERIODONTAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PA21	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL EDUCATIONAL PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA22	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL PROGRAM PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA23	REFER TO THE DURABLE MEDICAL EQUIPMENT INDEX FOR APPROPRIATE CODE AND DESCRIPTION. DO NOT USE AN "UNLISTED" CODE.
PA24	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUALIZED FAMILY SERVICE PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA25	INFORMATION ON THE REQUEST FORM IS ILLEGIBLE, AND THE REQUEST CANNOT BE PROCESSED.
PA26	RE-EVALUATE YOUR GOALS. EMPHASIS SHOULD BE ON FUNCTIONAL SELF-CARE. GOALS MUST BE RELATED TO FUNCTIONAL OUTCOME.
PA27	PLEASE CLARIFY THE NUMBER OF HOURS PER WEEK REQUESTED.
PA28	PLEASE CLARIFY THE NUMBER OF HOURS PER DAY REQUESTED.
PA29	PLEASE CLARIFY THE NUMBER OF VISITS PER DAY REQUESTED.
PA30	ATTACH SUPPORTIVE DOCUMENTATION; HOME EXERCISE PROGRAM AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA31	THE DIAGNOSIS CODE INDICATED ON THE REQUEST DOES NOT CORRESPOND TO THE DIAGNOSIS CODE DESCRIPTION.
PA32	PLEASE SUBMIT ADDITIONAL INFORMATION SUFFICIENT TO VERIFY APPROPRIATENESS AND NEED FOR TRANSPLANT.
PA33	PLEASE SUBMIT THE INITIAL AND PROGRESSIVE OBJECTIVE FINDINGS.
PA34	ATTACH SUPPORTIVE DOCUMENTATION, FACILITY PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA35	PLEASE SUBMIT THE CLIENTS ORIGINAL COMPLAINTS AND EXAMINATION FINDINGS.
PA36	ATTACH SUPPORTIVE DOCUMENTATION, IN-HOME AUTISM PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA37	PLEASE SUBMIT YOUR TREATMENT PLAN FOR THIS CLIENT.
PA38	ATTACH SUPPORTIVE DOCUMENTATION AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA39	INITIAL EVALUATIONS MUST BE PERFORMED BY AN OCCUPATIONAL THERAPIST REGISTERED (OTR), PER AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA) STANDARDS.
PA41	IDENTIFY THE PLACE OF SERVICE AND ITS EFFECT ON SUPPORTING THE DESIRED TREATMENT OUTCOME.
PA42	PLEASE INDICATE THE HOURS OF USE OF OXYGEN PER 24-HOUR PERIOD.
PA43	PROVIDE BASELINE DOCUMENTATION FOR THIS CLIENTS LIMITATIONS USING UNITS OF MEASUREMENT THAT ARE APPLIED CONSISTENTLY WHEN REPORTING STATUS.
PA44	IDENTIFY FUNCTIONAL LIMITATIONS AS THEY ARE RELATED TO IDENTIFIED CONDITIONS.
PA46	CORRELATE PLAN OF CARE TO REQUESTED PROCEDURE CODES.
PA47	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE FREQUENCY/DURATION REQUESTED.
PA48	PLEASE PROVIDE THE NAME AND CREDENTIALS OF THE RENDERING PROVIDER.
PA50	COLORADO MEDICAID RECORDS INDICATE THE CLIENT OWNS A WHEELCHAIR. DOCUMENT THE REASON AND NEED FOR REPLACEMENT AND COST TO REPAIR CURRENT WHEELCHAIR.
PA51	PLEASE DISTINGUISH PRIMARY AND SUPPORTIVE MODALITIES.
PA52	PLEASE SUBMIT A PROGRESS REPORT.
PA53	MULTIPLE FAMILY CLIENTS TREATMENT BY THE SAME PROVIDER REQUIRES FURTHER INFORMATION DOCUMENTING COORDINATION OF TREATMENT PLAN.
PA54	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE MINUTES REQUESTED.
PA55	MEDICAL NECESSITY OF TREATMENT REQUIRES ADDITIONAL DOCUMENTATION.

Denial Code	Long Description
PA56	GIVEN AGE, DIAGNOSES, CURRENT LEVEL OF FUNCTION, PAST RESPONSE TO TREATMENT, AND LIVING SITUATION, EXPAND ON POTENTIAL FOR SIGNIFICANT FUNCTIONAL PROGRESS WITHIN THE NEXT SIX MONTHS. EMPHASIZE WHY PROGRESS IS EXPECTED WITH SERVICES AT THIS TIME.
PA57	SUBMIT THE INITIAL FINDINGS. INCLUDE A COMPREHENSIVE EVALUATION.
PA58	SUBMIT PROGRESSIVE, OBJECTIVE FINDINGS. INCLUDE A PERTINENT RE-EVALUATION.
PA59	PLEASE SUPPLY INFORMATION REGARDING THE CLIENTS MEDICATION REQUIREMENTS, IF ANY.
PA60	PLEASE SPECIFY IF THE CLIENT IS IN AN EDUCATIONAL SETTING.
PA61	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA62	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
PA63	THE SKILLS OF A THERAPIST ARE PURPOSEFUL AND SKILLED INTERVENTIONS REQUIRED TO CONTINUALLY DESIGN, IMPLEMENT, REASSESS, MODIFY/GRADE, AND/OR DISCONTINUE A PLAN OF CARE IN A TIMELY MANNER, BASED ON THE COMPLEXITY OF THE CLIENTS MEDICAL CONDITION AND/OR CO
PA64	PLEASE SUBMIT A THERAPY PLAN OF CARE, INCLUDING A CURRENT, DATED EVALUATION.
PA65	A PLAN OF CARE SIGNED AND DATED BY THE PHYSICIAN IS REQUIRED.
PA66	THE SKILLS OF A THERAPIST ARE REQUIRED WHEN ONLY THE THERAPIST CAN SAFELY AND EFFECTIVELY DELIVER THE THERAPEUTIC PROCEDURES BECAUSE OF THEIR UNIQUE KNOWLEDGE, TRAINING, AND EXPERTISE. DESCRIBE THE REASON THAT SOMEONE OTHER THAN A THERAPIST CANNOT SAFELY
PA67	PLEASE SPECIFY IF THE CLIENTS WORK SITE DEMANDS GOOD BINAURAL HEARING.
PA68	DESCRIBE THE REASON, BASED ON THE CLIENTS COGNITIVE, PHYSICAL, COMMUNICATION, OR RESOURCE STATUS, THAT A HOME PROGRAM, EQUIPMENT, OR ENVIRONMENTAL ADAPTATIONS ALONE CANNOT MEET CLIENTS NEEDS.
PA69	PLEASE SPECIFY IF THE CLIENT HAS AN ACCOMPANYING DISABILITY THAT ADDS TO THE HEARING PROBLEM.
PA70	DISTINGUISH REQUESTED PROCEDURES AND GOALS FROM OTHER SERVICES THIS CLIENT RECEIVES. THEY MAY NOT BE DUPLICATIVE.
PA71	PLEASE INDICATE THE NUMBER OF DAYS REQUESTED.
PA73	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA74	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA75	PLEASE DOCUMENT CARRYOVER OF THE THERAPY PROGRAM TO NURSING.
PA76	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA79	PROVIDE EVIDENCE OF SIGNIFICANT FUNCTIONAL PROGRESS IN LAST SIX MONTHS.
PA84	THE GRANT DATE OF THIS REQUEST CANNOT BE PRIOR TO THE SIGNATURE DATE OF THE PRESCRIBING PHYSICIAN.
PA86	PROVIDE EVIDENCE OF SKILLS GAINED IN THERAPY CARRYING OVER TO OTHER SETTINGS WITHIN SIX MONTHS.
PA87	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE NUMBER OF SESSIONS REQUESTED.
PA88	THE REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL SCOPE OF PRACTICE.
PA89	PRIOR AUTHORIZATION IS NOT REQUIRED UNTIL LIMITATION OF SERVICE HAS BEEN REACHED.
PA91	PLEASE SUBMIT REQUIRED X-RAYS.
PA92	PLEASE PROVIDE AN EXPLANATION FOR THE MATERIAL SUBMITTED WITH THE REQUEST.
PA95	PLEASE DESCRIBE HOW THE PROVISION OF THIS SERVICE WOULD PREVENT INSTITUTIONALIZATION OF THE CLIENT.
PA96	COULD THE EXISTING DENTURE(S) BE RELINED OR REBASED? IF NOT, PLEASE EXPLAIN WHY NOT.
PA97	REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL STANDARDS OF PRACTICE.
PA98	PLEASE INDICATE IF THE CLIENT IS CURRENTLY BEING TUBE FED.
PB02	PLEASE PROVIDE THE REQUIRED DATED SIGNATURES ON THE ATTACHMENTS.
PB03	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING THE LOSS/DESTRUCTION/THEFT OF THE HEARING AID.

Denial Code	Long Description
PB04	DESCRIBE THE CLIENTS ABILITY TO STAND OR AMBULATE SUFFICIENTLY TO ACCOMPLISH SELF-CARE ACTIVITIES.
PB07	PLEASE SUBMIT AN ORTHODONTIC STUDY MODEL OR DIAGNOSTIC CASTS.
PB09	PLEASE PROVIDE A PHOTOGRAPH OF THE INVOLVED AREA(S).
PB10	PLEASE PROVIDE AN ESTIMATION (IN GRAMS) OF THE TOTAL AMOUNT OF TISSUE TO BE RESECTED.
PB11	PLEASE SUBMIT THE PLAN OF CARE FOR CO-TREATMENT.
PB12	FURNISH A DETAILED DESCRIPTION FOR THE PROCEDURE CODE REQUESTED.
PB13	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB15	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB18	PLEASE COMPLETE THE ATTACHED OUT-OF-STATE PROVIDER DATA SHEET, F-11001, AND RESUBMIT.
PB20	A SIGNED AND DATED PRESCRIPTION IS REQUIRED WITHIN THREE MONTHS OF RECEIPT BY COLORADO MEDICAID FOR INITIAL REQUESTS AND WITHIN 12 MONTHS OF RECEIPT BY COLORADO MEDICAID FOR SUBSEQUENT REQUESTS.
PB21	PLEASE COMPLETE THE APPROPRIATE PRIOR AUTHORIZATION ATTACHMENT. CONTACT PROVIDER SERVICES OR THE PRIOR AUTHORIZATION UNIT FOR ASSISTANCE.
PB23	PHYSICAL THERAPY ASSISTANT NOTES AND ALL FORMS SUBMITTED MUST BE COSIGNED BY A REGISTERED PHYSICAL THERAPIST.
PB31	ARE YOU REQUESTING A COMPLETE APPLIANCE, OR REPLACEMENT PARTS?
PB32	THE PROCEDURE CODE INDICATED ON THE REQUEST DOES NOT MATCH THE DESCRIPTION OF SERVICE; PLEASE CORRECT AND RESUBMIT.
PB35	THE SERVICE REQUESTED DOES NOT REQUIRE PRIOR AUTHORIZATION.
PB41	PLEASE FURNISH A CURRENT MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT, F-11090 (DATED WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID).
PB45	THE CERTIFICATION PERIOD ON THE PLAN OF CARE (POC) DOES NOT COVER THE REQUESTED GRANT/START DATE. PLEASE RESUBMIT YOUR REQUEST WITH A NEW POC.
PB49	A CERTIFIED OCCUPATIONAL THERAPY ASSISTANTS NOTES MUST BE COSIGNED BY AN OCCUPATIONAL THERAPIST REGISTERED.
PB51	ADDITIONAL INFORMATION IS REQUIRED ON PRIOR AUTHORIZATION TO ENABLE PRICING.
PB54	REQUESTED SERVICES DO NOT MATCH SERVICES ON THE PHYSICIANS ORDERS.
PB59	PLEASE PROVIDE AN INDIVIDUAL EDUCATIONAL PLAN (IEP), WHICH HAS BEEN SIGNED BY THE PROVIDER NO EARLIER THAN NINE MONTHS PRIOR TO RECEIPT AT COLORADO MEDICAID; OTHERWISE, DOCUMENT WHY NO IEP EXISTS.
PB65	PLEASE FURNISH THE ANTICIPATED TOTAL CHARGES FOR THIS REQUEST.
PB66	A PHOTOCOPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED; THE DATE MUST BE WITHIN SIX MONTHS OF RECEIPT BY COLORADO MEDICAID.
PB67	THE PRESCRIPTION DATE MUST INCLUDE MONTH, DAY, AND YEAR.
PB68	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID.
PB73	THE SERVICES IDENTIFIED ON THE PLAN OF CARE DO NOT APPEAR APPROPRIATE FOR THE PROCEDURE CODE(S) REQUESTED ON THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018.
PB74	THE CLIENT/PROVIDER DOES NOT HAVE RETROACTIVE ENROLLMENT.
PB75	THE REQUESTED START DATE IS MORE THAN 14 DAYS BEFORE OR 62 DAYS AFTER RECEIPT.
PB82	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
PB83	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A HOME HEALTH AIDE. PLEASE RESUBMIT AS A PERSONAL CARE WORKER OR PROVIDE ADDITIONAL DOCUMENTATION.
PB86	THE SERVICES REQUESTED ARE NOT BEING PROVIDED IN THE CLIENTS RESIDENCE. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL.
PB87	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A NURSE. PLEASE RESUBMIT AS A HOME HEALTH AIDE OR PROVIDE ADDITIONAL DOCUMENTATION.
PB92	PLEASE FURNISH THE CLIENTS COMPLETE ADDRESS.
PB94	IF THE CLIENT IS A RESIDENT OF A NURSING HOME, SUPPLY THE COMPLETE NAME AND ADDRESS OF THE NURSING HOME.
PB99	THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018, MUST BE SIGNED AND DATED.

Denial Code	Long Description
PC01	PLEASE SUPPLY THE RENDERING PROVIDERS PROVIDER NUMBER.
PC03	THE DRUG ENFORCEMENT ADMINISTRATION NUMBER IS MISSING OR INVALID.
PC06	PLEASE DESCRIBE YOUR PROGRAM; INCLUDE ENTRY DATE, TERMINATION DATE, HOURS PER WEEK, AND NUMBER OF WEEKS OF PRIMARY INTENSIVE SERVICE REQUESTED.
PC07	PLEASE DESCRIBE YOUR "AFTERCARE/FOLLOW-UP" PLANS FOR THIS CLIENT.
PC08	PLEASE SUPPLY DOCUMENTATION OF PREVIOUS SUBSTANCE ABUSE SERVICES WITH DATE(S) AND OUTCOME.
PC09	PLEASE DESCRIBE IN DETAIL THE TREATMENT OBJECTIVES/GOALS FOR THIS CLIENT.
PC10	PLEASE DESCRIBE THE FAMILY SITUATION/DYNAMICS. EXPLAIN HOW THE FAMILY WILL BE INCORPORATED INTO THE CLIENTS PLAN OF CARE.
PC12	PLEASE EXPLAIN IF YOUR SERVICE ENCOURAGES THE CLIENT TO ATTEND SELF-HELP GROUPS.
PC13	PLEASE SUPPLY A SPECIFIC SCHEDULE OF ACTIVITIES, INCLUDING DAY, TIME OF DAY, LENGTH OF SESSION, AND SERVICE TO BE RENDERED DURING THAT TIME.
PC15	PLEASE FURNISH DIAGNOSTIC RATIONALE.
PC17	PLEASE DOCUMENT IF THE CLIENT EVER RECEIVED SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT.
PC19	PLEASE FURNISH MORE EXTENSIVE AND IN-DEPTH HISTORICAL AND PSYCHOSOCIAL DATA.
PC20	PLEASE SUPPLY THE DATE THE CLIENT BECAME TOTALLY ENDENTULOUS.
PC23	PLEASE SUBMIT A PHYSICIANS STATEMENT REGARDING THE MEDICAL NECESSITY OF DENTURES FOR THIS CLIENT. THE PHYSICIANS STATEMENT MUST DOCUMENT THE MEDICAL NEED FOR DENTURES.
PC24	THE SERVICE REQUESTED WAS PREVIOUSLY AUTHORIZED. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT INDICATING THIS FACT IS REQUIRED.
PC25	PLEASE SUPPLY SUFFICIENT MITIGATING CIRCUMSTANCES TO WARRANT THE CONSTRUCTION OF NEW DENTURES(S).
PC26	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
PC28	PLEASE SUBMIT A PHYSICIANS STATEMENT INDICATING DENTURES ARE NECESSARY FOR THIS NURSING HOME CLIENT.
PC29	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING LOSS OR DESTRUCTION OF DENTURE(S). INCLUDE SIGNED STATEMENT FROM CLIENT OR FACILITY DIRECTOR REGARDING HOW, WHEN AND WHERE LOST.
PC30	PLEASE PROVIDE COMPLETE INTRAORAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PC31	PLEASE DESCRIBE ANY RELATED DEFORMITIES OF THE FEET.
PC34	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD WITH REQUESTED DME ITEM(S) AND DOCUMENT IF THE CLIENT CAN USE SAFELY AND INDEPENDENTLY.
PC35	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD AND DESCRIBE THE RESULTS AND EFFECTIVENESS OF THE SERVICE REQUESTED.
PC39	PLEASE INDICATE LITER FLOW PER MINUTE, HOURS OF USE PER 24 HOUR PERIOD, AND THE EXPECTED DURATION OF NEED.
PC40	THE ITEM DOES NOT REQUIRE PRIOR AUTHORIZATION UNTIL THE LIFE EXPECTANCY HAS BEEN REACHED.
PC41	PLEASE SUPPLY INFORMATION INDICATING THE NECESSITY OF POSITIONING THE CLIENT'S BODY IN MULTIPLE POSITIONS.
PC42	PLEASE INDICATE IF THE BED HEIGHT MUST BE CHANGED TO ALLOW FOR SAFE TRANSFER OR ADEQUATE BED CARE.
PC43	SUPPLY A PHYSICIANS STATEMENT INDICATING TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR UNIT HAS REDUCED PAIN, IMPROVED/INCREASED THE CLIENTS ACTIVITY LEVEL, AND/OR REDUCED CLIENTS USE OF PAIN MEDICATION.
PC44	A CURRENT AUTHORIZATION FOR THIS SERVICE IS ON FILE FOR ANOTHER PROVIDER. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT OF THAT FACT IS REQUIRED BY THE CLIENT OF FIRST PROVIDER.
PC59	DOCUMENT DECLINE OR PROGRESS IN SPECIFIC, MEASURABLE, OBJECTIVE TERMS.
PC60	DOCUMENT IF CLIENT HAS DEMONSTRATED A GOOD APPOINTMENT COMPLIANCE RECORD.
PC61	THE PHYSICIANS SIGNATURE DATE MUST NOT EXCEED 90 DAYS FROM THE DATE OF RECEIPT BY COLORADO MEDICAID.
PC62	REQUESTS FOR A CONTINUATION OF THERAPY SHOULD NOT BE SUBMITTED MORE THAN FOUR WEEKS PRIOR TO THE EXPIRATION DATE OF THE CURRENT AUTHORIZATION.

Denial Code	Long Description
PC63	PLEASE FURNISH THE STYLE AND MANUFACTURER OF THE FRAME.
PC64	PLEASE FURNISH THE CLIENTS LENS FORMULA.
PC66	ALL REQUESTS FOR TINTS REQUIRE DOCUMENTATION OF THE VISUAL OR MEDICAL CONDITION RELATED TO PHOTOPHOBIA.
PC67	PLEASE DOCUMENT THE REASON AND JUSTIFICATION FOR REPLACEMENT BEYOND THE FIRST LENS/FRAME.
PC68	DOCUMENT IF ALL REMAINING MAXILLARY AND/OR MANDIBULAR TEETH ARE DECAY-FREE, PROPERLY RESTORED, AND PERIODONTICALLY SOUND.
PC72	SUPPLY MORE DETAIL REGARDING PROGRESS (ATTACHMENT OF GOALS, ETC.). CORRELATE PROGRESS TO PREVIOUS GOALS AND IDENTIFIED LIMITATIONS.
PC77	PLEASE SUBMIT A PLAN OF CARE DESCRIBING THE SERVICES THAT WOULD BE PROVIDED.
PC78	PLEASE DOCUMENT SPECIFIC, MEASURABLE GOALS.
PC82	THE PRIOR AUTHORIZATION (PA) SYSTEM CAN PROCESS ONLY 26 DETAILS PER PA REQUEST. PLEASE RESUBMIT YOUR REQUEST WITH NO MORE THAN 26 DETAILS.
PC83	PLEASE SUPPLY A PHYSICIANS PRESCRIPTION DATED WITHIN ONE MONTH OF REQUESTED SUBSTANCE ABUSE DAY TREATMENT.
PC84	PLEASE PROVIDE INFORMATION INDICATING THIS CLIENT IS APPROPRIATELY DETOXIFIED FROM ALCOHOL AND/OR OTHER DRUGS.
PC85	PLEASE PROVIDE INFORMATION TO INDICATE THE CLIENTS ABILITY TO ABSTAIN FROM ALCOHOL OR DRUGS WHILE IN THE SUBSTANCE ABUSE DAY TREATMENT PROGRAM.
PC86	PLEASE INDICATE IF THIS CLIENT IS WILLING TO PARTICIPATE IN AFTERCARE OR CONTINUING CARE SERVICES.
PC87	PROVIDE MORE INFORMATION ON TREATMENT HISTORY; INCLUDE SERVICE PROVIDED, DATES, AND OUTCOME. PROVIDE DETAIL OF PREVIOUS TREATMENT.
PC88	PLEASE PROVIDE MORE RATIONALE FOR THE APPROPRIATENESS AND MEDICAL NECESSITY OF SUBSTANCE ABUSE DAY TREATMENT.
PC89	PROVIDE A TREATMENT PLAN THAT CONTAINS MEASURABLE GOALS AND OBJECTIVES CORRESPONDING TO THE IDENTIFIED DEFICIT.
PC91	PLEASE PROVIDE MORE INFORMATION ON FAMILY INVOLVEMENT TREATMENT.
PC92	PLEASE PROVIDE MORE HISTORY AND EXPLANATION ABOUT THE ISSUE OF ABSTINENCE FOR THIS CLIENT.
PC94	PLEASE PROVIDE THE ANTICIPATED BEGINNING DATE AND/OR THE ESTIMATED SUBSTANCE ABUSE DAY TREATMENT DISCHARGE DATE.
PC95	PLEASE SUPPLY JUSTIFICATION FOR BEGINNING CLIENT IN SERVICE PRIOR TO AUTHORIZATION BEING OBTAINED.
PC96	THE INITIAL THREE HOURS OF SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IN A CALENDAR YEAR DO NOT REQUIRE PRIOR AUTHORIZATION.
PC97	REIMBURSEMENT FOR INITIAL SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IS LIMITED TO THREE HOURS IN A CALENDAR YEAR AND DOES NOT REQUIRE PRIOR AUTHORIZATION.
PC98	THIS DRUG IS CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE BILL USING THE APPROPRIATE NATIONAL DRUG CODE (NDC) OR SUBMIT A COMPLETED DRUG ADDITION REQUEST FORM IF THE NDC IS NOT LISTED IN THE DRUG INDEX.
PC99	THIS DRUG IS NOT CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL, CURRENT ADMINISTRATIVE RULE, OR COLORADO DRUG INDEX FOR COVERAGE LIMITATIONS.
PD01	DOCUMENT THAT CLIENT HAS ACHIEVED GOOD ORAL HYGIENE, PERIODONTAL CASE TYPE 1 OR 2, AND IS MOTIVATED TO MAINTAIN SAME.
PD03	PLEASE PROVIDE AN ARTERIAL BLOOD GAS READING OR PULSE OXIMETRY RESULTS DONE ON ROOM AIR SIGNED AND DATED BY A MEDICAL DOCTOR. THIS SHOULD BE DONE WITHIN 60 DAYS OF REQUESTED SERVICE.
PD04	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 30 DAYS OF RECEIPT BY COLORADO MEDICAID.
PD07	SUBMIT A PHOTOCOPY OF A VALID PRESCRIPTION, ISSUED WITHIN THE PAST YEAR, OR COMPLETE SECTION B OF THE PRIOR AUTHORIZATION/DRUG ATTACHMENT (PA/DGA), F-11049.

Denial Code	Long Description
PD10	BRAND MEDICALLY NECESSARY MUST BE IN THE PRESCRIBERS OWN HANDWRITING AND WRITTEN DIRECTLY ON THE PRESCRIPTION OR A SEPARATE ORDER ATTACHED TO THE ORIGINAL PRESCRIPTION.
PD12	COMPLETE DENTURES, PARTIAL DENTURES, DENTURE RELINES, AND FIXED PROSTHODONTIC SERVICES ARE NOT COVERED SERVICES FOR ADULTS FOR DATES OF SERVICE ON AND AFTER OCTOBER 1, 1995.
PD22	PLEASE COMPLETE ALL REQUIRED ELEMENTS ON THE PERSONAL CARE SCREENING TOOL (PCST), F-11133.
PD24	THIS PRIOR AUTHORIZATION REQUEST IS UNABLE TO BE PROCESSED. PLEASE RESUBMIT WITH ADDITIONAL REQUIRED FORMS, INCLUDING THE ENTIRE PERSONAL CARE SCREENING TOOL (PCST), F-11133; PERSONAL CARE ADDENDUM, F-11136; AND SUPPORTING DOCUMENTATION, AS DIRECTED.
PD25	THERE IS A PERSONAL CARE SCREENING TOOL (PCST), F-11133, COMPLETED BY ANOTHER AGENCY. CONTACT THE AGENCY TO TRANSFER SCREEN.
PD26	THERE IS A LIMITED TERM CARE FUNCTIONAL SCREEN (LTC-FS) COMPLETED BY ANOTHER AGENCY. THE PERSONAL CARE SCREENING TOOL (PCST), F-11133, INFORMATION IS IN CONFLICT WITH LTC-FS.
PD27	ONLY ONE LEVEL OF FUNCTION MAY BE SELECTED FOR ALL ELEMENTS EXCEPT TOILETING. COLORADO MEDICAID IS UNABLE TO PROCESS THE PRIOR AUTHORIZATION REQUEST.
PD28	NO UNITS MAY BE REQUESTED USING THIS PRIOR AUTHORIZATION PROCESS. PLEASE SUBMIT WITH THE APPROPRIATE ATTACHMENTS FOR REQUESTING SPECIFIC PERSONAL CARE WORKER UNITS.
PD29	CLIENT IS NOT ELIGIBLE FOR THE REQUESTED SERVICE(S) AS OF THE REQUESTED START DATE.
PD30	NO TRAVEL TIME MAY BE AUTHORIZED WHEN NO PERSONAL CARE WORKER SERVICE IS AUTHORIZED.
PD32	PROVIDER NOT CERTIFIED TO RENDER THE SERVICE(S) REQUESTED.
PD34	BASED ON THE DOCUMENTATION SUBMITTED, THIS REQUEST CAN NOT BE PRIOR AUTHORIZED. REFER TO THE PA MESSAGES FROM THE CONSULTANT FOR COMPLETE EXPLANATION.
PD98	PLEASE DOCUMENT HOW AND WHEN EACH PREVIOUSLY AUTHORIZED PRO RE NATA VISIT WAS USED.

Post Eligibility Treatment of Income (PETI) Home and Community Based Services (HCBS)

Denial Code	Long Description
0201	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
0233	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0235	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0237	CLIENT IDENTIFICATION NUMBER DOES NOT MATCH CLIENTS FIRST NAME.
0238	THE CLIENT IDENTIFICATION NUMBER DOES NOT MATCH THE CLIENTS LAST NAME.
0242	SECONDARY DIAGNOSIS CODE IS INVALID.
0248	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0249	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0251	PROCEDURE CODE MODIFIER IN FIRST POSITION IS INVALID.
0252	THE PROCEDURE CODE MODIFIER IN SECOND POSITION IS INVALID FOR REQUESTED START DATE OR DATE OF RECEIPT.
0253	THE PROCEDURE CODE MODIFIER IN THIRD POSITION IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
0258	THE PRIMARY DIAGNOSIS CODE IS REQUIRED.
0272	THE PRIMARY DIAGNSOSIS CODE IS INVALID.
0400	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0853	HCPCS - ANNUAL UPDATE
0885	NEVER EVENTS MODIFIERS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
0886	NEVER EVENTS DIAGNOSIS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
1000	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
1002	RENDERING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.

Denial Code	Long Description
1003	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1007	RENDERING PROVIDER ID IS NOT ON FILE.
1047	THE RENDERING PROVIDERS CERTIFICATION HAS BEEN CANCELLED.
1048	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1801	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
1804	A CERTIFIED SUBSTANCE ABUSE DAY TREATMENT PROVIDER MUST SUBMIT A SUBSTANCE ABUSE DAY TREATMENT PROCEDURE CODE.
1806	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
1808	THE BILLING PROVIDER DOES NOT HAVE THE REQUIRED CERTIFICATION ADDENDUM ON FILE.
1900	THE BILLING PROVIDERS TAXONOMY CODE IS INVALID.
1901	THE RENDERING PROVIDERS TAXONOMY CODE IS INVALID.
1927	A NATIONAL PROVIDER IDENTIFIER IS REQUIRED FOR THE BILLING PROVIDER.
1934	A NATIONAL PROVIDER INDENTIFIER IS REQUIRED FOR THE RENDERING PROVIDER.
1936	THE BILLING PROVIDER NUMBER IS INVALID.
1937	THE RENDERING PROVIDER NUMBER IS INVALID.
1960	INTERNAL PROCESSING IS REQUIRED.
1963	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.
1964	THE BILLING PROVIDER INDICATED IS NOT ALLOWABLE AS A BILLING PROVIDER.
1965	RENDERING PROVIDER NUMBER IS MISSING/INVALID FOR THIS PROCEDURE PROVIDER.
1974	PRESCRIBING/REFERRING/ORDERING PROVIDER INDICATED IS NOT CERTIFIED AS A PRESCRIBING/REFERRING/ORDERING PROVIDER.
1975	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
1976	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
2001	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2003	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2017	THE CLIENT IS ENROLLED IN A MEDICAID OR OTHER MANAGED CARE PROGRAM.
2037	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2603	CLIENT LOCKED-IN TO A PROVIDER OR ENROLLED IN A HOSPICE. CONTACT CLIENTS HOSPICE FOR PAYMENT OF SERVICES OR RESUBMIT WITH DOCUMENTATION OF UNRELATED NATURE OF CARE.
3324	THE MODIFIER HAS BEEN DISCONTINUED BY THE CENTERS OF MEDICARE AND MEDICAID SERVICES OR THE AMERICAN MEDICAL ASSOCIATION FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
3337	THE PROCEDURE CODE HAS BEEN TERMINATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AMERICAN MEDICAL ASSOCIATION, OR AMERICAN DENTAL ASSOCIATION FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT. RESUBMIT WITH VALID A PROCEDURE CODE.
3339	THE PROCEDURE BILLED IS NOT PAYABLE ACCORDING TO DEFICIT REDUCTION ACT (DEFRA) GUIDELINES.
3351	THE PROCEDURE IS NOT COVERED FOR CLIENTS WITH A NURSING HOME AUTHORIZATION ON THE REQUESTED START DATE OR DATE OF RECEIPT.
3353	THE PROCEDURE IS NOT A COVERED SERVICE FOR HOME AND COMMUNITY-BASED WAIVER CLIENTS.
4021	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4027	THE DIAGNOSIS CODE IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
4031	THE PROCEDURE SUBMITTED IS NOT APPROPRIATE FOR CLIENTS GENDER.
4032	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4034	THE PROCEDURE CODE HAS AN AGE RESTRICTION.
4036	THE PLACE OF SERVICE CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4040	THE PRIMARY DIAGNOSIS CODE IS NOT ON FILE.
4041	THE SECONDARY DIAGNOSIS IS NOT ON FILE.
4046	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4127	INTERNAL PROCESSING IS REQUIRED.
4131	INTERNAL PROCESSING IS REQUIRED.
4141	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4149	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4150	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4236	ETIOLOGY DIAGNOSIS CODE(S) (E-CODES) ARE INVALID AS THE PRIMARY DIAGNOSIS.

Denial Code	Long Description
4244	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4245	THE FOURTH POSITION MODIFIER IS INVALID FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT.
4256	THE PROCEDURE CODE AND MODIFIER COMBINATION IS NOT PAYABLE FOR THE CLIENTS BENEFIT PLAN.
4257	THE MODIFIERS SUBMITTED ARE EITHER INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT OR THE MODIFIERS ARE MISSING.
4311	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4315	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4316	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4371	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4372	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4711	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR CLIENTS AGE.
4714	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS AGE.
4731	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS DIAGNOSIS.
4742	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4743	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4744	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4745	DIAGNOSIS AND/OR PROCEDURE AND/OR PLACE OF SERVICE (POS) CODE IS NOT COVERED FOR EXPRESS ENROLLMENT CLIENTS.
4746	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4801	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4802	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
4821	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
4871	PLEASE REFER TO PA MESSAGES FOR RETURN INFORMATION.
4963	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS GENDER.
4990	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
7500	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
7509	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
P001	THE BILLING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THE SERVICES.
P002	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P003	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P005	THE PRIOR AUTHORIZATION CAN NOT BE END DATED. THE PRIOR AUTHORIZATION STATUS IS NOT APPROVED OR APPROVED WITH REVISIONS.
P006	PLEASE FURNISH THE PROCEDURE CODE AND CORRESPONDING DESCRIPTION.
P008	THE BILLING PROVIDER NUMBER IS INVALID.
P009	THE BILLING PROVIDER NUMBER IS INVALID.
P010	THE REQUESTED END DATE IS INVALID.
P011	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P012	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P013	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P014	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P015	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P016	THE REQUESTED START DATE IS MISSING OR INVALID.
P019	THE REQUESTED START DATE IS MISSING OR INVALID.
P020	THE RENDERING PROVIDER NUMBER IS INVALID.
P021	THE RENDERING PROVIDER NUMBER IS INVALID.

Denial Code	Long Description
P022	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P023	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P024	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P026	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P027	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P030	FIRST MODIFIER IS INVALID.
P031	FIRST MODIFIER IS INVALID.
P032	SECOND MODIFIER IS INVALID.
P033	SECOND MODIFIER IS INVALID.
P034	THIRD MODIFIER IS INVALID.
P035	THIRD MODIFIER IS INVALID.
P036	FOURTH MODIFIER IS INVALID.
P037	FOURTH MODIFIER IS INVALID.
P038	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P039	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P040	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P041	CLIENTS FIRST NAME IS MISSING.
P042	CLIENTS LAST NAME IS MISSING.
P043	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P044	BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES REQUESTED.
P045	FIRST MODIFIER IS INVALID.
P046	SECOND MODIFIER IS INVALID.
P047	THIRD MODIFIER IS INVALID.
P048	FOURTH MODIFIER IS INVALID.
P052	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P053	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P054	RENDERING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES FOR THE BENEFIT PLAN.
P055	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P061	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P062	THE CLIENT ID AND/OR NAME INDICATED ON THE PA REQUEST IS INCORRECT. THE CLIENT ID AND/OR NAME HAS BEEN UPDATED. PLEASE VERIFY THE ID AND/OR NAME IS CORRECT.
P064	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
P067	THE FREQUENCY OF HOURS REQUESTED ARE NOT APPROPRIATE FOR THIS CLIENT AND HAVE BEEN MODIFIED ACCORDINGLY.
P079	BILLING PROVIDER IS ON PAYMENT SUSPENSION DUE TO CREDIBLE ALLEGATION OF FRAUD.
P120	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAS BEEN REDUCED.
P121	THE SERVICE/ PROCEDURE REQUESTED IS NOT SUPPORTED BY SUBMITTED DOCUMENTATION.
P126	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
P128	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.
P138	SERVICE(S) DO NOT MEET COLORADO MEDICAID GUIDELINES.
P167	REQUESTED DOCUMENTATION HAS NOT BEEN SUBMITTED.
P178	THE SERVICE REQUESTED IS NOT MEDICALLY NECESSARY.
P179	THE MEDICAL NECESSITY FOR THIS SERVICE IS NOT SUPPORTED BY THE SUBMITTED DOCUMENTATION.
P233	THE DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE ADDITIONAL CARE.
P257	THIS CLIENTS FUNCTIONAL ASSESSMENT SCORES PLACE THIS CLIENT OUTSIDE ELIGIBILITY FOR DAY TREATMENT.
P274	OUR RECORDS INDICATE THIS CLIENT IS INVOLVED IN EFFECTIVE AND APPROPRIATE SERVICE ELSEWHERE.

Denial Code	Long Description
P292	INTENSIVE REHABILITATION HOURS ARE NO LONGER APPROPRIATE AS INDICATED BY HISTORY, DIAGNOSIS, AND/ OR FUNCTIONAL ASSESSMENT SCORES.
P328	THE SERVICES REQUESTED INCLUDE NON-COVERED SERVICES, AND HOURS ARE REDUCED ACCORDINGLY.
P339	THE CLIENTS PAST HISTORY INDICATES REDUCED TREATMENT HOURS ARE WARRANTED.
P342	THE REQUEST DOES NOT MEET GENERALLY ACCEPTED CONDITIONS REQUIRING FLUORIDE TREATMENTS.
P346	SERVICES EXCEED COLORADO MEDICAID LIMITATION AND DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE MEDICAL NECESSITY OF THE SERVICE.
P349	THE SERVICE REQUESTED WAS PERFORMED LESS THAN FIVE YEARS AGO.
P353	THE EXISTING APPLIANCE HAS NOT BEEN WORN FOR THREE YEARS.
P367	THE CLIENT HAS BEEN TOTALLY WITHOUT TEETH AND AN APPLIANCE FOR FIVE YEARS.
P392	THE CLIENT IS MISSING AN ANTERIOR TOOTH AND/OR HAS TWO OR MORE POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P405	THE SERVICE(S) REQUESTED COULD ADEQUATELY BE PERFORMED IN THE DENTAL OFFICE.
P406	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE OF GOOD PERIODONTAL HEALTH (AMERICAN ACADEMY OF PERIODONTOLOGY PERIODONTAL CLASSIFICATION OF TYPE I OR II).
P407	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE VISIBLE ON RADIOGRAPHS THAT AT LEAST 50 PERCENT OF THE CLINICAL CROWN IS INTACT.
P409	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING SIX OR MORE TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED, INCLUDING THIRD MOLARS.
P410	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING ONE OR MORE ANTERIOR TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED.
P411	DOCUMENTATION DOES NOT SUPPORT THE NEED FOR PERIODONTIC SERVICES. POCKETS ARE LESS THAN 4MM AND/OR GREATER THAN 6MM FOR CLIENT AND/OR THE CLIENT IS UNDER THE AGE OF 13.
P412	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA.
P413	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA. THIS PA HAS BEEN GRANTED AS APPROVED NOT APPROVED WITH REVISIONS. THE DURATION REQUESTED MAY HAVE BEEN REDUCED TO REFLECT COVERAGE LIMITATIONS, PRESCRIBER ORDERS, CONFLICTI
P417	THE SERVICE(S) REQUESTED COULD BE ADEQUATELY PERFORMED WITH LOCAL ANESTHESIA.
P437	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO POOR ORAL HYGIENE.
P444	THIS LINE ITEM IS A DUPLICATE OF ANOTHER LINE ITEM ON THIS PRIOR AUTHORIZATION (PA) REQUEST. PLEASE CORRECT.
P446	THIS IS A DUPLICATE OF AN EXISTING PRIOR AUTHORIZATION (PA) REQUEST. YOU MAY CONTACT PROVIDER SERVICES IF YOU REQUIRE ASSISTANCE. DUPLICATE PA REQUEST
P448	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO DECAY HISTORY.
P449	QUESTIONABLE LONG TERM PROGNOSIS DUE TO GUM AND BONE DISEASE.
P456	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO APPARENT ROOT INFECTION.
P457	OUR RECORDS INDICATE THIS CLIENT HAS EXCEEDED ESTABLISHED PROGRAM LIMITATIONS. COLORADO MEDICAID WILL NOT AUTHORIZE NEW DENTURES.
P458	DOCUMENTATION PROVIDED INDICATES A LESS ELABORATE PROCEDURE SHOULD BE CONSIDERED.
P502	RENTAL ONLY ALLOWED; MEDICAL NEED FOR PURCHASE HAS NOT BEEN DOCUMENTED.
P503	PURCHASE ONLY ALLOWED; MEDICAL NEED FOR RENTAL HAS NOT BEEN DOCUMENTED.
P504	OCCUPATIONAL THERAPY GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P505	THE SERVICE REQUESTED IS INCLUDED IN THE NURSING HOME RATE STRUCTURE.
P511	THIS NATIONAL DRUG CODE IS ONLY BILLABLE AS PART OF A COMPOUND DRUG.
P515	THE PRESENCE OF A HANDICAPPING MALOCCLUSION OR HANDICAPPING DENTOFACIAL DEFORMITY IS NOT SUPPORTED BY THE DOCUMENTATION SUBMITTED.
P521	THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVERED BY COLORADO MEDICAID.
P522	GASTRO-INTESTINAL SURGERY FOR THE PURPOSE OF WEIGHT CONTROL IS COVERED ONLY AS A LIFE THREATENING PROCEDURE.
P523	THE TREATMENT REQUEST IS NOT CONSISTENT WITH THE CLIENT'S DIAGNOSIS.
P524	PSYCHOTHERAPY PROVIDED IN THE CLIENTS HOME IS NOT A COVERED BENEFIT OF COLORADO MEDICAID.

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P525	THE INFORMATION PROVIDED IS NOT CONSISTENT WITH THE INTENSITY OF SERVICES REQUESTED.
P526	INTENSIVE MULTIPLE MODALITY TREATMENT IS NOT CONSISTENT WITH THE INFORMATION PROVIDED.
P527	MULTIPLE PROVIDERS OF TREATMENT ARE NOT INDICATED FOR THIS CLIENT.
P528	THE DURATION OF TREATMENT SESSIONS EXCEED CURRENT COLORADO MEDICAID GUIDELINES.
P534	DOCUMENTATION OF POOR PHYSICAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P535	OTHER PHYSICAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P536	THE PHYSICAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P537	USE OF PHYSICAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P538	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF A PHYSICAL THERAPIST.
P539	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS AND LIVING ARRANGEMENT.
P540	GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P541	THE PROCEDURE(S) REQUESTED ARE NOT MEDICAL IN NATURE.
P542	DOCUMENTATION OF POOR OCCUPATIONAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P543	DOCUMENTATION OF POOR SPEECH THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P544	OTHER OCCUPATIONAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P546	THE OCCUPATIONAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P547	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF PHYSICAL THERAPY.
P548	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P549	ACTIVITIES TO PROMOTE DIVERSION OR GENERAL MOTIVATION ARE NONCOVERED COLORADO MEDICAID SERVICES.
P550	REVISIONS OF THE REQUEST IS NECESSITATED BY THE CLIENTS MINIMAL PROGRESS.
P551	RESTORATIVE NURSING INVOLVEMENT COULD BE INCREASED.
P552	CLIENTS DEMONSTRATED RESPONSE TO CURRENT THERAPY DOES NOT WARRANT THE INTENSE FREQUENCY REQUESTED.
P553	MAINTENANCE IS TWO TIMES PER WEEK OR LESS.
P554	THE SPEECH THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P555	USE OF OCCUPATIONAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P556	USE OF SPEECH THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P557	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF AN OCCUPATIONAL THERAPIST.
P558	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
P559	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P560	THE MATERIALS/ SERVICES REQUESTED ARE PRINCIPALLY COSMETIC IN NATURE.
P561	THE LENS FORMULA DOES NOT JUSTIFY REPLACEMENT.
P562	THE CHANGE IN THE LENS FORMULA DOES NOT WARRANT MULTIPLE REPLACEMENTS.
P563	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P564	LENSES ONLY ARE APPROVED; PLEASE DISPENSE A CONTRACTED FRAME. THE NON-CONTRACTED FRAME IS NOT MEDICALLY JUSTIFIED.
P565	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P566	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P567	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF OCCUPATIONAL THERAPY.

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P568	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF SPEECH THERAPY.
P569	LEVEL, INTENSITY, OR EXTENT OF SERVICE(S) REQUESTED HAS BEEN MODIFIED CONSISTENT WITH MEDICAL NEED AS DEFINED IN THE PLAN OF CARE.
P570	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P571	THE SERVICE ASKED FOR IS NOT COVERED BY COLORADO MEDICAID AS THESE TASKS CAN BE DONE BY NURSES OR ACTIVITY STAFF.
P572	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P573	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.
P574	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P575	MEDICAL NEED FOR EQUIPMENT/ SUPPLY REQUESTED IS NOT SUPPORTED BY DOCUMENTATION SUBMITTED.
P576	OTHER SPEECH THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P577	DOCUMENTATION SUBMITTED IDENTIFIES THAT THE CLIENT HAS FEWER THAN TWO POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P582	LESS EXPENSIVE ALTERNATIVE SERVICES ARE AVAILABLE FOR THIS CLIENT.
P634	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P711	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING PERIODONTAL SCALING AND ROOT PLANNING.
P712	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING GINGIVECTOMY.
P754	AN APPROVED SUBSTANCE ABUSE DAY TREATMENT PROGRAM CANNOT EXCEED A SIX WEEK PERIOD.
P761	THE CLIENT DOES NOT APPEAR TO BE ABLE OR WILLING TO ABSTAIN FROM ALCOHOL/DRUG USAGE WHILE IN TREATMENT. THEREFORE, SUBSTANCE ABUSE DAY TREATMENT SERVICES ARE NOT APPROVED.
P764	THIS CLIENT HAS COMPLETED INTENSIVE SUBSTANCE ABUSE TREATMENT WITHIN THE PAST 12 MONTHS. THE DOCUMENTATION PROVIDED IS NOT ADEQUATE TO JUSTIFY ADDITIONAL INTENSIVE TREATMENT AT THIS TIME.
P785	A LESS THAN SIX-WEEK HEALING PERIOD HAS BEEN SPECIFIED FOR THIS PRIOR AUTHORIZATION. THEREFORE IT IS NOT NECESSARY TO WAIT THE FULL SIX WEEKS AFTER EXTRACTIONS BEFORE TAKING DENTURE IMPRESSIONS.
P818	SIX-WEEK HEALING TIME IS REQUIRED BETWEEN EDENTULATION AND FINAL IMPRESSIONS. PAYMENT FOR DENTURES WILL BE DENIED OR RECOUPED IF HEALING PERIOD IS NOT OBSERVED.
P849	COLORADO MEDICAID HAS DETERMINED THERE WERE (ARE) SEVERAL HOME HEALTH AGENCIES WILLING TO PROVIDE MEDICALLY NECESSARY SKILLED NURSING SERVICES TO THIS CLIENT.
P864	THE DOCUMENTATION YOU HAVE SUBMITTED DOES NOT MEET THE REQUIREMENTS OF COLORADO MEDICAID.
P873	THE MEDICAL NECESSITY FOR THE HOURS REQUESTED IS NOT SUPPORTED BY THE INFORMATION SUBMITTED.
P874	THE DOCUMENTATION SUBMITTED INDICATES THE TASKS SPECIFIED CAN BE COMPLETED DURING THE VISITS APPROVED.
P878	THE DOCUMENTATION SUBMITTED DOES NOT INDICATE THAT MEDICALLY ORIENTED TASKS ARE MEDICALLY NECESSARY; THEREFORE PERSONAL CARE SERVICES HAVE BEEN APPROVED.
P880	THE QUANTITY OF SERVICES AUTHORIZED FOR THIS CLIENTS PERSONAL CARE HAS BEEN AMENDED BASED ON INFORMATION RECEIVED FROM ONE OR MORE OF THESE SOURCES: THE CLIENT, THEIR PHYSICIAN, AND/OR THE IN-HOME VISIT BY STAFF OF THE OIG (OFFICE OF INSPECTOR GENERAL).
P885	THE USE OF THIS DRUG FOR THE INTENDED PURPOSE IS NOT COVERED BY COLORADO MEDICAID, CONSISTENT WITH COLORADO ADMINISTRATIVE CODE AND FEDERAL LAW.
P924	THE MEDICAL RECORDS SUBMITTED WITH THE CURRENT REQUEST CONFLICT OR DISAGREE WITH OUR MEDICAL RECORDS ON THIS CLIENT.
P950	INDEPENDENT NURSES, PLEASE NOTE PAYABLE SERVICES MAY NOT EXCEED 12 HOURS/DAY OR 60 HOURS/WEEK.

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P951	SERVICES CAN ONLY BE AUTHORIZED THROUGH ONE YEAR FROM THE PRESCRIPTION DATE.
P952	LEAD INSPECTION IS A COVERED COLORADO MEDICAID SERVICE WHEN THE CHILD HAS BEEN SHOWN TO HAVE LEAD POISONING (E.G., CHILD HAS A BLOOD LEAD LEVEL > 19 UG/DL OR TWO CONSECUTIVE BLOOD LEAD LEVELS OF 15-19 UG/DL DONE AT LEAST 90 DAYS APART). THE INSPECTION MUS
P953	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P954	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P956	THE REQUEST CAN ONLY BE BACKDATED A MAXIMUM OF 14 DAYS FROM FIRST DATE RECEIVED BY COLORADO MEDICAID.
P957	COMPLETE PERIODONTAL CHARTING AT TIME OF SERVICE, AND SUBMIT CHARTING, COPY OF OPERATIVE REPORT, TOGETHER WITH A COPY OF THE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF), F-11035, TO PA UNIT ATTENTION DENTAL CONTSULTANT.
P958	NOTE THAT CODE D4341 HAS BEEN CHANGED. REFER TO THE DECISION NOTICE FOR AUTHORIZED QUANTITY.
P960	YOUR PA HAS BEEN APPROVED FOR 90 DAYS. THE 90 DAY APPROVAL DOES NOT IMPLY THE PA REQUEST MEETS PRIOR AUTHORIZATION CRITERIA. AFTER ADDITIONAL INFORMATION IS AVAILABLE IN INTERCHANGE, COLORADO MEDICAID WILL CREATE AN AMENDMENT REQUEST TO EXTEND THE PA FOR
P961	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P962	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
PA10	THE REQUESTED END DATE IS INVALID.
PA12	PLEASE FURNISH A WRITTEN DESCRIPTION OF THE CLIENTS DIAGNOSIS.
PA13	PROVIDE DIAGNOSES WITH DATES OF ONSET.
PA14	IDENTIFY PROBLEMS TO BE TREATED.
PA15	THE AUDIOLOGISTS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1), F-11020, AND PRIOR AUTHORIZATION REQUEST/HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2), F-11021.
PA16	THE PHYSICIANS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION/PHYSICIAN OTOLOGICAL REPORT (PA/POR), F-11019.
PA17	SUBMIT BRIEF HISTORY WITH REFERRAL INFORMATION, LIVING SITUATION, FUNCTIONAL STATUS, AND OTHER PERTINENT INFORMATION. WHAT CHANGE OF STATUS RESULTED IN REFERRAL AT THIS TIME?
PA18	PLEASE FURNISH THE CLIENTS HEIGHT AND WEIGHT.
PA19	PLEASE SUBMIT CLINICAL INFORMATION SUFFICIENT TO VERIFY THE NEED FOR THE REQUESTED SERVICE(S).
PA20	PLEASE RESUBMIT WITH COMPLETE PERIODONTAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PA21	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL EDUCATIONAL PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA22	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL PROGRAM PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA23	REFER TO THE DURABLE MEDICAL EQUIPMENT INDEX FOR APPROPRIATE CODE AND DESCRIPTION. DO NOT USE AN "UNLISTED" CODE.
PA24	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUALIZED FAMILY SERVICE PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA25	INFORMATION ON THE REQUEST FORM IS ILLEGIBLE, AND THE REQUEST CANNOT BE PROCESSED.
PA26	RE-EVALUATE YOUR GOALS. EMPHASIS SHOULD BE ON FUNCTIONAL SELF-CARE. GOALS MUST BE RELATED TO FUNCTIONAL OUTCOME.
PA27	PLEASE CLARIFY THE NUMBER OF HOURS PER WEEK REQUESTED.
PA28	PLEASE CLARIFY THE NUMBER OF HOURS PER DAY REQUESTED.
PA29	PLEASE CLARIFY THE NUMBER OF VISITS PER DAY REQUESTED.

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PA30	ATTACH SUPPORTIVE DOCUMENTATION; HOME EXERCISE PROGRAM AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA31	THE DIAGNOSIS CODE INDICATED ON THE REQUEST DOES NOT CORRESPOND TO THE DIAGNOSIS CODE DESCRIPTION.
PA32	PLEASE SUBMIT ADDITIONAL INFORMATION SUFFICIENT TO VERIFY APPROPRIATENESS AND NEED FOR TRANSPLANT.
PA33	PLEASE SUBMIT THE INITIAL AND PROGRESSIVE OBJECTIVE FINDINGS.
PA34	ATTACH SUPPORTIVE DOCUMENTATION, FACILITY PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA35	PLEASE SUBMIT THE CLIENTS ORIGINAL COMPLAINTS AND EXAMINATION FINDINGS.
PA36	ATTACH SUPPORTIVE DOCUMENTATION, IN-HOME AUTISM PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA37	PLEASE SUBMIT YOUR TREATMENT PLAN FOR THIS CLIENT.
PA38	ATTACH SUPPORTIVE DOCUMENTATION AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA39	INITIAL EVALUATIONS MUST BE PERFORMED BY AN OCCUPATIONAL THERAPIST REGISTERED (OTR), PER AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA) STANDARDS.
PA41	IDENTIFY THE PLACE OF SERVICE AND ITS EFFECT ON SUPPORTING THE DESIRED TREATMENT OUTCOME.
PA42	PLEASE INDICATE THE HOURS OF USE OF OXYGEN PER 24-HOUR PERIOD.
PA43	PROVIDE BASELINE DOCUMENTATION FOR THIS CLIENTS LIMITATIONS USING UNITS OF MEASUREMENT THAT ARE APPLIED CONSISTENTLY WHEN REPORTING STATUS.
PA44	IDENTIFY FUNCTIONAL LIMITATIONS AS THEY ARE RELATED TO IDENTIFIED CONDITIONS.
PA46	CORRELATE PLAN OF CARE TO REQUESTED PROCEDURE CODES.
PA47	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE FREQUENCY/DURATION REQUESTED.
PA48	PLEASE PROVIDE THE NAME AND CREDENTIALS OF THE RENDERING PROVIDER.
PA50	COLORADO MEDICAID RECORDS INDICATE THE CLIENT OWNS A WHEELCHAIR. DOCUMENT THE REASON AND NEED FOR REPLACEMENT AND COST TO REPAIR CURRENT WHEELCHAIR.
PA51	PLEASE DISTINGUISH PRIMARY AND SUPPORTIVE MODALITIES.
PA52	PLEASE SUBMIT A PROGRESS REPORT.
PA53	MULTIPLE FAMILY CLIENTS TREATMENT BY THE SAME PROVIDER REQUIRES FURTHER INFORMATION DOCUMENTING COORDINATION OF TREATMENT PLAN.
PA54	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE MINUTES REQUESTED.
PA55	MEDICAL NECESSITY OF TREATMENT REQUIRES ADDITIONAL DOCUMENTATION.
PA56	GIVEN AGE, DIAGNOSES, CURRENT LEVEL OF FUNCTION, PAST RESPONSE TO TREATMENT, AND LIVING SITUATION, EXPAND ON POTENTIAL FOR SIGNIFICANT FUNCTIONAL PROGRESS WITHIN THE NEXT SIX MONTHS. EMPHASIZE WHY PROGRESS IS EXPECTED WITH SERVICES AT THIS TIME.
PA57	SUBMIT THE INITIAL FINDINGS. INCLUDE A COMPREHENSIVE EVALUATION.
PA58	SUBMIT PROGRESSIVE, OBJECTIVE FINDINGS. INCLUDE A PERTINENT RE-EVALUATION.
PA59	PLEASE SUPPLY INFORMATION REGARDING THE CLIENTS MEDICATION REQUIREMENTS, IF ANY.
PA60	PLEASE SPECIFY IF THE CLIENT IS IN AN EDUCATIONAL SETTING.
PA61	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA62	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
PA63	THE SKILLS OF A THERAPIST ARE PURPOSEFUL AND SKILLED INTERVENTIONS REQUIRED TO CONTINUALLY DESIGN, IMPLEMENT, REASSESS, MODIFY/GRADE, AND/OR DISCONTINUE A PLAN OF CARE IN A TIMELY MANNER, BASED ON THE COMPLEXITY OF THE CLIENTS MEDICAL CONDITION AND/OR CO
PA64	PLEASE SUBMIT A THERAPY PLAN OF CARE, INCLUDING A CURRENT, DATED EVALUATION.
PA65	A PLAN OF CARE SIGNED AND DATED BY THE PHYSICIAN IS REQUIRED.
PA66	THE SKILLS OF A THERAPIST ARE REQUIRED WHEN ONLY THE THERAPIST CAN SAFELY AND EFFECTIVELY DELIVER THE THERAPEUTIC PROCEDURES BECAUSE OF THEIR UNIQUE KNOWLEDGE, TRAINING, AND EXPERTISE. DESCRIBE THE REASON THAT SOMEONE OTHER THAN A THERAPIST CANNOT SAFELY

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PA67	PLEASE SPECIFY IF THE CLIENTS WORK SITE DEMANDS GOOD BINAURAL HEARING.
PA68	DESCRIBE THE REASON, BASED ON THE CLIENTS COGNITIVE, PHYSICAL, COMMUNICATION, OR RESOURCE STATUS, THAT A HOME PROGRAM, EQUIPMENT, OR ENVIRONMENTAL ADAPTATIONS ALONE CANNOT MEET CLIENTS NEEDS.
PA69	PLEASE SPECIFY IF THE CLIENT HAS AN ACCOMPANYING DISABILITY THAT ADDS TO THE HEARING PROBLEM.
PA70	DISTINGUISH REQUESTED PROCEDURES AND GOALS FROM OTHER SERVICES THIS CLIENT RECEIVES. THEY MAY NOT BE DUPLICATIVE.
PA71	PLEASE INDICATE THE NUMBER OF DAYS REQUESTED.
PA73	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA74	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA75	PLEASE DOCUMENT CARRYOVER OF THE THERAPY PROGRAM TO NURSING.
PA76	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA79	PROVIDE EVIDENCE OF SIGNIFICANT FUNCTIONAL PROGRESS IN LAST SIX MONTHS.
PA84	THE GRANT DATE OF THIS REQUEST CANNOT BE PRIOR TO THE SIGNATURE DATE OF THE PRESCRIBING PHYSICIAN.
PA86	PROVIDE EVIDENCE OF SKILLS GAINED IN THERAPY CARRYING OVER TO OTHER SETTINGS WITHIN SIX MONTHS.
PA87	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE NUMBER OF SESSIONS REQUESTED.
PA88	THE REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL SCOPE OF PRACTICE.
PA89	PRIOR AUTHORIZATION IS NOT REQUIRED UNTIL LIMITATION OF SERVICE HAS BEEN REACHED.
PA91	PLEASE SUBMIT REQUIRED X-RAYS.
PA92	PLEASE PROVIDE AN EXPLANATION FOR THE MATERIAL SUBMITTED WITH THE REQUEST.
PA95	PLEASE DESCRIBE HOW THE PROVISION OF THIS SERVICE WOULD PREVENT INSTITUTIONALIZATION OF THE CLIENT.
PA96	COULD THE EXISTING DENTURE(S) BE RELINED OR REBASED? IF NOT, PLEASE EXPLAIN WHY NOT.
PA97	REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL STANDARDS OF PRACTICE.
PA98	PLEASE INDICATE IF THE CLIENT IS CURRENTLY BEING TUBE FED.
PB02	PLEASE PROVIDE THE REQUIRED DATED SIGNATURES ON THE ATTACHMENTS.
PB03	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING THE LOSS/DESTRUCTION/THEFT OF THE HEARING AID.
PB04	DESCRIBE THE CLIENTS ABILITY TO STAND OR AMBULATE SUFFICIENTLY TO ACCOMPLISH SELF-CARE ACTIVITIES.
PB07	PLEASE SUBMIT AN ORTHODONTIC STUDY MODEL OR DIAGNOSTIC CASTS.
PB09	PLEASE PROVIDE A PHOTOGRAPH OF THE INVOLVED AREA(S).
PB10	PLEASE PROVIDE AN ESTIMATION (IN GRAMS) OF THE TOTAL AMOUNT OF TISSUE TO BE RESECTED.
PB11	PLEASE SUBMIT THE PLAN OF CARE FOR CO-TREATMENT.
PB12	FURNISH A DETAILED DESCRIPTION FOR THE PROCEDURE CODE REQUESTED.
PB13	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB15	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB18	PLEASE COMPLETE THE ATTACHED OUT-OF-STATE PROVIDER DATA SHEET, F-11001, AND RESUBMIT.
PB20	A SIGNED AND DATED PRESCRIPTION IS REQUIRED WITHIN THREE MONTHS OF RECEIPT BY COLORADO MEDICAID FOR INITIAL REQUESTS AND WITHIN 12 MONTHS OF RECEIPT BY COLORADO MEDICAID FOR SUBSEQUENT REQUESTS.
PB21	PLEASE COMPLETE THE APPROPRIATE PRIOR AUTHORIZATION ATTACHMENT. CONTACT PROVIDER SERVICES OR THE PRIOR AUTHORIZATION UNIT FOR ASSISTANCE.
PB23	PHYSICAL THERAPY ASSISTANT NOTES AND ALL FORMS SUBMITTED MUST BE COSIGNED BY A REGISTERED PHYSICAL THERAPIST.
PB31	ARE YOU REQUESTING A COMPLETE APPLIANCE, OR REPLACEMENT PARTS?
PB32	THE PROCEDURE CODE INDICATED ON THE REQUEST DOES NOT MATCH THE DESCRIPTION OF SERVICE; PLEASE CORRECT AND RESUBMIT.

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PB35	THE SERVICE REQUESTED DOES NOT REQUIRE PRIOR AUTHORIZATION.
PB41	PLEASE FURNISH A CURRENT MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT, F-11090 (DATED WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID).
PB45	THE CERTIFICATION PERIOD ON THE PLAN OF CARE (POC) DOES NOT COVER THE REQUESTED GRANT/START DATE. PLEASE RESUBMIT YOUR REQUEST WITH A NEW POC.
PB49	A CERTIFIED OCCUPATIONAL THERAPY ASSISTANTS NOTES MUST BE COSIGNED BY AN OCCUPATIONAL THERAPIST REGISTERED.
PB51	ADDITIONAL INFORMATION IS REQUIRED ON PRIOR AUTHORIZATION TO ENABLE PRICING.
PB54	REQUESTED SERVICES DO NOT MATCH SERVICES ON THE PHYSICIANS ORDERS.
PB59	PLEASE PROVIDE AN INDIVIDUAL EDUCATIONAL PLAN (IEP), WHICH HAS BEEN SIGNED BY THE PROVIDER NO EARLIER THAN NINE MONTHS PRIOR TO RECEIPT AT COLORADO MEDICAID; OTHERWISE, DOCUMENT WHY NO IEP EXISTS.
PB65	PLEASE FURNISH THE ANTICIPATED TOTAL CHARGES FOR THIS REQUEST.
PB66	A PHOTOCOPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED; THE DATE MUST BE WITHIN SIX MONTHS OF RECEIPT BY COLORADO MEDICAID.
PB67	THE PRESCRIPTION DATE MUST INCLUDE MONTH, DAY, AND YEAR.
PB68	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID.
PB73	THE SERVICES IDENTIFIED ON THE PLAN OF CARE DO NOT APPEAR APPROPRIATE FOR THE PROCEDURE CODE(S) REQUESTED ON THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018.
PB74	THE CLIENT/PROVIDER DOES NOT HAVE RETROACTIVE ENROLLMENT.
PB75	THE REQUESTED START DATE IS MORE THAN 14 DAYS BEFORE OR 62 DAYS AFTER RECEIPT.
PB82	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
PB83	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A HOME HEALTH AIDE. PLEASE RESUBMIT AS A PERSONAL CARE WORKER OR PROVIDE ADDITIONAL DOCUMENTATION.
PB86	THE SERVICES REQUESTED ARE NOT BEING PROVIDED IN THE CLIENTS RESIDENCE. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL.
PB87	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A NURSE. PLEASE RESUBMIT AS A HOME HEALTH AIDE OR PROVIDE ADDITIONAL DOCUMENTATION.
PB92	PLEASE FURNISH THE CLIENTS COMPLETE ADDRESS.
PB94	IF THE CLIENT IS A RESIDENT OF A NURSING HOME, SUPPLY THE COMPLETE NAME AND ADDRESS OF THE NURSING HOME.
PB99	THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018, MUST BE SIGNED AND DATED.
PC01	PLEASE SUPPLY THE RENDERING PROVIDERS PROVIDER NUMBER.
PC03	THE DRUG ENFORCEMENT ADMINISTRATION NUMBER IS MISSING OR INVALID.
PC06	PLEASE DESCRIBE YOUR PROGRAM; INCLUDE ENTRY DATE, TERMINATION DATE, HOURS PER WEEK, AND NUMBER OF WEEKS OF PRIMARY INTENSIVE SERVICE REQUESTED.
PC07	PLEASE DESCRIBE YOUR "AFTERCARE/FOLLOW-UP" PLANS FOR THIS CLIENT.
PC08	PLEASE SUPPLY DOCUMENTATION OF PREVIOUS SUBSTANCE ABUSE SERVICES WITH DATE(S) AND OUTCOME.
PC09	PLEASE DESCRIBE IN DETAIL THE TREATMENT OBJECTIVES/GOALS FOR THIS CLIENT.
PC10	PLEASE DESCRIBE THE FAMILY SITUATION/DYNAMICS. EXPLAIN HOW THE FAMILY WILL BE INCORPORATED INTO THE CLIENTS PLAN OF CARE.
PC12	PLEASE EXPLAIN IF YOUR SERVICE ENCOURAGES THE CLIENT TO ATTEND SELF-HELP GROUPS.
PC13	PLEASE SUPPLY A SPECIFIC SCHEDULE OF ACTIVITIES, INCLUDING DAY, TIME OF DAY, LENGTH OF SESSION, AND SERVICE TO BE RENDERED DURING THAT TIME.
PC15	PLEASE FURNISH DIAGNOSTIC RATIONALE.
PC17	PLEASE DOCUMENT IF THE CLIENT EVER RECEIVED SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT.
PC19	PLEASE FURNISH MORE EXTENSIVE AND IN-DEPTH HISTORICAL AND PSYCHOSOCIAL DATA.
PC20	PLEASE SUPPLY THE DATE THE CLIENT BECAME TOTALLY ENDENTULOUS.
PC23	PLEASE SUBMIT A PHYSICIANS STATEMENT REGARDING THE MEDICAL NECESSITY OF DENTURES FOR THIS CLIENT. THE PHYSICIANS STATEMENT MUST DOCUMENT THE MEDICAL NEED FOR DENTURES.
PC24	THE SERVICE REQUESTED WAS PREVIOUSLY AUTHORIZED. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT INDICATING THIS FACT IS REQUIRED.

Denial Code	Long Description
PC25	PLEASE SUPPLY SUFFICIENT MITIGATING CIRCUMSTANCES TO WARRANT THE CONSTRUCTION OF NEW DENTURES(S).
PC26	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
PC28	PLEASE SUBMIT A PHYSICIANS STATEMENT INDICATING DENTURES ARE NECESSARY FOR THIS NURSING HOME CLIENT.
PC29	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING LOSS OR DESTRUCTION OF DENTURE(S). INCLUDE SIGNED STATEMENT FROM CLIENT OR FACILITY DIRECTOR REGARDING HOW, WHEN AND WHERE LOST.
PC30	PLEASE PROVIDE COMPLETE INTRAORAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PC31	PLEASE DESCRIBE ANY RELATED DEFORMITIES OF THE FEET.
PC34	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD WITH REQUESTED DME ITEM(S) AND DOCUMENT IF THE CLIENT CAN USE SAFELY AND INDEPENDENTLY.
PC35	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD AND DESCRIBE THE RESULTS AND EFFECTIVENESS OF THE SERVICE REQUESTED.
PC39	PLEASE INDICATE LITER FLOW PER MINUTE, HOURS OF USE PER 24 HOUR PERIOD, AND THE EXPECTED DURATION OF NEED.
PC40	THE ITEM DOES NOT REQUIRE PRIOR AUTHORIZATION UNTIL THE LIFE EXPECTANCY HAS BEEN REACHED.
PC41	PLEASE SUPPLY INFORMATION INDICATING THE NECESSITY OF POSITIONING THE CLIENT'S BODY IN MULTIPLE POSITIONS.
PC42	PLEASE INDICATE IF THE BED HEIGHT MUST BE CHANGED TO ALLOW FOR SAFE TRANSFER OR ADEQUATE BED CARE.
PC43	SUPPLY A PHYSICIANS STATEMENT INDICATING TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR UNIT HAS REDUCED PAIN, IMPROVED/INCREASED THE CLIENTS ACTIVITY LEVEL, AND/OR REDUCED CLIENTS USE OF PAIN MEDICATION.
PC44	A CURRENT AUTHORIZATION FOR THIS SERVICE IS ON FILE FOR ANOTHER PROVIDER. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT OF THAT FACT IS REQUIRED BY THE CLIENT OF FIRST PROVIDER.
PC59	DOCUMENT DECLINE OR PROGRESS IN SPECIFIC, MEASURABLE, OBJECTIVE TERMS.
PC60	DOCUMENT IF CLIENT HAS DEMONSTRATED A GOOD APPOINTMENT COMPLIANCE RECORD.
PC61	THE PHYSICIANS SIGNATURE DATE MUST NOT EXCEED 90 DAYS FROM THE DATE OF RECEIPT BY COLORADO MEDICAID.
PC62	REQUESTS FOR A CONTINUATION OF THERAPY SHOULD NOT BE SUBMITTED MORE THAN FOUR WEEKS PRIOR TO THE EXPIRATION DATE OF THE CURRENT AUTHORIZATION.
PC63	PLEASE FURNISH THE STYLE AND MANUFACTURER OF THE FRAME.
PC64	PLEASE FURNISH THE CLIENTS LENS FORMULA.
PC66	ALL REQUESTS FOR TINTS REQUIRE DOCUMENTATION OF THE VISUAL OR MEDICAL CONDITION RELATED TO PHOTOPHOBIA.
PC67	PLEASE DOCUMENT THE REASON AND JUSTIFICATION FOR REPLACEMENT BEYOND THE FIRST LENS/FRAME.
PC68	DOCUMENT IF ALL REMAINING MAXILLARY AND/OR MANDIBULAR TEETH ARE DECAY-FREE, PROPERLY RESTORED, AND PERIODONTICALLY SOUND.
PC72	SUPPLY MORE DETAIL REGARDING PROGRESS (ATTACHMENT OF GOALS, ETC.). CORRELATE PROGRESS TO PREVIOUS GOALS AND IDENTIFIED LIMITATIONS.
PC77	PLEASE SUBMIT A PLAN OF CARE DESCRIBING THE SERVICES THAT WOULD BE PROVIDED.
PC78	PLEASE DOCUMENT SPECIFIC, MEASURABLE GOALS.
PC82	THE PRIOR AUTHORIZATION (PA) SYSTEM CAN PROCESS ONLY 26 DETAILS PER PA REQUEST. PLEASE RESUBMIT YOUR REQUEST WITH NO MORE THAN 26 DETAILS.
PC83	PLEASE SUPPLY A PHYSICIANS PRESCRIPTION DATED WITHIN ONE MONTH OF REQUESTED SUBSTANCE ABUSE DAY TREATMENT.
PC84	PLEASE PROVIDE INFORMATION INDICATING THIS CLIENT IS APPROPRIATELY DETOXIFIED FROM ALCOHOL AND/OR OTHER DRUGS.
PC85	PLEASE PROVIDE INFORMATION TO INDICATE THE CLIENTS ABILITY TO ABSTAIN FROM ALCOHOL OR DRUGS WHILE IN THE SUBSTANCE ABUSE DAY TREATMENT PROGRAM.

Denial Code	Long Description
PC86	PLEASE INDICATE IF THIS CLIENT IS WILLING TO PARTICIPATE IN AFTERCARE OR CONTINUING CARE SERVICES.
PC87	PROVIDE MORE INFORMATION ON TREATMENT HISTORY; INCLUDE SERVICE PROVIDED, DATES, AND OUTCOME. PROVIDE DETAIL OF PREVIOUS TREATMENT.
PC88	PLEASE PROVIDE MORE RATIONALE FOR THE APPROPRIATENESS AND MEDICAL NECESSITY OF SUBSTANCE ABUSE DAY TREATMENT.
PC89	PROVIDE A TREATMENT PLAN THAT CONTAINS MEASURABLE GOALS AND OBJECTIVES CORRESPONDING TO THE IDENTIFIED DEFICIT.
PC91	PLEASE PROVIDE MORE INFORMATION ON FAMILY INVOLVEMENT TREATMENT.
PC92	PLEASE PROVIDE MORE HISTORY AND EXPLANATION ABOUT THE ISSUE OF ABSTINENCE FOR THIS CLIENT.
PC94	PLEASE PROVIDE THE ANTICIPATED BEGINNING DATE AND/OR THE ESTIMATED SUBSTANCE ABUSE DAY TREATMENT DISCHARGE DATE.
PC95	PLEASE SUPPLY JUSTIFICATION FOR BEGINNING CLIENT IN SERVICE PRIOR TO AUTHORIZATION BEING OBTAINED.
PC96	THE INITIAL THREE HOURS OF SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IN A CALENDAR YEAR DO NOT REQUIRE PRIOR AUTHORIZATION.
PC97	REIMBURSEMENT FOR INITIAL SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IS LIMITED TO THREE HOURS IN A CALENDAR YEAR AND DOES NOT REQUIRE PRIOR AUTHORIZATION.
PC98	THIS DRUG IS CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE BILL USING THE APPROPRIATE NATIONAL DRUG CODE (NDC) OR SUBMIT A COMPLETED DRUG ADDITION REQUEST FORM IF THE NDC IS NOT LISTED IN THE DRUG INDEX.
PC99	THIS DRUG IS NOT CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL, CURRENT ADMINISTRATIVE RULE, OR COLORADO DRUG INDEX FOR COVERAGE LIMITATIONS.
PD01	DOCUMENT THAT CLIENT HAS ACHIEVED GOOD ORAL HYGIENE, PERIODONTAL CASE TYPE 1 OR 2, AND IS MOTIVATED TO MAINTAIN SAME.
PD03	PLEASE PROVIDE AN ARTERIAL BLOOD GAS READING OR PULSE OXIMETRY RESULTS DONE ON ROOM AIR SIGNED AND DATED BY A MEDICAL DOCTOR. THIS SHOULD BE DONE WITHIN 60 DAYS OF REQUESTED SERVICE.
PD04	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 30 DAYS OF RECEIPT BY COLORADO MEDICAID.
PD07	SUBMIT A PHOTOCOPY OF A VALID PRESCRIPTION, ISSUED WITHIN THE PAST YEAR, OR COMPLETE SECTION B OF THE PRIOR AUTHORIZATION/DRUG ATTACHMENT (PA/DGA), F-11049.
PD10	BRAND MEDICALLY NECESSARY MUST BE IN THE PRESCRIBERS OWN HANDWRITING AND WRITTEN DIRECTLY ON THE PRESCRIPTION OR A SEPARATE ORDER ATTACHED TO THE ORIGINAL PRESCRIPTION.
PD12	COMPLETE DENTURES, PARTIAL DENTURES, DENTURE RELINES, AND FIXED PROSTHODONTIC SERVICES ARE NOT COVERED SERVICES FOR ADULTS FOR DATES OF SERVICE ON AND AFTER OCTOBER 1, 1995.
PD22	PLEASE COMPLETE ALL REQUIRED ELEMENTS ON THE PERSONAL CARE SCREENING TOOL (PCST), F-11133.
PD24	THIS PRIOR AUTHORIZATION REQUEST IS UNABLE TO BE PROCESSED. PLEASE RESUBMIT WITH ADDITIONAL REQUIRED FORMS, INCLUDING THE ENTIRE PERSONAL CARE SCREENING TOOL (PCST), F-11133; PERSONAL CARE ADDENDUM, F-11136; AND SUPPORTING DOCUMENTATION, AS DIRECTED.
PD25	THERE IS A PERSONAL CARE SCREENING TOOL (PCST), F-11133, COMPLETED BY ANOTHER AGENCY. CONTACT THE AGENCY TO TRANSFER SCREEN.
PD26	THERE IS A LIMITED TERM CARE FUNCTIONAL SCREEN (LTC-FS) COMPLETED BY ANOTHER AGENCY. THE PERSONAL CARE SCREENING TOOL (PCST), F-11133, INFORMATION IS IN CONFLICT WITH LTC-FS.
PD27	ONLY ONE LEVEL OF FUNCTION MAY BE SELECTED FOR ALL ELEMENTS EXCEPT TOILETING. COLORADO MEDICAID IS UNABLE TO PROCESS THE PRIOR AUTHORIZATION REQUEST.
PD28	NO UNITS MAY BE REQUESTED USING THIS PRIOR AUTHORIZATION PROCESS. PLEASE SUBMIT WITH THE APPROPRIATE ATTACHMENTS FOR REQUESTING SPECIFIC PERSONAL CARE WORKER UNITS.
PD29	CLIENT IS NOT ELIGIBLE FOR THE REQUESTED SERVICE(S) AS OF THE REQUESTED START DATE.
PD30	NO TRAVEL TIME MAY BE AUTHORIZED WHEN NO PERSONAL CARE WORKER SERVICE IS AUTHORIZED.
PD32	PROVIDER NOT CERTIFIED TO RENDER THE SERVICE(S) REQUESTED.

Denial Code	Long Description
PD34	BASED ON THE DOCUMENTATION SUBMITTED, THIS REQUEST CAN NOT BE PRIOR AUTHORIZED. REFER TO THE PA MESSAGES FROM THE CONSULTANT FOR COMPLETE EXPLANATION.
PD98	PLEASE DOCUMENT HOW AND WHEN EACH PREVIOUSLY AUTHORIZED PRO RE NATA VISIT WAS USED.

Post Eligibility Treatment of Income (PETI) Nursing Facility

Denial Code	Long Description
0201	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
0233	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0235	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0237	CLIENT IDENTIFICATION NUMBER DOES NOT MATCH CLIENTS FIRST NAME.
0238	THE CLIENT IDENTIFICATION NUMBER DOES NOT MATCH THE CLIENTS LAST NAME.
0242	SECONDARY DIAGNOSIS CODE IS INVALID.
0248	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0249	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0251	PROCEDURE CODE MODIFIER IN FIRST POSITION IS INVALID.
0252	THE PROCEDURE CODE MODIFIER IN SECOND POSITION IS INVALID FOR REQUESTED START DATE OR DATE OF RECEIPT.
0253	THE PROCEDURE CODE MODIFIER IN THIRD POSITION IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
0258	THE PRIMARY DIAGNOSIS CODE IS REQUIRED.
0272	THE PRIMARY DIAGNSOSIS CODE IS INVALID.
0400	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0853	HCPCS - ANNUAL UPDATE
0885	NEVER EVENTS MODIFIERS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
0886	NEVER EVENTS DIAGNOSIS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
1000	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
1002	RENDERING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1003	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1007	RENDERING PROVIDER ID IS NOT ON FILE.
1047	THE RENDERING PROVIDERS CERTIFICATION HAS BEEN CANCELLED.
1048	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1801	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
1804	A CERTIFIED SUBSTANCE ABUSE DAY TREATMENT PROVIDER MUST SUBMIT A SUBSTANCE ABUSE DAY TREATMENT PROCEDURE CODE.
1806	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
1808	THE BILLING PROVIDER DOES NOT HAVE THE REQUIRED CERTIFICATION ADDENDUM ON FILE.
1900	THE BILLING PROVIDERS TAXONOMY CODE IS INVALID.
1901	THE RENDERING PROVIDERS TAXONOMY CODE IS INVALID.
1927	A NATIONAL PROVIDER IDENTIFIER IS REQUIRED FOR THE BILLING PROVIDER.
1934	A NATIONAL PROVIDER INDENTIFIER IS REQUIRED FOR THE RENDERING PROVIDER.
1936	THE BILLING PROVIDER NUMBER IS INVALID.
1937	THE RENDERING PROVIDER NUMBER IS INVALID.
1960	INTERNAL PROCESSING IS REQUIRED.
1963	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.
1964	THE BILLING PROVIDER INDICATED IS NOT ALLOWABLE AS A BILLING PROVIDER.

Denial Code	Long Description
1965	RENDERING PROVIDER NUMBER IS MISSING/INVALID FOR THIS PROCEDURE PROVIDER.
1974	PRESCRIBING/REFERRING/ORDERING PROVIDER INDICATED IS NOT CERTIFIED AS A PRESCRIBING/REFERRING/ORDERING PROVIDER.
1975	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
1976	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
2001	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2003	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2017	THE CLIENT IS ENROLLED IN A MEDICAID OR OTHER MANAGED CARE PROGRAM.
2037	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2603	CLIENT LOCKED-IN TO A PROVIDER OR ENROLLED IN A HOSPICE. CONTACT CLIENTS HOSPICE FOR PAYMENT OF SERVICES OR RESUBMIT WITH DOCUMENTATION OF UNRELATED NATURE OF CARE.
3324	THE MODIFIER HAS BEEN DISCONTINUED BY THE CENTERS OF MEDICARE AND MEDICAID SERVICES OR THE AMERICAN MEDICAL ASSOCIATION FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
3337	THE PROCEDURE CODE HAS BEEN TERMINATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AMERICAN MEDICAL ASSOCIATION, OR AMERICAN DENTAL ASSOCIATION FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT. RESUBMIT WITH VALID A PROCEDURE CODE.
3339	THE PROCEDURE BILLED IS NOT PAYABLE ACCORDING TO DEFICIT REDUCTION ACT (DEFRA) GUIDELINES.
3351	THE PROCEDURE IS NOT COVERED FOR CLIENTS WITH A NURSING HOME AUTHORIZATION ON THE REQUESTED START DATE OR DATE OF RECEIPT.
3353	THE PROCEDURE IS NOT A COVERED SERVICE FOR HOME AND COMMUNITY-BASED WAIVER CLIENTS.
4021	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4027	THE DIAGNOSIS CODE IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
4031	THE PROCEDURE SUBMITTED IS NOT APPROPRIATE FOR CLIENTS GENDER.
4032	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4034	THE PROCEDURE CODE HAS AN AGE RESTRICTION.
4036	THE PLACE OF SERVICE CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4040	THE PRIMARY DIAGNOSIS CODE IS NOT ON FILE.
4041	THE SECONDARY DIAGNOSIS IS NOT ON FILE.
4046	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4127	INTERNAL PROCESSING IS REQUIRED.
4131	INTERNAL PROCESSING IS REQUIRED.
4141	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4149	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4150	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4236	ETIOLOGY DIAGNOSIS CODE(S) (E-CODES) ARE INVALID AS THE PRIMARY DIAGNOSIS.
4244	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4245	THE FOURTH POSITION MODIFIER IS INVALID FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT.
4256	THE PROCEDURE CODE AND MODIFIER COMBINATION IS NOT PAYABLE FOR THE CLIENTS BENEFIT PLAN.
4257	THE MODIFIERS SUBMITTED ARE EITHER INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT OR THE MODIFIERS ARE MISSING.
4311	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4315	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4316	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4371	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4372	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4711	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR CLIENTS AGE.
4714	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS AGE.
4731	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS DIAGNOSIS.
4742	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4743	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4744	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.

Denial Code	Long Description
4745	DIAGNOSIS AND/OR PROCEDURE AND/OR PLACE OF SERVICE (POS) CODE IS NOT COVERED FOR EXPRESS ENROLLMENT CLIENTS.
4746	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4801	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4802	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
4821	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
4871	PLEASE REFER TO PA MESSAGES FOR RETURN INFORMATION.
4963	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS GENDER.
4990	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
7500	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
7509	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
C001	This prior authorization was denied because the prior authorization form was not completed or the necessary attachment was not included.
C002	This prior authorization was denied because the client does not meet the criteria to receive a non-preferred product on the Colorado Medicaid Preferred Drug List.
C003	This prior authorization was denied because of a non-approved diagnosis. See Prior Authorization criteria (APPENDIX P) for approved diagnoses for this drug at http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1201542571132.
C004	This prior authorization was denied because the quantity limits have been exceeded. See Drug Limits for the allowable quantities for this medication at http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1201542571132.
C005	This prior authorization was denied because of the dosing schedule. See Prior Authorization criteria (APPENDIX P) for the approved dosing schedule for this drug at http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1201542571132.
C006	This prior authorization was denied because medications administered in a hospital, physician office or dialysis unit should be billed directly by those facilities as a medical item. These medications are not a pharmacy benefit under Colorado Medicaid.
C007	This prior authorization was denied because DESI drugs (medications determined not to be safe and effective by the FDA) and non-rebate able drugs (medications that have not signed a rebate agreement with the Centers for Medicare and Medicaid Services) are not a benefit of Colorado Medicaid.
C008	This prior authorization (PA) was denied because a pain evaluation was not submitted to the Prior Authorization Helpdesk with the PA form. Please fax a pain evaluation to the PA Helpdesk for reconsideration.
C009	This prior authorization was denied because the client has exceeded the 90 day lifetime benefit for smoking cessation products
C010	This prior authorization was denied because durable medical equipment (DME) and supplies are a medical benefit of Colorado Medicaid and need to be billed as a medical cl DME are not a pharmacy benefit.
C011	This prior authorization was denied because the client does not meet the criteria for approval. See Prior Authorization criteria (APPENDIX P) at http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1201542571132.
C01Z	This is not a final denial. Please do not submit an appeal request. The required Client State Id number is missing or invalid. Please resubmit PAR request with the corrected information to CFMC via FAX at: 303-790-4643.
C02Z	*INACTIVE* This is not a final denial. Please do not submit an appeal request. The required Client State Id number does not match the Client Name. Please resubmit PAR request with the corrected information to CFMC via FAX at: 303-790-4643.
C03Z	*INACTIVE* This is not a final denial. Please do not submit an appeal request. The required Client date of birth is missing or invalid. Please resubmit PAR request with the corrected information to CFMC via FAX at: 303-790-4643.
C04Z	*INACTIVE* This is not a final denial. Please do not submit an appeal request. The required Requesting Provider Number is missing or invalid. Please resubmit PAR request with the corrected information to CFMC via FAX at: 303-790-4643.

Denial Code	Long Description
C05Z	*INACTIVE* This is not a final denial. Please do not submit an appeal request. The required Billing Provider Number is missing or invalid. Please resubmit PAR request with the corrected information to CFMC via FAX at: 303-790-4643.
C100	The item or service requested is not a Medicaid benefit.
C101	*INACTIVE* DENIAL 1 The procedure is not a benefit of the Colorado Medicaid program.
C102	*INACTIVE* Denial 2 The procedure is not a benefit for children, recipients age birth through age 20.
C103	*INACTIVE* Denial 3 The procedure is not a benefit for adults, recipients age 21 and older.
C104	*INACTIVE* Denial 4 A report of the dental condition which supports the need for service was not submitted. ELECTRONIC PAR: 1. You can re-submit this PAR. 2. Click on the PROVIDER TAB during electronic dental prior authorization. 3. Describe the DENTAL CONDITION that supports the need for service. PAPER PAR: 1. You can re-submit this PAR. 2. On the ADA claim in area 32 "remarks for unusual services" 3. Describe the DENTAL CONDITION that supports the need for service.
C105	*INACTIVE* Denial 5 Report of dental condition/concurrent med condition which supports need not submitted. ELECTRONIC PAR 1. Re-submit PAR. 2. Click PROVIDER TAB during electronic dental PAR, 3. Describe DENTAL CONDITION supporting need for service. 4. Describe CONCURRENT MEDICAL CONDITION supporting need for service. PAPER PAR 1. You can re-submit this PAR. 2. On the ADA claim in area 32 "remarks for unusual services" 3. Describe DENTAL CONDITION supporting need for service. 4. Describe CONCURRENT MEDICAL CONDITION supporting need for service.
C106	*INACTIVE* Denial 6 The procedure code is not valid for the described procedure. ELECTRONIC AND PAPER PAR 1. You can re-submit this PAR. 2. Please refer to the DECEMBER 1998 Medicaid bulletin 3. See current codes and their descriptions. 4. You may submit ADA or Medicaid codes.
C107	*INACTIVE* Denial 07 The procedure code is not a benefit for this tooth number. ELECTRONIC AND PAPER 1. You can re-submit this PAR. 2. Please refer to the DECEMBER 1998 Medicaid bulletin 3. See procedure code tooth number limitations.
C108	*INACTIVE* Denial 8 The tooth surface designation submitted is not valid for this tooth number.
C109	*INACTIVE* Denial 9 The procedure is a duplicate service.
C110	*INACTIVE* Denial 10 Info required for PAR review not submitted. ELECTRONIC PAR 1. Re-submit this PAR. 2. Click on PROVIDER TAB during electronic dental PAR, 3. See the December 1998 Medicaid bulletin for this procedure code. 4. Briefly describe the information required as listed in the last column. PAPER PAR 1. You can resubmit this PAR. 2. On the ADA claim in area 32 " remarks for unusual services" 3. See the December 1998 Medicaid bulletin for the procedure code. 4. Briefly describe the information required as listed in the last column.
C111	*INACTIVE* Denial 11 Periodontal diag and class not submitted. ELECTRONIC PAR 1. Re-submit this PAR. 2. Click on PROVIDER TAB during electronic dental PAR, 3. Briefly describe PERIODONTAL DIAGNOSIS supporting need for service. 4. Write the PERIODONTAL CLASSIFICATION supporting need for service. PAPER PAR 1. Re-submit this PAR. 2. On the ADA claim in are 32 "remarks for unusual services" 3. Briefly describe PERIODONTAL DIAGNOSIS supporting need for service. 4. Write the PERIODONTAL CLASSIFICATION supporting need for service.
C112	*INACTIVE* Denial 12 The orthodontic diagnosis which supports the need for the procedure was not submitted. ELECTRONIC PAR 1. You can re-submit this PAR. 2. Click on the PROVIDER TAB during electronic dental prior authorization. 3. Describe the ORTHODONTIC DIAGNOSIS supporting need for service. PAPER PAR 1. You can re-submit this PAR. 2. On the ADA claim in area 32 "remarks for unusual services" 3. Describe the ORTHODONTIC DIAGNOSIS supporting need for service.
C113	*INACTIVE* Denial 13 The info submitted does not support need for procedure. ELECTRONIC PAR 1. Re-submit this PAR. 2. Click on PROVIDER TAB during electronic dental PAR. 3. Describe in more detail DENTAL CONDITION supporting need for service. 4. Describe in more detail CONCURRENT MEDICAL CONDITION supporting need for service. PAPER PAR 1. Re-submit PAR. 2. On ADA claim in 32 "remarks for unusual services" 3. Describe in more detail DENTAL CONDITION need for service. 4. Describe in more detail CONCURRENT MEDICAL CONDITION need for service.
C114	*INACTIVE* Denial 14 Submitted information does not support a favorable prognosis.
C115	*INACTIVE* Denial 15 The "TMJ Pre-surgical evaluation form" for primary surgeon was not submitted. PAPER PAR 1. You can re-submit this PAR. 2. This prior authorization must be submitted on paper. 3. We need the ADA claim form and TMJ Pre-surgical evaluation form. 4. Contact ACS at 534-0109, ext 724 request a copy of the TMJ Pre-surgical evaluation form. 5. This is the only attachment in addition to the ADA claim form which is required for review.

Denial Code	Long Description
C116	*INACTIVE* 16 PAR cannot be approved after the service has been started.
C117	Client ID is missing or invalid. Please resubmit with a correct client ID.
C120	*INACTIVE* The PAR that you sent directly to ACS is being denied. Please send this PAR to the authorizing agent: CFMC, P.O. Box 17300, Denver, CO 80217. Upon approval, CFMC will forward the PAR to ACS for PAR entry.
C121	*INACTIVE* The item or service requested is not a Medicaid Home Health benefit.
C122	*INACTIVE* The item or service requested is available under other Colorado Medicaid benefits for which the client is eligible. (eg. Private Duty Nursing, HCBS Personal Care, School Health and Related Services, outpatient therapy)
C123	*INACTIVE* The information submitted does not support the need for the services requested, you may re-submit the PAR describing in more detail current medical conditions supporting the need for services.
C124	*INACTIVE* The requested information has not been submitted. You may submit a new PAR with the requested information-Home Health plan of care and/or therapy assessments, current clinical summary.
C125	*INACTIVE* The requested information has not been submitted. You may submit a new PAR with the requested information-Written documentation of the results of the EPSDT medical screening, or other equivalent examination results provided by the client's third-party insurance.
C126	*INACTIVE* This service does not require prior authorization. Submit charges on the appropriate claim form.
C127	*INACTIVE* The revenue code is already authorized for this client, this provider, this date span. Please bill using the information on the original PAR, or submit a new PAR for revision to increase services.
C128	*INACTIVE* The clinical information does not substantiate medical necessity.
C129	*INACTIVE* The information submitted is insufficient. Completion of the prior authorization request information is required to review this Prior Authorization.
C130	*INACTIVE* The agency is not a Medicaid Provider.
C131	*INACTIVE* No services shall be approved for dates of service prior to the date of receipt of the complete prior authorization request by the State or its agent.
C132	*INACTIVE* Extended Home Health Aide visits requested without submitting sufficient information about services on each visit.
C133	*INACTIVE* Therapy services requested are not included in the plan of care, which does not list the specific procedures and modalities to be used nor the amount, duration, and frequency.
C134	*INACTIVE* Detailed information on each planned Home Health visit, including the times in and out, all tasks to be performed on each visit, and the place of service for each service is not included on the prior authorization request.
C135	Nursing visits solely for psychiatric counseling are not reimbursable.
C136	*INACTIVE* Any visit made solely for supervision of the Home Health Aide shall not be reimbursed.
C151	*INACTIVE* This item or service requested is not a Home and Community Based Services-Brain Injury program/ Medicaid benefit.
C152	*INACTIVE* The requested clinical information does not substantiate how the device or service will result in enhancement of the clients ability to perform activities of daily living, or to perceive, control or communicate with the environment in which they live.
C153	Item is not of direct medical or remedial benefit to the client.
C154	This item is primarily for a vocational or education application. Funding must first be pursued through the Division of Vocational Rehabilitation/Dept. of Education.
C155	Home modification request/environmental modification does not contain supporting documentation, which substantiates the necessity of the modification.
C156	*INACTIVE* The requested modification is not a direct medical or remedial benefit to the client.
C157	*INACTIVE* The Prior Authorization Request does not contain the required documentation of an Occupational Therapist or Physical Therapist in home assessment.
C158	Home modification request is not reasonable in cost when compared to usual and customary charges.
C159	*INACTIVE* Non-medical transportation request does not provide transportation for services, which prevent institutionalization.
C160	Transitional living prior authorization was requested for a client who does not meet the definition of "in need" according to 10 C.C.R. 2505-10, Sec. 8.516.30.B.2-3.
C161	Prior authorization period exceeds benefit defined in 10 C.C.R. 2505-10, sec.8.516.30.C.5.

Denial Code	Long Description
C162	Prior authorization period exceeds benefit defined in 10 C.C.R. 2505-10, sec.8.516.30.C.5.
C163	The prior authorization request must include: a medical prescription, the name and Medicaid identification number of the client, the clinic name, business address, phone number, and Medicaid provider number, the referring physician name, business address, phone number, the rendering therapist name, provider number, business address, and phone number, Billing Provider information, a service plan for the client, Physical therapy history (including home health program involvement). Medicaid Bulletin B0200140.
C164	The prior authorization request is not needed. The original prior authorization is still in effect. Medicaid Bulletin B0200139.
C165	The service requested for this client is covered under another program (i.e., Home Health or Hospital Services, DME, etc.).
C166	Therapy services for this client have been authorized to a different provider. Medicaid Bulletin B0200139.
C167	*INACTIVE* Category of Handicapping Malocclusion not checked.
C168	Procedure does not require Prior Authorization approval for this client.
C169	Outpatient individual and individual brief counseling visits are limited to 35 visits per state fiscal year.
C170	Documentation supporting medical necessity is not sufficient.
C171	The Prior authorization request shall include: * a medical prescription, * client name and Medicaid identification * clinic name, business address, phone number and Medicaid provider number, * the rendering therapist name, provider number, business address and phone number, * billing provider information, * a service plan for the client, * mental health history (including the Mental Health Capitation Program (MHASA) or Home Health Program Involvement).
C172	Service requested for this client is covered under another program (i.e. 10 C.C.R. 2505-10, section 8.212 Mental Health Capitation Program).
C173	Mental Health visits for this client have been authorized to a different provider.
C174	This client is exempted from prefabricated crown services if the client was scheduled for hospitalization for dental services before May 13, 2004.
C175	Procedure does not require a prior authorization.
C176	*INACTIVE* The PAR that you sent directly to ACS is being denied. Please send this PAR to the authorizing agent: CFMC, Attention Medicaid/DME PARS, 23 Inverness Way East, Suite 100, Englewood, CO 80112-5708.
C177	*INACTIVE* The PAR that you sent directly to ACS is being denied. Please send this PAR to the authorizing agent: CFMC, Attention Medicaid/DME PARs, to the fax server number at 303 695-3377.
C190	Item or service requested is not a benefit of the Home and Community Based Services Persons with Brain Injury Waiver.
C191	Alternative funding for modification has not been considered.
C192	Modification did not include two bids.
C193	Cost of modification exceeds lifetime cap.
C194	Requested clinical information does not substantiate how the device or service will result in enhancement of the client's ability to perform activities of daily living, or to perceive, control or communicate within the clients environment.
C195	Modification is not a direct medical or remedial benefit to the client.
C196	Documentation was not provided from an Occupational Therapist or Physical Therapist.
C197	Request for non-medical transportation request is not required by care plan to prevent institutionalization.
C200	The Diagnosis/clinical information does not substantiate medical necessity.
C201	*INACTIVE* Client has not utilized the equipment in the manner for which it was intended. Repairs and/or replacement of equipment will not be allowed in cases of repeated misuse.
C202	*INACTIVE* This product cannot be approved as its primary purpose is to either enhance the personal comfort of the client or provide Convenience for the client caregiver.
C203	*INACTIVE* The information submitted does not meet the Colorado Medicaid Program guidelines for medical necessity.
C204	*INACTIVE* This product has been provided in the recent past. Please submit additional information documenting the reason for its being requested once again.
C205	*INACTIVE* This request is for a WHEELCHAIR. The Colorado Medicaid Program has provided a similar product within the last few years. It is Medicaid policy that the original wheelchair should be utilized for a minimum of 5 years. Please submit additional information documenting the need for a new wheelchair at this point in time.

Denial Code	Long Description
C206	*INACTIVE* It is the responsibility of the provider to service, repair and supply necessary parts for any Durable Medical Equipment product covered by a warranty during the warranty period. No replacement parts or repairs will be reimbursed by Colorado Medicaid during the warranty period.
C207	*INACTIVE* This product would more appropriately be provided on a rental basis.
C208	*INACTIVE* This product intended usage is for exercise. Colorado Medicaid does not cover products that are prescribed primarily for exercise.
C209	*INACTIVE* This product has been requested for a client who is currently residing in a nursing facility or hospital setting. Therefore, it will not be reimbursed through the Durable Medical Equipment program of Colorado Medicaid. It is the responsibility of the facility to provide this product.
C210	*INACTIVE* Please resubmit on paper. Prior Authorization Requests (PARS) must be submitted on paper for the following items: Electric Wheelchairs, Scooters, Orthotics and Prosthetics, Augmentative Communication Devices. Medicaid Bulletin B9900014, May 1999, Front Page Send paper PARS for these items directly to: CFMC, Attention: Medicaid/DME PARS, PO Box 17300, Denver, Colorado 80217 - 0300
C211	*INACTIVE* This product is not a benefit of the Durable Medical Equipment program. However, it may be covered under one of the Department waiver programs
C212	*INACTIVE* The information submitted does not support the need for the equipment requested. You may re-submit the Prior Authorization Request describing in more detail the current medical conditions that support the need for the equipment.
C213	*INACTIVE* The information submitted does not support the need for the medical supplies requested. You may re-submit the Prior Authorization Request describing in more detail the current medical conditions that support the need for the supplies.
C214	*INACTIVE* The requested information has not been submitted.
C215	*INACTIVE* The requested additional information is insufficient. Completion of the requested information is required to review this Prior Authorization Request.
C216	*INACTIVE* This product does not require prior authorization. Submit charges on the appropriate claim form.
C217	*INACTIVE* Serial number is required for all repairs. Please resubmit Prior Authorization Request with the serial number. Medicaid Bulletin B0100089, January 2001, Page 3
C218	*INACTIVE* Please send invoiced acquisition cost for this item.
C219	*INACTIVE* Following info needed to review request for SPECIALIZED BED. 1. Hours a day client in bed? 2. What bed does client have now? 3. Why does current bed not meet needs? 3. Other alternatives tried? 4. Can client work controls, change positions independently? 5. Does client have caregiver assistant? 6. Medical necessity semi-electric or total electric bed will meet? 7. Explain why manual hospital bed will not meet needs. Submit letter with info requested and return to ACS, PARS Unit, P.O. Box 30, Denver, Colorado 80201-0030.
C220	*INACTIVE* WHEELCHAIR purchases must have the manufacturer, brand name, model name and serial number. Medicaid Bulletin B0100089, January 2001, Page 3. Please submit this letter with the information requested and return to ACS, PARS Unit, P.O. Box 30, Denver, Colorado 80201-0030.
C221	*INACTIVE* Following info needed to review request for SEAT LIFT. 1. Does client have severe hip arthritis/knee or severe neuromuscular disease? 2. Is seat lift mechanism part of physician course of treatment and prescribed to effect improvement or arrest or retard deterioration in patient condition? 3. Is client completely incapable of standing from any chair in home? 4. Once standing, can client ambulate independently? Submit this letter with info requested and return to ACS, PARS Unit, P.O. Box 30, Denver, Colorado 80201-0030.
C222	*INACTIVE* Info needed to review request for PATIENT LIFT. 1. Does transfer between bed, chair, wheelchair or commode require assistance of more than one person? 2. Without use of lift will client be confined to bed? 3. Other alternatives tried? 4. How long will client require use of lift? 5. Provide info about physical dimensions of home environment that should be taken into consideration. 10 C.C.R. 2505-10, Sec. 8.593.02 (A) - (G). Submit this letter with info requested and return to ACS, PARS Unit, P.O. Box 30, Denver, Colorado 80201-0030
C223	*INACTIVE* Info needed to review request for ELECTRIC/POWER LIFT. 1. Identify spasticity of patient. 2. How lift allow approp position of patient with one caregiver? 3. Caregiver need for proximity or physical contact during transfer for safety reasons. 4. Desc how lift will provide safe method of transfer for caregivers with restrictions/dysfunctions. 5. Info about physical dimensions of home environ. 10 C.C.R. 2505-10, Sec. 8.593.02 (A) - (G). Submit letter with info requested to ACS, PARS Unit, P.O. Box 30, Denver, Colorado 80201-0030.

Denial Code	Long Description
C224	*INACTIVE* The following information is needed to review this request for the MATTRESS. 1. Does the client have a history of skin breakdown or currently have skin breakdown? Please explain? 2. What other alternatives have been tried? 3. What is the length of necessity of the mattress? 10 C.C.R. 2505-10, Sec. 8.593.02 (A) - (G). Please submit this letter with the information requested and return to ACS, PARS Unit, P.O. Box 30, Denver, Colorado 80201-0030.
C225	*INACTIVE* The following information is needed to review this request for the BLOOD PRESSURE MONITOR. 1. Please send the latest three blood pressure readings, the dates of the readings, medication and how frequently the blood pressure needs to be monitored. 2. If ordering an automatic monitor, please explain why a manual monitor will not meet the client needs. 10 C.C.R. 2505-10, Sec. 8.593.02 (A) - (G). Please submit this letter with the information requested and return to ACS, PARS Unit, P.O. Box 30, Denver, Colorado 80201-0030.
C226	*INACTIVE* The following information is needed to review this request for the FORMULA. Please provide the brand name being requested and the number of calories required per day from the formula. Specialty Provider Manual, Supply/DME, Page 2. Please submit this letter with the information requested and return to ACS, PARS Unit, P.O. Box 30, Denver, Colorado 80201-0030.
C227	*INACTIVE* Prior Authorization does not indicate a physician signature. A physician signature is required.
C228	*INACTIVE* Info is needed: 1. During trial period, did TENS: A. Produce no relief? B. Produce greater discomfort? C. Alleviate pain? 2. List pain med/dosage prior to treatment? 3. Was pain med/dosage reduced after application? 4. Degree of mobility prior to treatment? 5. Did degree of mobility improve? 6. Did patient derive significant therapeutic benefit? 7. Does patient own TENS unit or owned/used TENS unit in past? 8. Alternative treatments and/or clinical results. A. Traction B. Trigger point injections C. Surgery D. Drugs.
C229	*INACTIVE* Prior Authorization Requests must be submitted on paper for the following items: electric wheelchairs, scooters, orthotics and prosthetics, augmentative communication devices. Please send the Prior Authorization Request for these items directly to CFMC, Attention Medicaid/DME PARs, 23 Inverness Way East, Suite 100, Englewood, CO 80112-5708.
C230	*INACTIVE* This product is not a benefit of the Durable Medical Equipment program.
C231	*INACTIVE* The information submitted does not support the need for the equipment requested. You may re-submit the Prior Authorization Request describing in more detail the current medical conditions that support the need for the equipment.
C232	*INACTIVE* The information submitted does not support the need for the medical supplies or equipment requested. You may resubmit the Prior Authorization Request describing in more detail the current medical conditions that support the need for the supplies.
C233	*INACTIVE* This product does not require prior authorization. Submit charges on the appropriate claim form.
C234	*INACTIVE* Serial number is required for all repairs. Please resubmit Prior Authorization Request with the serial number. Medicaid Bulletin B0100089, January 2001, Page 3.
C235	*INACTIVE* Hospital Bed Questionnaire #1 is needed to review this request. Please submit this letter with the information requested.
C236	*INACTIVE* Wheelchair purchases must have the manufacturer, brand name and model name. Please submit this letter with the information requested.
C237	*INACTIVE* Seat Lift Questionnaire #4 is needed to review this request. Please submit this letter with the information requested.
C238	*INACTIVE* Patient Lift Questionnaire #3 is needed to review this request. Please submit this letter with the information requested.
C239	*INACTIVE* Electric/Power Lift Questionnaire #3 is needed to review this request. Please submit this letter with the information requested.
C240	*INACTIVE* Pressure Relief Mattress Questionnaire #2 is needed to review this request. Please submit this letter with the information requested.
C241	*INACTIVE* Blood Pressure Unit/Monitor Questionnaire #5 is needed to review this request. Please submit this letter with the information requested.
C242	*INACTIVE* Oral and Enteral Nutrition Formula Questionnaire #10 (with particular attention to the number of calories per day) is needed to review this request. Please submit this letter with the information requested.
C243	*INACTIVE* The Prior Authorization Request does not indicate a physician signature. A physician signature is required.
C244	*INACTIVE* TENS or NMES Questionnaire #9 is needed to review this request. Please submit this letter with the information requested.

Denial Code	Long Description
C245	*INACTIVE* Service previously authorized to this provider or another provider. The procedure code is already authorized for this client, this date span.
C246	*INACTIVE* Service previously authorized to this provider. The procedure code is already authorized for this client, this provider, and this date span. Please bill using the information on the original PAR.
C247	*INACTIVE* Services authorized to another provider.
C248	*INACTIVE* Please send product information on this item.
C249	*INACTIVE* A serial number is required for all repairs. Please resubmit PAR with the serial number.
C250	*INACTIVE* The dates entered either on the Header or Detail lines are invalid. Please review the dates and submit a new Prior Authorization Request with valid dates, including correct dates.
C251	This individual is not a Medicaid-eligible individual under age 21.
C252	The item or service requested is not a Medicaid benefit.
C253	The requested information has not been submitted. You may submit a new Prior Authorization Request with the requested information-Early and Periodic Screening, Diagnosis and Treatment screen and additional documentation indicating medical necessity.
C254	The information submitted does not support the medical need for the services requested, you may re-submit the Prior Authorization Request describing in more detail current medical necessity supporting the need for services.
C255	The clinical information does not substantiate medical necessity.
C256	*INACTIVE* This agency/individual is not a Medicaid Provider.
C257	*INACTIVE* This audiological service is not a benefit of the Health Care Program for Children with Special Needs.
C258	*INACTIVE* This audiological service is not a benefit of the Health Care Program for Children with Special Needs.
C259	This vision service was not provided by an ophthalmologist, optometrist or optician.
C260	These eyeglasses were not ordered by an ophthalmologist or an optometrist.
C261	These eyeglasses were not dispensed by an optician.
C262	There is no prior authorization for these orthoptic vision treatment services.
C263	There is no prior authorization for these contact lenses.
C264	Service previously authorized to this provider. The procedure code is already authorized for this client, this provider, this date span. Please bill using the information on the original PAR.
C265	Services authorized to another provider.
C266	The dates entered either on the Header or Detail lines are invalid. Please review the dates and submit a new Prior Authorization Request with valid dates.
C271	Client is not eligible for all or part of the dates covered in this prior authorization. Verify eligibility prior to performing services.
C290	Modification did not include two bids.
C291	Request for non-medical transportation is not required by care plan to prevent institutionalization.
C292	Item or service requested is not a benefit of the Home and Community Based Services for the Elderly, Blind, and Disabled Waiver.
C315	*INACTIVE* Info needed to complete PAR review: 1. During trial period did TENS: A. Produce no relief? B. Produce greater discomfort? C. Significantly alleviate pain? 2. Was patient on pain med before treatment? List med/dosage. 3. Was med/dosage reduced? 4. Degree of mobility prior to treatment? 5. Did mobility improve? 6. Do therapeutic benefits warrant continued use? 7. Does patient own or owned/used TENS unit? 8. Appropriateness of alternative treatments and/or the clinical results. A. Traction B. Trigger point injections C. Surgery D. Drugs
C316	*INACTIVE* The procedure code requested has been changed. Please note the new procedure code.
C317	*INACTIVE* Please review the dates and submit a new PAR with valid dates, including correct year. The dates entered either on the header or detail lines are invalid.
C318	*INACTIVE* Please provide the Medicaid Provider ID number of the Pharmacy or DME Supply company supplying the requested items
C351	*INACTIVE* The item or service requested is not a Medicaid Home Health benefit.
C352	The information submitted does not support the need for the services requested, you may re-submit the PAR describing in more detail current medical conditions supporting the need for services.
C353	*INACTIVE* The requested information has not been submitted. You may submit a new PAR with the requested information-Home Health plan of care and/or therapy assessments, current clinical summary.

Denial Code	Long Description
C354	*INACTIVE* This service does not require prior authorization. Submit charges on the appropriate claim form (Acute Home Health or Long Term Home Health with Acute Episode).
C355	*INACTIVE* The revenue code is already authorized for this client, this provider, this date span. Please bill using the information on the original PAR, or submit a new PAR for revision to increase services.
C356	*INACTIVE* The PAR that you sent directly to ACS is being denied. Please send this PAR to the authorizing agent: Single Entry Point Agency in county of client residence.
C357	*INACTIVE* The clinical information does not substantiate medical necessity.
C358	*INACTIVE* The requested additional information is insufficient. Completion of the requested information is required to review this Prior Authorization.
C359	*INACTIVE* The agency is not a Medicaid Provider.
C360	*INACTIVE* Nursing visits solely for the purpose of assess and teach are not billable in this case.
C361	Nursing visits are unreasonable in amount, frequency, or duration.
C362	*INACTIVE* Home health Aide units are requested, no skilled tasks are identified.
C363	*INACTIVE* Health Aide visits are not medically necessary.
C364	*INACTIVE* Home Health services shall be provided at the client place of residence except for EPSDT extraordinary HH which is prior authorized using a different process and form.
C365	*INACTIVE* The client is 18 years old or over and skilled therapies are not a benefit under Long Term Home Health.
C366	*INACTIVE* Extended Home Health Aide visits requested without submitting sufficient information about services on each visit.
C367	*INACTIVE* Documentation to support PRN visits has not been submitted.
C368	*INACTIVE* Written instructions from the therapist or other medical professional are required to support the need for ROM when it is the only skilled service performed by a Home Health Aide.
C369	*INACTIVE* Medication set-up by a nurse is the only reason for visits and documentation that the pharmacy was contacted is missing.
C370	*INACTIVE* Documentation does not support the need for two Home Health Aides at the same time for a two-person transfer.
C371	*INACTIVE* Client PAR is sent to the wrong authorizing agent, EPSDT HH, PDN, and Outpatient Therapy should be submitted to CFMC at PO Box 17300, Denver, CO, 80217.
C372	*INACTIVE* Based on the needs of the client, authorization is being given for a lesser amount of services than requested.
C373	*INACTIVE* PAR form has been submitted later than 10 days from the HCFA-485 "from" date. PAR dates have been adjusted.
C374	*INACTIVE* Revisions for increases in services shall be submitted and processed according to the same requirements as for new PARs, with a current written assessment/physician orders pertaining to the increase.
C377	*INACTIVE* Nursing visits solely for foot care shall be reimbursed only if the client has a documented diagnosis that supports the need for a nurse, and the client or family caregiver is not able or willing to provide the foot care.
C378	To be eligible for Long Term Home Health services, as set forth at Section 8.523.11K, Medicaid clients 18 years and over shall meet the level of care screening guidelines for Long Term Care Services at Section 10CCR 2505-10/8.401; 10CCR 2505-10/8.522.10.
C379	*INACTIVE* The PAR that you sent directly to the SEP is being denied. Please send this PAR to the authorizing agent: ACS.
C380	*INACTIVE* Client PAR is sent to the wrong authorizing agent, EPSDT HH, or Outpatient Therapy should be submitted to CFMC.
C381	*INACTIVE* Based on the needs of the client, authorization is being given for a lesser amount of services than requested.
C382	*INACTIVE* Any visit made solely for supervision of the Home Health Aide shall not be reimbursed.
C383	*INACTIVE* The requested information has not been submitted. You may submit a new PAR with the requested information-Home Health plan of care and/or therapy assessments, current clinical summary.
C384	*INACTIVE* Client PAR is sent to the wrong authorizing agent, Private Duty Nursing PARs and application paperwork should be submitted do DDM Ascend via fax to 877-431-9568.

Denial Code	Long Description
C385	*INACTIVE* Improper billing may result from visits that are unreasonable in amount, frequency and duration or visits performed when skilled tasks performed are not medically necessary.
C386	*INACTIVE* Service previously authorized to this provider. The procedure code is already authorized for this client, this provider, this date span. Please bill using the information on the original PAR.
C387	*INACTIVE* Services authorized to another provider.
C390	*INACTIVE* Extended Home Health Aide visits requested without submitting sufficient information about services on each visit.
C391	*INACTIVE* Client PAR is sent to the wrong authorizing agent, EPSDT HH, and Outpatient Therapy should be submitted to CFMC.
C392	*INACTIVE* Based on the needs of the client, authorization is being given for a lesser amount of services than requested.
C393	*INACTIVE* PAR form has been submitted later than 10 days from the PAR start date. PAR units have been adjusted.
C394	*INACTIVE* The requested information has not been submitted. You may submit a new PAR with the requested information-Home Health plan of care and/or therapy assessments, current clinical summary.
C395	*INACTIVE* The PAR that you sent directly to ACS is being denied. Please send this PAR to the authorizing agent: Single Entry Point Agency in county of client residence.
C396	*INACTIVE* Service previously authorized to this provider. The procedure code is already authorized for this client, this provider, this date span. Please bill using the information on the original PAR.
C397	The dates entered either on the Header or Detail lines are invalid. Please review the dates and submit a new Prior Authorization Request with valid dates.
C400	The requested information has not been submitted. You may submit a new PAR with the requested information.
C401	*INACTIVE* The service is not a benefit of the Colorado Medicaid medical transportation program. 10 C.C.R. 2505-10, Sec. 8.680-8.691 OTHER HEALTH SERVICES - TRANSPORTATION (As of February 1, 2002, the citations will be: 10 C.C.R. 2505-10, Sec. 8.680-8.688 NON-EMERGENT MEDICAL TRANSPORTATION
C402	Transportation to medical treatment located on or at military facilities is excluded from the Colorado Medicaid medical transportation program. (As of February 1, 2002, the citation will be: 10 C.C.R. 2505-10, Sec. 8.682 BENEFITS/EXCLUSIONS.)
C403	Transportation to medical treatment to providers not enrolled in the Medicaid program when Medicaid is the primary payer is excluded from the Colorado Medicaid medical transportation program. (As of February 1, 2002, the citation will be: 10 C.C.R. 2505-10, Sec. 8.682 BENEFITS/EXCLUSIONS.)
C404	Transportation to medical treatment to providers not enrolled in the Medicaid program when Medicaid is the primary payer is excluded from the Colorado Medicaid medical transportation program. (As of February 1, 2002, the citation will be: 10 C.C.R. 2505-10, Sec. 8.682 BENEFITS/EXCLUSIONS.)
C405	Transportation to pick up or deliver prescriptions, medical supplies, or durable medical equipment is excluded from the Colorado Medicaid medical transportation program. (As of February 1, 2002, the citation will be: 10 C.C.R. 2505-10, Sec. 8.682 BENEFITS/EXCLUSIONS.)
C406	Transportation for nursing facility or group home residents to any medical or rehabilitative services required to be part of the facility program by Federal or State law is excluded from the Colorado Medicaid medical transportation program. (As of February 1, 2002, the citation will be: 10 C.C.R. 2505-10, Sec. 8.682 BENEFITS/EXCLUSIONS.)
C407	Charges when the client is not in the vehicle is excluded from the Colorado Medicaid medical transportation program. (As of February 1, 2002, the citation will be: 10 C.C.R. 2505-10, Sec. 8.682 BENEFITS/EXCLUSIONS.)
C408	Transportation to court-ordered medical services that are not a benefit of Medicaid is excluded from the Colorado Medicaid medical transportation program. (As of February 1, 2002, the citation will be: 10 C.C.R. 2505-10, Sec. 8.682 BENEFITS/EXCLUSIONS.)
C409	Meals and lodging expenses when travel to and from a non-emergent medically necessary covered service can reasonably be completed in one calendar day is excluded from the Colorado Medicaid medical transportation program. (As of February 1, 2002, the citation will be: 10 C.C.R. 2505-10, Sec. 8.682 BENEFITS/EXCLUSIONS.)
C410	Reimbursement for travel expenses of an escort when the travel is not expected to extend beyond one calendar day is excluded from the Colorado Medicaid medical transportation program. (As of February 1, 2002, the citation will be: 10 C.C.R. 2505-10, Sec. 8.682 BENEFITS/EXCLUSIONS.)

Denial Code	Long Description
C411	The required documentation was not submitted for authorization of out-of-state medical transportation. (As of February 1, 2002, the citation will be: 10 C.C.R. 2505-10, Sec. 8.686 OUT-OF-STATE TRANSPORTATION AUTHORIZATIONS.)
C412	The required documentation was not submitted for authorization of commercial airline or train transportation. (As of February 1, 2002, the citation will be: 10 C.C.R. 2505-10, Sec. 8.685.07 PRIOR AUTHORIZATION REQUIREMENTS/PROCEDURES, COMMERCIAL AIRLINE OR TRAIN.)
C413	The required documentation was not submitted for authorization of ambulance and air ambulance transportation. (As of February 1, 2002, the citation will be: 10 C.C.R. 2505-10, Sec. 8.685.08 PRIOR AUTHORIZATION REQUIREMENTS/PROCEDURES, AMBULANCE AND AIR AMBULANCE.)
C414	The required documentation was not submitted for authorization of ancillary services related to medical transportation. (As of February 1, 2002, the citation will be: 10 C.C.R. 2505-10, Sec. 8.685.09 PRIOR AUTHORIZATION REQUIREMENTS/PROCEDURES, ANCILLARY SERVICES.)
C415	Services authorized to another provider.
C420	Request for non-medical transportation is not required by care plan to prevent institutionalization.
C421	Item or service requested is not a benefit of the Home and Community Based Services for Persons Living with AIDS Waiver.
C430	Modification is not to prevent institutionalization of the client.
C431	Alternative funding for modification has not been considered.
C432	Modification did not include two bids.
C433	Amount of Modification exceeds cost containment.
C434	Cost of modification exceeds lifetime cap.
C435	Request for non-medical transportation is not required by care plan to prevent institutionalization.
C436	Item or service requested is not a benefit of the Home and Community Based Services for Persons with Mental Illness Waiver.
C437	Modification does not give client greater independence.
C438	Modification does not ensure the health safety and welfare of the client.
C439	Modification is not a direct medical or remedial benefit to the client.
C440	Modification duplicates an existing adaptation.
C441	Modification is part of new construction.
C442	Documentation was not provided from an Occupational Therapist or Physical Therapist.
C443	Modification includes purchase cost of durable medical equipment.
C444	Modification requested is not the most cost effective solution.
C445	The dates entered either on the Header or Detail lines are invalid. Please review the dates and submit a new Prior Authorization Request with valid dates.
C451	Provider is not active for all or part of the dates on this Prior Authorization Request. Please verify provider number.
C452	The information submitted does not support the need for the services requested, you may re-submit the PAR describing in more detail current medical conditions supporting the need for services.
C453	The requested information has not been submitted. You may submit a new PAR with the requested information-nursing assessment, plan of care and/or therapy assessments, current clinical summary.
C454	The revenue code is already authorized for this client, this provider, this date span. Please bill using the information on the original PAR, or submit a new PAR for revision to increase or decrease services.
C455	The clinical information does not substantiate medical necessity.
C456	The requested additional information is insufficient. Completion of the requested information is required to review this Prior Authorization.
C457	The agency is not a Medicaid Provider.
C458	PDN PARs shall include only Private Duty Nursing RN or LPN services. Other services are included on this PAR.
C459	Based on the needs of the client, authorization is being given for a lesser amount of services than requested.
C460	Revisions for increases in services shall be submitted and processed according to the same requirements as for new PARs, with a current written assessment/physician orders pertaining to the increase.
C461	Services total more than twenty-four (24) hours per day.
C462	No services shall be approved for dates of service before the date that the completed PAR is received.

Denial Code	Long Description
C463	Services requested are duplicative of care that is being reimbursed under another benefit or funding source, including but not limited to home health, other insurance, or medical foster care.
C464	*INACTIVE* Services requested are beyond the 20 hour per day benefit limitation as a result of an EPSDT medical screening however the correct documentation has not been received. (the EPSDT claim form does not meet this requirement.)
C465	*INACTIVE* A PAR shall cover a period of no longer than six (6) months.
C466	The plan of care you submitted with your PDN PAR does not indicate the frequency and the times of day that all technology-related care will be administered.
C467	The application you submitted for PDN is incomplete, please send the required information.
C468	This client is ineligible for Medicaid in the non-institutional setting.
C469	This client is ineligible for PDN.
C470	The hours requested on the PAR are greater than the plan of care orders.
C471	Nursing visits are unreasonable in amount, frequency, or duration.
C472	Information submitted does not support the need for the services requested, you may re-submit the PAR describing in more detail current medical conditions supporting the need for services.
C473	*INACTIVE* Client PAR is sent to the wrong authorizing agent, EPSDT HH, or Outpatient Therapy should be submitted to CFMC.
C474	Nursing visits solely for psychiatric counseling are not reimbursable.
C475	The requested additional information is insufficient. Completion of the requested information is required to review this Prior Authorization.
C476	Service previously authorized to this provider. The procedure code is already authorized for this client, this provider, this date span. Please bill using the information on the original PAR.
C477	Services authorized to another provider.
C478	Services requested are beyond the 16 hour per day benefit limitation as a result of an EPSDT medical screening however the correct documentation has not been received. (the EPSDT claim form does not meet this requirement.)
C479	The PAR shall cover a period of no longer than six (6) months.
C50A	*INACTIVE* The PAR that you sent directly to ACS is being denied. Please send this PAR to the authorizing agent: CFMC, Attention Medicaid/DME PARs, to the fax server number at 303-790-4643.
C518	*INACTIVE* Instructions from the therapist or other medical professional are required to support the need for ROM when it is the only skilled service performed by a Home Health Aide.
C51A	*INACTIVE* This is not a final denial. Please do not submit an appeal request. The required Client State Id number is missing or invalid. Please resubmit the 5615 and ULTC 100.2 Certification page with the correct information to DDM Ascend via FAX at: 877-431-9568.
C52A	*INACTIVE* This is not a final denial. Please do not submit an appeal request. The Client State Id number does not match the Client name. Please resubmit the 5615 and ULTC 100.2 Certification page with the correct information to DDM Ascend via FAX at: 877-431-9568.
C53A	*INACTIVE* This is not a final denial. Please do not submit an appeal request. The required Client date of birth is missing or invalid. Please resubmit the 5615 and ULTC 100.2 Certification page with the correct information to DDM Ascend via FAX at: 877-431-9568.
C55A	*INACTIVE* This is not a final denial. Please do not submit an appeal request. The required Billing Provider number is missing or invalid. Please resubmit the 5615 and ULTC 100.2 Certification page with the correct information to DDM Ascend via FAX at: 877-431-9568.
C600	Service does not require prior authorization. Submit charges on the appropriate claim form.
C643	Cost containment information is missing. Please resubmit with required information.
C700	This vision service was not provided by an ophthalmologist, optometrist or optician.
C800	*INACTIVE* Service previously authorized to this provider. The procedure code is already authorized for this client, this provider, this date span. Please bill using the information on the original PAR.
C850	*INACTIVE* Services authorized to another provider.
C851	Services authorized to another provider.
C852	Duplicate requests cannot be processed. This prior authorization request (PAR) is a duplicate of another PAR that is currently in the system.

Denial Code	Long Description
C899	The Prior Authorization did not include the appropriate procedure coding and/or modifier(s) for the effective dates submitted. Both the service and the administration fee must be included with the same effective dates. Please resubmit with corrected coding.
C900	Modification is not to prevent institutionalization of the client.
C901	Modification does not give client greater independence.
C902	Modification does not ensure the health safety and welfare of the client.
C903	Modification is not a direct medical or remedial benefit to the client.
C904	Modification duplicates an existing adaptation.
C905	Duplicates an existing adaptation.
C906	Documentation was not provided from an Occupational Therapist or Physical Therapist.
C907	Modification includes purchase cost of durable medical equipment.
C908	Modification requested is not the most cost effective solution.
C909	Alternative funding has not been considered.
C910	Modification did not include two bids.
C911	*INACTIVE* Amount of Modification exceeds cost containment.
C912	*INACTIVE* The item or service requested is not a Medicaid Home Health benefit.
C913	The item or service requested is not a Medicaid Private Duty Nursing (PDN) benefit.
C914	The procedure is not a benefit of the Colorado Medicaid program.
C915	The procedure is not a benefit for a child Medicaid client, age birth through age 20.
C916	The procedure is not a benefit for an adult Medicaid client, age 21 and older.
C917	A report of the dental condition that supports the need for service was not submitted for this child client.
C918	A report of dental condition and concurrent medical condition that supports the need for service not submitted for this adult client.
C919	The procedure code is not valid for the described procedure.
C920	The procedure code is not a benefit for this tooth number.
C921	The tooth surface designation submitted is not valid for this tooth number.
C922	The procedure is a duplicate service.
C923	Information required for prior authorization review was not submitted.
C924	Periodontal diagnosis and classification were not submitted.
C925	The information submitted does not support the need for the procedure.
C926	Submitted information does not support a favorable prognosis.
C927	*INACTIVE* TMJ PAR information from the primary surgeon was incomplete or not D14 X COCT669 2004-01-1320.36.06
C928	PAR is not required for the assistant surgeon.
C929	Prior Authorization Request cannot be approved after the service has been started.
C930	*INACTIVE* Condition does not qualify as a Handicapping Malocclusion.
C931	*INACTIVE* No certification that orthodontics is not in preparation for corrective jaw surgery.
C933	Orthodontic treatment is not a benefit to treat dental conditions which are primarily cosmetic in nature.
C934	Orthodontic treatment is not a benefit when there is no severe Handicapping malocclusion, and self-esteem is the primary reason for treatment.
C935	Phase One orthodontic treatment is not a benefit for the reported condition/s.
C936	Orthodontic prior authorization cannot be approved when the requesting provider is not enrolled as a Medicaid orthodontic provider.
CA01	*INACTIVE* This is not a final denial. Please do not submit an appeal request. The required Client State Id number is missing or invalid. Please resubmit PAR request with the corrected information to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CA02	*INACTIVE* This is not a final denial. Please do not submit an appeal request. The required Client State Id number does not match the Client Name. Please resubmit PAR request with the corrected information to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CA03	*INACTIVE* This is not a final denial. Please do not submit an appeal request. The required Client date of birth is missing or invalid. Please resubmit PAR request with the corrected information to: ACS, P.O. Box 30, Denver, CO 80201-0030.

Denial Code	Long Description
CA04	*INACTIVE* This is not a final denial. Please do not submit an appeal request. The required Requesting Provider Number is missing or invalid. Please resubmit PAR request with the corrected information to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CA05	*INACTIVE* This is not a final denial. Please do not submit an appeal request. The required Billing Provider Number is missing or invalid. Please resubmit PAR request with the corrected information to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CA06	This is not a final denial. Please do not submit an appeal request. The required Client State ID number is missing or invalid. Please resubmit PAR request with the corrected information to the authorizing agency listed in Appendix D.
CA07	This is not a final denial. Please do not submit an appeal request. The required Client State ID number does not match the Client Name. Please resubmit PAR request with the corrected information to the authorizing agency listed in Appendix D.
CA08	This is not a final denial. Please do not submit an appeal request. The required Client date of birth is missing or invalid. Please resubmit PAR request with the corrected information to the authorizing agency listed in Appendix D.
CA09	This is not a final denial. Please do not submit an appeal request. The required Requesting Provider Number is missing or invalid. Please resubmit PAR request with the corrected information to the authorizing agency listed in Appendix D.
CA10	This is not a final denial. Please do not submit an appeal request. The required Billing Provider Number is missing or invalid. Please resubmit PAR request with the corrected information to the authorizing agency listed in Appendix D.
CA11	The PAR that you sent directly to ACS is being denied. Please send this PAR to the authorizing agency listed in Appendix D.
CA12	*INACTIVE* This is not a final denial. Please do not submit an appeal request. The required Client State ID number is missing or invalid. Please resubmit PAR request with the corrected information to the authorizing agency listed in Appendix D.
CA13	*INACTIVE* This is not a final denial. Please do not submit an appeal request. The required Client State ID number does not match the Client Name. Please resubmit PAR request with the corrected information to the authorizing agency listed in Appendix D.
CA14	*INACTIVE* This is not a final denial. Please do not submit an appeal request. The required Client date of birth is missing or invalid. Please resubmit PAR request with the corrected information to the authorizing agency listed in Appendix D.
CA15	*INACTIVE* This is not a final denial. Please do not submit an appeal request. The required Requesting Provider Number is missing or invalid. Please resubmit PAR request with the corrected information to the authorizing agency listed in Appendix D.
CA16	*INACTIVE* This is not a final denial. Please do not submit an appeal request. The required Billing Provider Number is missing or invalid. Please resubmit PAR request with the corrected information to the authorizing agency listed in Appendix D.
CA17	Provider must be an enrolled in the Colorado Medical Assistance Program.
CA18	This is not a final denial. Please do not submit an appeal request. The required Client State Id number is missing or invalid. Please resubmit the 5615 and ULTC 100.2 Certification page with the correct information to the authorizing agency listed in Appendix D.
CA19	This is not a final denial. Please do not submit an appeal request. The Client State Id number does not match the Client name. Please resubmit the 5615 and ULTC 100.2 Certification page with the correct information to the authorizing agency listed in Appendix D.
CA20	This is not a final denial. Please do not submit an appeal request. The required Client date of birth is missing or invalid. Please resubmit the 5615 and ULTC 100.2 Certification page with the correct information to the authorizing agency listed in Appendix D.
CA21	This is not a final denial. Please do not submit an appeal request. The required Billing Provider number is missing or invalid. Please resubmit the 5615 and ULTC 100.2 Certification page with the correct information to the authorizing agency listed in Appendix D.
CC01	Consumer Directed Attendant Support (CDAS) services must be submitted on the same Prior Authorization Request (PAR) as the administration fee. Please resubmit the PAR with both the administration fee/modifier and the service procedure code.

Denial Code	Long Description
CD01	*INACTIVE* Client has not utilized the equipment in the manner for which it was intended. Repairs and/or replacement of equipment will not be allowed in cases of repeated misuse.
CD02	*INACTIVE* This product cannot be approved as its primary purpose is to either enhance the personal comfort of the client or provide convenience for the client caregiver.
CD03	The information submitted does not meet the Colorado Medicaid Program guidelines for medical necessity.
CD04	Service previously authorized to this provider or another provider. The procedure code is already authorized for this client, this date span.
CD05	This request is for a WHEELCHAIR. The Colorado Medicaid Program has provided a similar product within the last few years. It is Medicaid policy that the original wheelchair should be utilized for a minimum of 5 years. Please submit additional information documenting the need for a new wheelchair at this point in time.
CD06	It is the responsibility of the provider to service, repair and supply necessary parts for any Durable Medical Equipment product covered by a warranty during the warranty period. No replacement parts or repairs will be reimbursed by Colorado Medicaid during the warranty period.
CD07	This product would more appropriately be provided on a rental basis.
CD08	This product intended usage is for exercise. Colorado Medicaid does not cover products that are prescribed primarily for exercise.
CD09	This product has been requested for a client who is currently residing in a nursing facility or hospital setting. Therefore, it will not be reimbursed through the Durable Medical Equipment program of Colorado Medicaid. It is the responsibility of the facility to provide this product.
CD10	*INACTIVE* Prior Authorization Requests must be faxed to CFMC for the following items: electric wheelchairs, scooters, orthotics and prosthetics, augmentative communication devices. Please send the Prior Authorization Request for these items directly to CFMC, Attention Medicaid/DME PARs, to the fax server line at 303-790-4643.
CD11	This product is not a benefit of the Durable Medical Equipment program.
CD14	The requested information has not been submitted.
CD16	This product does not require prior authorization. Submit charges on the appropriate claim form.
CD21	Prior authorizations requests must be submitted in a timely fashion. Retroactive requests beyond three months shall only be considered in cases of client retroactive program eligibility.
CD23	Effective August 1, 2007 Pulse Oximeters will have a maximum allowable rental cap of $750.00 per year. Once the total rental payment reaches $750.00 the equipment will convert to a purchase. This change is in accordance with the following Rule: 8.590.2.R. Rental Policy.
CD30	This product would be more appropriately provided as a purchase.
CD31	As per Medicaid Bulletin March 2003, 1 unit equals 100. Your requested quantity has been divided by 100.
CD32	The amount requested exceeds the allowed quantity and has been reduced accordingly. Please refer to the current Medicaid Supply Bulletin and 10 C.C.R. 2505-10, Sec. 8.590.2.NP.
CD33	The amount requested is excessive for the diagnosis and has been reduced accordingly. Please refer to the current Medicaid Supply Bulletin and 10 C.C.R. 2505-10, Sec. 8. 590.2.NP.
CD35	Per Medicaid supply bulletin, A9900 is limited to specialized, detailed or complex work in the initial preparation of a product.
CD59	Prior Authorization is not required for Medicare Crossover claims. (8.590.3.B) Providers are required to bill Medicare first before billing Medicaid for this service. (Sec. 8.590.7.K)
CD60	*INACTIVE* Service previously authorized to this provider. The procedure code is already authorized for this client, this provider, this date span. Please bill using the information on the original PAR.
CD61	*INACTIVE* Services authorized to another provider.
CD63	This item is included in the rental/purchase of the equipment or service that has been approved. Please refer to the current Medicaid Supply Bulletin.
CDA1	*INACTIVE* This is not a final denial. Please do not submit an appeal request. The date(s) entered either on the Header or Detail lines are invalid. Please review the dates and submit a new PAR with valid dates to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDA2	*INACTIVE* This is not a final denial. Please do not submit an appeal request. The information submitted does not support the need for the medical supplies or equipment requested. Please resubmit the PAR describing in more detail the current medical conditions that support the need for the supplies to: ACS, P.O. Box 30, Denver, CO 80201-0030.

Denial Code	Long Description
CDA3	*INACTIVE* This is not a final denial. Please do not submit an appeal request. The additional information submitted is insufficient. Completion of the requested information is required for review. Please resubmit PAR with the requested information to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDA4	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Serial number is required for all repairs. Please resubmit PAR with the serial number to: ACS, P.O. Box 30, Denver, CO 80201-0030. Current Medicaid Supply Bulletin and 10 C.C.R. 2505-10, Sec. 8.590.3 (A).
CDA5	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Please resubmit PAR with the invoiced acquisition cost for this item to: ACS, P.O. Box 30, Denver, CO 80201-0030. Current Medicaid Supply Bulletin and 10 C.C.R. 2505-10, Sec. 8.590.6 (A-IK).
CDA6	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Wheelchair purchases must have the manufacturer, brand name and model name. Please resubmit PAR with the information requested above to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDA7	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Requesting providers must have prescriptive authority for this item. Please resubmit PAR with the name of the prescribing physician to: ACS, P.O. Box 30, Denver, CO 80201-0030. Current Medicaid Supply Bulletin.
CDA8	*INACTIVE* This is not a final denial. Please do not submit an appeal request. The Prior Authorization Request requires a physician signature. Please resubmit PAR with a physician signature to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDA9	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Procedure Code requested is invalid/incorrect or incomplete. Please resubmit PAR with proper code(s) from the current Medicaid Supply Bulletin to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDB1	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Please resubmit PAR with the name of meds, frequency, route and length of need to: ACS, P.O. Box 30, Denver, CO 80201-0030. Current Medicaid Supply Bulletin and 10 C.C.R. 2505-10, Sec. 8. 590.3.d.
CDB2	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Please resubmit PAR with the number of units requested to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDB3	*INACTIVE* This is not a final denial. Please do not submit an appeal request. PAR dates must be for one year. Please resubmit PAR with corrected date span or provide an explanation as to why dates are less than one year to: ACS, P.O. Box 30, Denver, CO 80201-0030. Please refer to the current Medicaid Supply Bulletin.
CDB4	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Additional information is required for this item. Please resubmit PAR and include whether these items are intended for use with a client owned piece of equipment to: ACS, P.O. Box 30, Denver, CO 80201-0030. Current Medicaid Supply Bulletin.
CDB5	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Additional information is required for this item. Please resubmit PAR and describe 1) the client level of impairment, 2) what has been used in the past, 3) if the client has available assistance 4) why this client is in need of this equipment/supply to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDB6	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Additional information is required for this item. Please resubmit PAR and describe 1) exactly why this item is needed, 2) what it will be used for, 3) the intended use for this item to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDB7	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Product information is required on this item. Please resubmit PAR with product information to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDB8	*INACTIVE* This is not a final denial. Please do not submit an appeal request. A serial number is required for all repairs. Please resubmit PAR with the serial number for the repair to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDB9	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Hospital Bed Questionnaire #1 is needed to review this request. Please resubmit PAR with the information requested to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDC1	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Pressure Relief Mattress Questionnaire #2 is needed to review this request. Please resubmit Prior Authorization Request with the information requested to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDC2	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Patient Lift Questionnaire #3 is needed to review this request. Please resubmit PAR with the information requested to: ACS, P.O. Box 30, Denver, CO 80201-0030.

Denial Code	Long Description
CDC3	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Electric/Power Lift Questionnaire #3 is needed to review this request. Please resubmit PAR with the information requested to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDC4	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Seat Lift Questionnaire #4 is needed to review this request. Please resubmit PAR with the information requested to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDC5	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Blood Pressure Unit/Monitor Questionnaire #5 is needed to review this request. Please resubmit PAR with the information requested to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDC6	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Pulse Oximeter Questionnaire #6 (with SaO2 readings) is needed to review this request. Please resubmit PAR with the information requested to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDC7	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Apnea Monitor Questionnaire #7 is needed to review this request. Please resubmit PAR with the information requested to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDC8	*INACTIVE* This is not a final denial. Please do not submit an appeal request. CPAP/BiPAP Questionnaire #8 with copy of sleep study is needed to review this request. Please resubmit PAR with the information requested to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDC9	*INACTIVE* This is not a final denial. Please do not submit an appeal request. TENS or NMES Questionnaire #9 is needed to review this request. Please resubmit PAR with the information requested to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDD1	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Oral and Enteral Nutrition Formula Questionnaire #10 (with particular attention to the number of calories per day) is needed to review this request. Please resubmit PAR with the information requested to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDD2	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Adult Orthotics and Prosthetics Questionnaire #11 is needed to review this request. Please resubmit PAR with the information requested to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDD3	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Wound Closure Therapy Questionnaire #12 is needed to review this request. Please resubmit PAR with the information requested to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDD4	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Augmentative Communication Device Questionnaire #13 is needed to review this request. Please resubmit PAR with the information requested to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDD5	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Mechanical High Frequency Chest Wall Oscillation Questionnaire #14 is needed to review this request. Please resubmit PAR with information requested to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDD6	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Wheelchair Tilt/Recline Device Questionnaire #15 is needed to review this request. Please resubmit PAR with the information requested to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDD7	*INACTIVE* This is not a final denial. Please do not submit an appeal request. The Questionnaire form you submitted is no longer valid. Please resubmit PAR with the current Questionnaire form to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CE01	This vision service was not provided by an ophthalmologist, optometrist or optician.
CE02	The clinical information does not substantiate medical necessity.
CF01	Proof of prior Medicaid orthodontic approval from another state was not submitted.
CF02	TMJ PAR information from the primary surgeon was incomplete
CF03	Condition does not qualify as a Handicapping Malocclusion.
CF04	Crowns and fixed prostheses that fail in less than five years do not meet a reasonable standard of care and the billing provider is expected to replace them at their own expense.
CF05	The services/treatments are not a covered benefit for Evaluation Procedures.
CF06	The services/treatments are not a covered benefit for Diagnostic Imaging Procedures.
CF07	The services/treatments are not a covered benefit for Preventive Services.
CF08	The services/treatments are not a covered benefit for Minor Restorative Services.

Denial Code	Long Description
CF09	The services/treatments are not a covered benefit for Major Restorative Services.
CF10	The services/treatments are not a covered benefit for Endodontic Services.
CF11	The services/treatments are not a covered benefit for Periodontal Treatment.
CF12	The services/treatments are not a covered benefit for Removable Prosthetics.
CF13	The services/treatments are not a covered benefit for Oral Surgery, palliative treatment and anesthesia.
CF14	The services/treatments are not a covered benefit for Adult Clients under any circumstances.
CF15	Prior authorization request was not submitted.
CF16	Dental services shall only be provided by a licensed dentist or dental hygienist who is enrolled with Colorado Medicaid.
CF17	Dental services described in 8.201.2 shall be available to Adult Clients age 21 years and older.
CF18	Dental services for adults 21 years of age and older are limited to a total of $1,000 per adult Medicaid recipient per state fiscal year.
CH10	*INACTIVE* Nursing visits solely for the purpose of assess and teach are not billable in this case.
CH11	*INACTIVE* Nursing visits are unreasonable in amount, frequency, or duration.
CH12	*INACTIVE* Home Health Aide units are requested, no skilled tasks are identified.
CH13	*INACTIVE* Home Health Aide visits are not medically necessary.
CH14	*INACTIVE* Home Health services shall be provided at the client place of residence except for EPSDT extraordinary HH which is prior authorized using a different process and form.
CH15	*INACTIVE* The client is 18 years old or over and skilled therapies are not a benefit under Long Term Home Health.
CH16	*INACTIVE* Extended Home Health Aide visits requested without submitting sufficient information about services on each visit.
CH17	*INACTIVE* Documentation to support PRN visits has not been submitted.
CH18	*INACTIVE* Written instructions from the therapist or other medical professional are required to support the need for ROM when it is the only skilled service performed by a Home Health Aide.
CH19	*INACTIVE* Medication set-up by a nurse is the only reason for visits and documentation that the pharmacy was contacted is missing.
CH2	*INACTIVE* information submitted does not support the need for the services requested, you may re-submit the PAR describing in more detail current medical conditions supporting the need for services.
CH20	*INACTIVE* Documentation does not support the need for two Home Health Aides at the same time for a two-person transfer.
CH21	*INACTIVE* Client PAR is sent to the wrong authorizing agent, EPSDT HH, PDN and Outpatient Therapy should be submitted to CFMC at PO Box 17300, Denver, CO 80217.
CH22	*INACTIVE* Based on the needs of the client, authorization is being given for a lesser amount of services than requested.
CH23	*INACTIVE* PAR form has been submitted later than 10 days from the HCFA-485 "from" date. PAR dates have been adjusted.
CH24	*INACTIVE* Revisions for increases in services shall be submitted and processed according to the same requirements as for new PARs, with a current written assessment/physician orders pertaining to the increase.
CH25	*INACTIVE* Nursing visits solely for psychiatric counseling are not reimbursable.
CH26	*INACTIVE* Any visit made solely for supervision of the Home Health aide shall not be reimbursed.
CH27	*INACTIVE* Nursing visits solely for foot care shall be reimbursed only if the client has a documented diagnosis that supports the need for a nurse, and the client or family caregiver is not able or willing to provide the foot care.
CH3	*INACTIVE* The requested information has not been submitted. You may submit a new PAR with the requested information-Home Health plan of care and/or therapy assessments, current clinical summary.
CH30	*INACTIVE* Client PAR is sent to the wrong authorizing agent, Private Duty Nursing PARs and application paperwork should be submitted do DDM Ascend via fax to 877-431-9568.
CH31	*INACTIVE* Improper billing may result from visits that are unreasonable in amount, frequency and duration or visits performed when skilled tasks performed are not medically necessary.
CH4	*INACTIVE* This service does not require prior authorization. Submit charges on the appropriate claim form (Acute Home Health or Long Term Home Health with Acute Episode)

Denial Code	Long Description
CH5	*INACTIVE* The revenue code is already authorized for this client, this provider, this date span. Please bill using the information on the original PAR, or submit a new PAR for revision to increase services.
CH6	*INACTIVE* The PAR that you sent directly to ACS is being denied. Please send this PAR to the authorizing agent: Single Entry Point Agency in county of client residence.
CH7	*INACTIVE* The clinical information does not substantiate medical necessity.
CH8	*INACTIVE* The requested additional information is insufficient. Completion of the requested information is required to review this Prior Authorization.
CH9	*INACTIVE* The agency is not a Medicaid Provider.
CJ01	The service is not a benefit of the Colorado Medicaid medical transportation program.
CN01	This is not a final denial. Please do not submit an appeal request. The Required 5615 noted in the Nursing Facility Billing Manual; General Prior Authorization Requirements is missing or incomplete. Please resubmit the 5615 and ULTC 100.2 certification page to the authorizing agent.
CN02	This is not a final denial. Please do not submit an appeal request. The Required ULTC 100.2 certification page noted in the Nursing Facility Billing Manual; General Prior Authorization Requirements is missing or incomplete. Please resubmit the 5615 and ULTC 100.2 certification page to the authorizing agent.
CN03	This is a not final denial. Please do not submit an appeal request. The required client's social security number is invalid or does not match the social security number of file with the Colorado Medical Assistance Program. Please correct and resubmit both the 5615 and the UTLC 100.2 certification page to the authorizing agent.
CN04	This is not a final denial. Please do not submit an appeal request. The required Client State Id number is missing or invalid. Please resubmit the 5615 and ULTC 100.2 Certification page with the correct information to the authorizing agency listed in Appendix D.
CN05	This is not a final denial. Please do not submit an appeal request. The Client State Id number does not match the Client name. Please resubmit the 5615 and ULTC 100.2 Certification page with the correct information to the authorizing agency listed in Appendix D.
CN06	This is not a final denial. Please do not submit an appeal request. The required Client date of birth is missing or invalid. Please resubmit the 5615 and ULTC 100.2 Certification page with the correct information to the authorizing agency listed in Appendix D.
CN07	This is not a final denial. Please do not submit an appeal request. The required Billing Provider number is missing or invalid. Please resubmit the 5615 and ULTC 100.2 Certification page with the correct information to the authorizing agency listed in Appendix D.
CQ01	This is not a final denial. Please do not submit an appeal request. The date(s) entered either on the Header or Detail lines are invalid. Please review the dates and submit a new PAR with valid dates to the appropriate authorizing agency listed in Appendix D.
CQ02	This is not a final denial. Please do not submit an appeal request. The information submitted does not support the need for the medical supplies or equipment requested. Please resubmit the PAR describing in more detail the current medical conditions that support the need for the supplies to the appropriate authorizing agency listed in Appendix D.
CQ03	This is not a final denial. Please do not submit an appeal request. The additional information submitted is insufficient. Completion of the requested information is required for review. Please resubmit PAR with the requested information to the appropriate authorizing agency listed in Appendix D.
CQ04	This is not a final denial. Please do not submit an appeal request. Serial number is required for all repairs. Please resubmit PAR with the serial number to the appropriate authorizing agency listed in Appendix D. Current Medicaid Supply Bulletin and 10 C.C.R. 2505-10, Sec. 8.590.3.D.8.
CQ05	This is not a final denial. Please do not submit an appeal request. Please resubmit PAR with the invoiced acquisition cost for this item to the appropriate authorizing agency listed in Appendix D. Current Medicaid Supply Bulletin and 10 C.C.R. 2505-10, Sec. 8.590.4.D.5.c.
CQ06	This is not a final denial. Please do not submit an appeal request. Wheelchair purchases must have the manufacturer, brand name and model name. Please resubmit PAR with the information requested above to the appropriate authorizing agency listed in Appendix D.
CQ07	This is not a final denial. Please do not submit an appeal request. Requesting providers must have prescriptive authority for this item. Please resubmit PAR with the name of the prescribing physician to the appropriate authorizing agency listed in Appendix D. Current Medicaid Supply Bulletin.

Denial Code	Long Description
CQ08	This is not a final denial. Please do not submit an appeal request. The Prior Authorization Request requires a physician's signature. Please resubmit PAR with a physician's signature to the appropriate authorizing agency listed in Appendix D.
CQ09	This is not a final denial. Please do not submit an appeal request. Procedure Code requested is invalid/incorrect or incomplete. Please resubmit PAR with proper code(s) from the current Medicaid Supply Bulletin to the appropriate authorizing agency listed in Appendix D.
CQ10	This is not a final denial. Please do not submit an appeal request. Please resubmit PAR with the name of meds, frequency, route and length of need to the appropriate authorizing agency listed in Appendix D. Current Medicaid Supply Bulletin and 10 C.C.R. 2505-10, Sec. 8. 590.3.d.
CQ11	This is not a final denial. Please do not submit an appeal request. Please resubmit PAR with the number of units requested to the appropriate authorizing agency listed in Appendix D.
CQ12	This is not a final denial. Please do not submit an appeal request. PAR dates must be for one year. Please resubmit PAR with corrected date span or provide an explanation as to why dates are less than one year to the appropriate authorizing agency listed in Appendix D. Please refer to the current Medicaid Supply Bulletin.
CQ13	This is not a final denial. Please do not submit an appeal request. Additional information is required for this item. Please resubmit PAR and include whether these items are intended for use with a client owned piece of equipment to the appropriate authorizing agency listed in Appendix D. Current Medicaid Supply Bulletin.
CQ14	This is not a final denial. Please do not submit an appeal request. Additional information is required for this item. Please resubmit PAR and describe 1) the client's level of impairment, 2) what has been used in the past, 3) if the client has available assistance 4) why this client is in need of this equipment/supply to the appropriate authorizing agency listed in Appendix D.
CQ15	This is not a final denial. Please do not submit an appeal request. Additional information is required for this item. Please resubmit PAR and describe 1) exactly why this item is needed, 2) what it will be used for, 3) the intended use for this item to the appropriate authorizing agency listed in Appendix D.
CQ16	This is not a final denial. Please do not submit an appeal request. Product information is required on this item. Please resubmit PAR with product information to the appropriate authorizing agency listed in Appendix D.
CQ17	This is not a final denial. Please do not submit an appeal request. A serial number is required for all repairs. Please resubmit PAR with the serial number for the repair to the appropriate authorizing agency listed in Appendix D.
CQ18	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Hospital Bed Questionnaire #1 is needed to review this request. Please resubmit PAR with the information requested to the appropriate authorizing agency listed in Appendix D.
CQ19	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Pressure Relief Mattress Questionnaire #2 is needed to review this request. Please resubmit Prior Authorization Request with the information requested to the appropriate authorizing agency listed in Appendix D.
CQ20	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Patient Lift Questionnaire #3 is needed to review this request. Please resubmit PAR with the information requested to the appropriate authorizing agency listed in Appendix D.
CQ21	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Electric/Power Lift Questionnaire #3 is needed to review this request. Please resubmit PAR with the information requested to the appropriate authorizing agency listed in Appendix D.
CQ22	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Seat Lift Questionnaire #4 is needed to review this request. Please resubmit PAR with the information requested to the appropriate authorizing agency listed in Appendix D.
CQ23	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Blood Pressure Unit/Monitor Questionnaire #5 is needed to review this request. Please resubmit PAR with the information requested to the appropriate authorizing agency listed in Appendix D.
CQ24	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Pulse Oximeter Questionnaire #6 (with SaO2 readings) is needed to review this request. Please resubmit PAR with the information requested to the appropriate authorizing agency listed in Appendix D.
CQ25	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Apnea Monitor Questionnaire #7 is needed to review this request. Please resubmit PAR with the information requested to the appropriate authorizing agency listed in Appendix D.

Denial Code	Long Description
CQ26	*INACTIVE* This is not a final denial. Please do not submit an appeal request. CPAP/BiPAP Questionnaire #8 with copy of sleep study is needed to review this request. Please resubmit PAR with the information requested to the appropriate authorizing agency listed in Appendix D.
CQ27	*INACTIVE* This is not a final denial. Please do not submit an appeal request. TENS or NMES Questionnaire #9 is needed to review this request. Please resubmit PAR with the information requested to the appropriate authorizing agency listed in Appendix D.
CQ28	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Oral and Enteral Nutrition Formula Questionnaire #10 (with particular attention to the number of calories per day) is needed to review this request. Please resubmit PAR with the information requested to the appropriate authorizing agency listed in Appendix D.
CQ29	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Adult Orthotics and Prosthetics Questionnaire #11 is needed to review this request. Please resubmit PAR with the information requested to the appropriate authorizing agency listed in Appendix D.
CQ30	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Wound Closure Therapy Questionnaire #12 is needed to review this request. Please resubmit PAR with the information requested to the appropriate authorizing agency listed in Appendix D.
CQ31	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Augmentative Communication Device Questionnaire #13 is needed to review this request. Please resubmit PAR with the information requested to the appropriate authorizing agency listed in Appendix D.
CQ32	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Mechanical High Frequency Chest Wall Oscillation Questionnaire #14 is needed to review this request. Please resubmit PAR with the information requested to the appropriate authorizing agency listed in Appendix D.
CQ33	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Wheelchair Tilt/Recline Device Questionnaire #15 is needed to review this request. Please resubmit PAR with the information requested to the appropriate authorizing agency listed in Appendix D.
CQ34	This is not a final denial. Please do not submit an appeal request. The Questionnaire form you submitted is no longer valid. Please resubmit PAR with the current Questionnaire form to the appropriate authorizing agency listed in Appendix D.
CQ35	Prior Authorization Requests must be submitted on paper for the following items: electric wheelchairs, scooters, orthotics and prosthetics, augmentative communication devices. Please send the Prior Authorization Request for these items directly to the appropriate authorizing agency listed in Appendix D.
CQ36	Client has not utilized the equipment in the manner for which it was intended. Repairs and/or replacement of equipment will not be allowed in cases of repeated misuse.
CQ37	This product cannot be approved as its primary purpose is to either enhance the personal comfort of the client or provide convenience for the client caregiver.
CQ38	This is a rejection, not a final denial. Please do not submit an appeal request. Completion of PAR requirements have not been met.
CQ39	Same or similar services have already been previously approved for this client.
CY01	*INACTIVE* Client PAR is sent to the wrong authorizing agent. Please refer to Appendix D for the appropriate authorizing agency when submitting EPSDT HH, or Outpatient Therapy PARs.
CY03	*INACTIVE* PAR form has been submitted later than 10 business days from the PAR start date. PAR units have been adjusted.
CY04	*INACTIVE* PAR form has been submitted later than 10 business days from the PAR start date. PAR units have been adjusted.
CZ01	*INACTIVE* Client PAR is sent to the wrong authorizing agent. Please refer to Appendix D for the appropriate authorizing agency when submitting EPSDT HH, or Outpatient Therapy PARs.
CZ02	*INACTIVE* Based on the needs of the client, authorization is being given for a lesser amount of services than requested.
CZ03	PAR form has been submitted later than 10 business days from the PAR start date. PAR units have been adjusted.
CZ04	The requested information has not been submitted. You may submit a new PAR with the requested information- Home Health plan of care and/or therapy assessments, current clinical summary.
CZ05	*INACTIVE* Home Health services shall be provided at the client place of residence (excluding nursing facilities and hospitals) except for EPSDT extraordinary HH which is prior authorized using a different process and form.

Denial Code	Long Description
CZ06	*INACTIVE* Client PAR is sent to the wrong authorizing agent, Private Duty Nursing PARs and application paperwork should be submitted to the authorizing agency listed in Appendix D.
CZ07	*INACTIVE* The revenue code is already authorized for this client, this provider, this date span. Please bill using the information on the original PAR, or submit a new PAR for revision to increase services.
CZ08	*INACTIVE* The clinical information does not substantiate medical necessity.
CZ09	*INACTIVE* The requested additional information is insufficient. Completion of the requested information is required to review this Prior Authorization.
CZ10	The agency is not a Medicaid Provider.
CZ11	*INACTIVE* Client PAR is sent to the wrong authorizing agent. Please refer to Appendix D for the appropriate authorizing agency.
CZ12	The item or service requested is not a Medicaid Home Health benefit.
CZ13	Skilled therapies are not a benefit under Adult Long Term Home Health.
CZ14	Revisions for increases to Home Health services shall be submitted and processed according to the same requirements defined for new PARs, and shall be submitted timely and include a current plan of care, physician's orders and any other required documentation to support the revision as listed in the Home Health Benefit Coverage Standard.
CZ15	Based on the needs of the client, authorization is being given for a lesser amount of services than requested.
CZ16	This client is 21 years or older and Home Health services shall be provided at the client place of residence (excluding nursing facilities and hospitals).
CZ17	The client is 18 years or older and the PAR was sent to the wrong authorizing agent; Adult Long Term Home Health PARs and applicable paperwork should be submitted to the authorizing agency listed in Appendix D.
CZ18	The revenue code is already authorized for this client, this provider and/or this date span. Please bill using the information on the original PAR, or submit a new PAR revision to increase or change services.
CZ19	The clinical information does not substantiate medical necessity.
CZ20	The information submitted is insufficient to make a medical necessity determination. Additional information is required to review this Prior Authorization.
CZ21	The Colorado Medical Assistance Program previously sent a letter notifying you of a decrease in your home health services and wants to make sure you have received all of the information you need. You may be eligible for a plan to decrease the amount of services over a three month period of time to help adjust to the change. You may talk with your case manager or home health provider to make a step-down plan if you need one. If you have not heard from your case manager or provider, or if you have any questions, please call 303-866-3447.
P001	THE BILLING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THE SERVICES.
P002	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P003	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P005	THE PRIOR AUTHORIZATION CAN NOT BE END DATED. THE PRIOR AUTHORIZATION STATUS IS NOT APPROVED OR APPROVED WITH REVISIONS.
P006	PLEASE FURNISH THE PROCEDURE CODE AND CORRESPONDING DESCRIPTION.
P008	THE BILLING PROVIDER NUMBER IS INVALID.
P009	THE BILLING PROVIDER NUMBER IS INVALID.
P010	THE REQUESTED END DATE IS INVALID.
P011	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P012	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P013	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P014	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P015	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P016	THE REQUESTED START DATE IS MISSING OR INVALID.
P019	THE REQUESTED START DATE IS MISSING OR INVALID.
P020	THE RENDERING PROVIDER NUMBER IS INVALID.

Denial Code	Long Description
P021	THE RENDERING PROVIDER NUMBER IS INVALID.
P022	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P023	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P024	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P026	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P027	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P030	FIRST MODIFIER IS INVALID.
P031	FIRST MODIFIER IS INVALID.
P032	SECOND MODIFIER IS INVALID.
P033	SECOND MODIFIER IS INVALID.
P034	THIRD MODIFIER IS INVALID.
P035	THIRD MODIFIER IS INVALID.
P036	FOURTH MODIFIER IS INVALID.
P037	FOURTH MODIFIER IS INVALID.
P038	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P039	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P040	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P041	CLIENTS FIRST NAME IS MISSING.
P042	CLIENTS LAST NAME IS MISSING.
P043	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P044	BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES REQUESTED.
P045	FIRST MODIFIER IS INVALID.
P046	SECOND MODIFIER IS INVALID.
P047	THIRD MODIFIER IS INVALID.
P048	FOURTH MODIFIER IS INVALID.
P052	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P053	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P054	RENDERING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES FOR THE BENEFIT PLAN.
P055	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P061	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P062	THE CLIENT ID AND/OR NAME INDICATED ON THE PA REQUEST IS INCORRECT. THE CLIENT ID AND/OR NAME HAS BEEN UPDATED. PLEASE VERIFY THE ID AND/OR NAME IS CORRECT.
P064	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
P067	THE FREQUENCY OF HOURS REQUESTED ARE NOT APPROPRIATE FOR THIS CLIENT AND HAVE BEEN MODIFIED ACCORDINGLY.
P079	BILLING PROVIDER IS ON PAYMENT SUSPENSION DUE TO CREDIBLE ALLEGATION OF FRAUD.
P120	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAS BEEN REDUCED.
P121	THE SERVICE/ PROCEDURE REQUESTED IS NOT SUPPORTED BY SUBMITTED DOCUMENTATION.
P126	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
P128	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.
P138	SERVICE(S) DO NOT MEET COLORADO MEDICAID GUIDELINES.
P167	REQUESTED DOCUMENTATION HAS NOT BEEN SUBMITTED.
P178	THE SERVICE REQUESTED IS NOT MEDICALLY NECESSARY.
P179	THE MEDICAL NECESSITY FOR THIS SERVICE IS NOT SUPPORTED BY THE SUBMITTED DOCUMENTATION.
P233	THE DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE ADDITIONAL CARE.
P257	THIS CLIENTS FUNCTIONAL ASSESSMENT SCORES PLACE THIS CLIENT OUTSIDE ELIGIBILITY FOR DAY TREATMENT.

Denial Code	Long Description
P274	OUR RECORDS INDICATE THIS CLIENT IS INVOLVED IN EFFECTIVE AND APPROPRIATE SERVICE ELSEWHERE.
P292	INTENSIVE REHABILITATION HOURS ARE NO LONGER APPROPRIATE AS INDICATED BY HISTORY, DIAGNOSIS, AND/ OR FUNCTIONAL ASSESSMENT SCORES.
P328	THE SERVICES REQUESTED INCLUDE NON-COVERED SERVICES, AND HOURS ARE REDUCED ACCORDINGLY.
P339	THE CLIENTS PAST HISTORY INDICATES REDUCED TREATMENT HOURS ARE WARRANTED.
P342	THE REQUEST DOES NOT MEET GENERALLY ACCEPTED CONDITIONS REQUIRING FLUORIDE TREATMENTS.
P346	SERVICES EXCEED COLORADO MEDICAID LIMITATION AND DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE MEDICAL NECESSITY OF THE SERVICE.
P349	THE SERVICE REQUESTED WAS PERFORMED LESS THAN FIVE YEARS AGO.
P353	THE EXISTING APPLIANCE HAS NOT BEEN WORN FOR THREE YEARS.
P367	THE CLIENT HAS BEEN TOTALLY WITHOUT TEETH AND AN APPLIANCE FOR FIVE YEARS.
P392	THE CLIENT IS MISSING AN ANTERIOR TOOTH AND/OR HAS TWO OR MORE POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P405	THE SERVICE(S) REQUESTED COULD ADEQUATELY BE PERFORMED IN THE DENTAL OFFICE.
P406	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE OF GOOD PERIODONTAL HEALTH (AMERICAN ACADEMY OF PERIODONTOLOGY PERIODONTAL CLASSIFICATION OF TYPE I OR II).
P407	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE VISIBLE ON RADIOGRAPHS THAT AT LEAST 50 PERCENT OF THE CLINICAL CROWN IS INTACT.
P409	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING SIX OR MORE TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED, INCLUDING THIRD MOLARS.
P410	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING ONE OR MORE ANTERIOR TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED.
P411	DOCUMENTATION DOES NOT SUPPORT THE NEED FOR PERIODONTIC SERVICES. POCKETS ARE LESS THAN 4MM AND/OR GREATER THAN 6MM FOR CLIENT AND/OR THE CLIENT IS UNDER THE AGE OF 13.
P412	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA.
P413	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA. THIS PA HAS BEEN GRANTED AS APPROVED NOT APPROVED WITH REVISIONS. THE DURATION REQUESTED MAY HAVE BEEN REDUCED TO REFLECT COVERAGE LIMITATIONS, PRESCRIBER ORDERS, CONFLICTI
P417	THE SERVICE(S) REQUESTED COULD BE ADEQUATELY PERFORMED WITH LOCAL ANESTHESIA.
P437	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO POOR ORAL HYGIENE.
P444	THIS LINE ITEM IS A DUPLICATE OF ANOTHER LINE ITEM ON THIS PRIOR AUTHORIZATION (PA) REQUEST. PLEASE CORRECT.
P446	THIS IS A DUPLICATE OF AN EXISTING PRIOR AUTHORIZATION (PA) REQUEST. YOU MAY CONTACT PROVIDER SERVICES IF YOU REQUIRE ASSISTANCE. DUPLICATE PA REQUEST
P448	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO DECAY HISTORY.
P449	QUESTIONABLE LONG TERM PROGNOSIS DUE TO GUM AND BONE DISEASE.
P456	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO APPARENT ROOT INFECTION.
P457	OUR RECORDS INDICATE THIS CLIENT HAS EXCEEDED ESTABLISHED PROGRAM LIMITATIONS. COLORADO MEDICAID WILL NOT AUTHORIZE NEW DENTURES.
P458	DOCUMENTATION PROVIDED INDICATES A LESS ELABORATE PROCEDURE SHOULD BE CONSIDERED.
P502	RENTAL ONLY ALLOWED; MEDICAL NEED FOR PURCHASE HAS NOT BEEN DOCUMENTED.
P503	PURCHASE ONLY ALLOWED; MEDICAL NEED FOR RENTAL HAS NOT BEEN DOCUMENTED.
P504	OCCUPATIONAL THERAPY GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P505	THE SERVICE REQUESTED IS INCLUDED IN THE NURSING HOME RATE STRUCTURE.
P511	THIS NATIONAL DRUG CODE IS ONLY BILLABLE AS PART OF A COMPOUND DRUG.
P515	THE PRESENCE OF A HANDICAPPING MALOCCLUSION OR HANDICAPPING DENTOFACIAL DEFORMITY IS NOT SUPPORTED BY THE DOCUMENTATION SUBMITTED.
P521	THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVERED BY COLORADO MEDICAID.
P522	GASTRO-INTESTINAL SURGERY FOR THE PURPOSE OF WEIGHT CONTROL IS COVERED ONLY AS A LIFE THREATENING PROCEDURE.
P523	THE TREATMENT REQUEST IS NOT CONSISTENT WITH THE CLIENT'S DIAGNOSIS.

Denial Code	Long Description
P524	PSYCHOTHERAPY PROVIDED IN THE CLIENTS HOME IS NOT A COVERED BENEFIT OF COLORADO MEDICAID.
P525	THE INFORMATION PROVIDED IS NOT CONSISTENT WITH THE INTENSITY OF SERVICES REQUESTED.
P526	INTENSIVE MULTIPLE MODALITY TREATMENT IS NOT CONSISTENT WITH THE INFORMATION PROVIDED.
P527	MULTIPLE PROVIDERS OF TREATMENT ARE NOT INDICATED FOR THIS CLIENT.
P528	THE DURATION OF TREATMENT SESSIONS EXCEED CURRENT COLORADO MEDICAID GUIDELINES.
P534	DOCUMENTATION OF POOR PHYSICAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P535	OTHER PHYSICAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P536	THE PHYSICAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P537	USE OF PHYSICAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P538	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF A PHYSICAL THERAPIST.
P539	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS AND LIVING ARRANGEMENT.
P540	GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P541	THE PROCEDURE(S) REQUESTED ARE NOT MEDICAL IN NATURE.
P542	DOCUMENTATION OF POOR OCCUPATIONAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P543	DOCUMENTATION OF POOR SPEECH THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P544	OTHER OCCUPATIONAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P546	THE OCCUPATIONAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P547	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF PHYSICAL THERAPY.
P548	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P549	ACTIVITIES TO PROMOTE DIVERSION OR GENERAL MOTIVATION ARE NONCOVERED COLORADO MEDICAID SERVICES.
P550	REVISIONS OF THE REQUEST IS NECESSITATED BY THE CLIENTS MINIMAL PROGRESS.
P551	RESTORATIVE NURSING INVOLVEMENT COULD BE INCREASED.
P552	CLIENTS DEMONSTRATED RESPONSE TO CURRENT THERAPY DOES NOT WARRANT THE INTENSE FREQUENCY REQUESTED.
P553	MAINTENANCE IS TWO TIMES PER WEEK OR LESS.
P554	THE SPEECH THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P555	USE OF OCCUPATIONAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P556	USE OF SPEECH THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P557	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF AN OCCUPATIONAL THERAPIST.
P558	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
P559	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P560	THE MATERIALS/ SERVICES REQUESTED ARE PRINCIPALLY COSMETIC IN NATURE.
P561	THE LENS FORMULA DOES NOT JUSTIFY REPLACEMENT.
P562	THE CHANGE IN THE LENS FORMULA DOES NOT WARRANT MULTIPLE REPLACEMENTS.
P563	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P564	LENSES ONLY ARE APPROVED; PLEASE DISPENSE A CONTRACTED FRAME. THE NON-CONTRACTED FRAME IS NOT MEDICALLY JUSTIFIED.
P565	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P566	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P567	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF OCCUPATIONAL THERAPY.

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P568	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF SPEECH THERAPY.
P569	LEVEL, INTENSITY, OR EXTENT OF SERVICE(S) REQUESTED HAS BEEN MODIFIED CONSISTENT WITH MEDICAL NEED AS DEFINED IN THE PLAN OF CARE.
P570	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P571	THE SERVICE ASKED FOR IS NOT COVERED BY COLORADO MEDICAID AS THESE TASKS CAN BE DONE BY NURSES OR ACTIVITY STAFF.
P572	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P573	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.
P574	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P575	MEDICAL NEED FOR EQUIPMENT/ SUPPLY REQUESTED IS NOT SUPPORTED BY DOCUMENTATION SUBMITTED.
P576	OTHER SPEECH THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P577	DOCUMENTATION SUBMITTED IDENTIFIES THAT THE CLIENT HAS FEWER THAN TWO POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P582	LESS EXPENSIVE ALTERNATIVE SERVICES ARE AVAILABLE FOR THIS CLIENT.
P634	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P711	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING PERIODONTAL SCALING AND ROOT PLANNING.
P712	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING GINGIVECTOMY.
P754	AN APPROVED SUBSTANCE ABUSE DAY TREATMENT PROGRAM CANNOT EXCEED A SIX WEEK PERIOD.
P761	THE CLIENT DOES NOT APPEAR TO BE ABLE OR WILLING TO ABSTAIN FROM ALCOHOL/DRUG USAGE WHILE IN TREATMENT. THEREFORE, SUBSTANCE ABUSE DAY TREATMENT SERVICES ARE NOT APPROVED.
P764	THIS CLIENT HAS COMPLETED INTENSIVE SUBSTANCE ABUSE TREATMENT WITHIN THE PAST 12 MONTHS. THE DOCUMENTATION PROVIDED IS NOT ADEQUATE TO JUSTIFY ADDITIONAL INTENSIVE TREATMENT AT THIS TIME.
P785	A LESS THAN SIX-WEEK HEALING PERIOD HAS BEEN SPECIFIED FOR THIS PRIOR AUTHORIZATION. THEREFORE IT IS NOT NECESSARY TO WAIT THE FULL SIX WEEKS AFTER EXTRACTIONS BEFORE TAKING DENTURE IMPRESSIONS.
P818	SIX-WEEK HEALING TIME IS REQUIRED BETWEEN EDENTULATION AND FINAL IMPRESSIONS. PAYMENT FOR DENTURES WILL BE DENIED OR RECOUPED IF HEALING PERIOD IS NOT OBSERVED.
P849	COLORADO MEDICAID HAS DETERMINED THERE WERE (ARE) SEVERAL HOME HEALTH AGENCIES WILLING TO PROVIDE MEDICALLY NECESSARY SKILLED NURSING SERVICES TO THIS CLIENT.
P864	THE DOCUMENTATION YOU HAVE SUBMITTED DOES NOT MEET THE REQUIREMENTS OF COLORADO MEDICAID.
P873	THE MEDICAL NECESSITY FOR THE HOURS REQUESTED IS NOT SUPPORTED BY THE INFORMATION SUBMITTED.
P874	THE DOCUMENTATION SUBMITTED INDICATES THE TASKS SPECIFIED CAN BE COMPLETED DURING THE VISITS APPROVED.
P878	THE DOCUMENTATION SUBMITTED DOES NOT INDICATE THAT MEDICALLY ORIENTED TASKS ARE MEDICALLY NECESSARY; THEREFORE PERSONAL CARE SERVICES HAVE BEEN APPROVED.
P880	THE QUANTITY OF SERVICES AUTHORIZED FOR THIS CLIENTS PERSONAL CARE HAS BEEN AMENDED BASED ON INFORMATION RECEIVED FROM ONE OR MORE OF THESE SOURCES: THE CLIENT, THEIR PHYSICIAN, AND/OR THE IN-HOME VISIT BY STAFF OF THE OIG (OFFICE OF INSPECTOR GENERAL).
P885	THE USE OF THIS DRUG FOR THE INTENDED PURPOSE IS NOT COVERED BY COLORADO MEDICAID, CONSISTENT WITH COLORADO ADMINISTRATIVE CODE AND FEDERAL LAW.
P924	THE MEDICAL RECORDS SUBMITTED WITH THE CURRENT REQUEST CONFLICT OR DISAGREE WITH OUR MEDICAL RECORDS ON THIS CLIENT.
P950	INDEPENDENT NURSES, PLEASE NOTE PAYABLE SERVICES MAY NOT EXCEED 12 HOURS/DAY OR 60 HOURS/WEEK.

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P951	SERVICES CAN ONLY BE AUTHORIZED THROUGH ONE YEAR FROM THE PRESCRIPTION DATE.
P952	LEAD INSPECTION IS A COVERED COLORADO MEDICAID SERVICE WHEN THE CHILD HAS BEEN SHOWN TO HAVE LEAD POISONING (E.G., CHILD HAS A BLOOD LEAD LEVEL > 19 UG/DL OR TWO CONSECUTIVE BLOOD LEAD LEVELS OF 15-19 UG/DL DONE AT LEAST 90 DAYS APART). THE INSPECTION MUS
P953	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P954	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P956	THE REQUEST CAN ONLY BE BACKDATED A MAXIMUM OF 14 DAYS FROM FIRST DATE RECEIVED BY COLORADO MEDICAID.
P957	COMPLETE PERIODONTAL CHARTING AT TIME OF SERVICE, AND SUBMIT CHARTING, COPY OF OPERATIVE REPORT, TOGETHER WITH A COPY OF THE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF), F-11035, TO PA UNIT ATTENTION DENTAL CONTSULTANT.
P958	NOTE THAT CODE D4341 HAS BEEN CHANGED. REFER TO THE DECISION NOTICE FOR AUTHORIZED QUANTITY.
P960	YOUR PA HAS BEEN APPROVED FOR 90 DAYS. THE 90 DAY APPROVAL DOES NOT IMPLY THE PA REQUEST MEETS PRIOR AUTHORIZATION CRITERIA. AFTER ADDITIONAL INFORMATION IS AVAILABLE IN INTERCHANGE, COLORADO MEDICAID WILL CREATE AN AMENDMENT REQUEST TO EXTEND THE PA FOR
P961	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P962	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
PA10	THE REQUESTED END DATE IS INVALID.
PA12	PLEASE FURNISH A WRITTEN DESCRIPTION OF THE CLIENTS DIAGNOSIS.
PA13	PROVIDE DIAGNOSES WITH DATES OF ONSET.
PA14	IDENTIFY PROBLEMS TO BE TREATED.
PA15	THE AUDIOLOGISTS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1), F-11020, AND PRIOR AUTHORIZATION REQUEST/HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2), F-11021.
PA16	THE PHYSICIANS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION/PHYSICIAN OTOLOGICAL REPORT (PA/POR), F-11019.
PA17	SUBMIT BRIEF HISTORY WITH REFERRAL INFORMATION, LIVING SITUATION, FUNCTIONAL STATUS, AND OTHER PERTINENT INFORMATION. WHAT CHANGE OF STATUS RESULTED IN REFERRAL AT THIS TIME?
PA18	PLEASE FURNISH THE CLIENTS HEIGHT AND WEIGHT.
PA19	PLEASE SUBMIT CLINICAL INFORMATION SUFFICIENT TO VERIFY THE NEED FOR THE REQUESTED SERVICE(S).
PA20	PLEASE RESUBMIT WITH COMPLETE PERIODONTAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PA21	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL EDUCATIONAL PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA22	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL PROGRAM PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA23	REFER TO THE DURABLE MEDICAL EQUIPMENT INDEX FOR APPROPRIATE CODE AND DESCRIPTION. DO NOT USE AN "UNLISTED" CODE.
PA24	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUALIZED FAMILY SERVICE PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA25	INFORMATION ON THE REQUEST FORM IS ILLEGIBLE, AND THE REQUEST CANNOT BE PROCESSED.
PA26	RE-EVALUATE YOUR GOALS. EMPHASIS SHOULD BE ON FUNCTIONAL SELF-CARE. GOALS MUST BE RELATED TO FUNCTIONAL OUTCOME.
PA27	PLEASE CLARIFY THE NUMBER OF HOURS PER WEEK REQUESTED.
PA28	PLEASE CLARIFY THE NUMBER OF HOURS PER DAY REQUESTED.
PA29	PLEASE CLARIFY THE NUMBER OF VISITS PER DAY REQUESTED.

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PA30	ATTACH SUPPORTIVE DOCUMENTATION; HOME EXERCISE PROGRAM AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA31	THE DIAGNOSIS CODE INDICATED ON THE REQUEST DOES NOT CORRESPOND TO THE DIAGNOSIS CODE DESCRIPTION.
PA32	PLEASE SUBMIT ADDITIONAL INFORMATION SUFFICIENT TO VERIFY APPROPRIATENESS AND NEED FOR TRANSPLANT.
PA33	PLEASE SUBMIT THE INITIAL AND PROGRESSIVE OBJECTIVE FINDINGS.
PA34	ATTACH SUPPORTIVE DOCUMENTATION, FACILITY PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA35	PLEASE SUBMIT THE CLIENTS ORIGINAL COMPLAINTS AND EXAMINATION FINDINGS.
PA36	ATTACH SUPPORTIVE DOCUMENTATION, IN-HOME AUTISM PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA37	PLEASE SUBMIT YOUR TREATMENT PLAN FOR THIS CLIENT.
PA38	ATTACH SUPPORTIVE DOCUMENTATION AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA39	INITIAL EVALUATIONS MUST BE PERFORMED BY AN OCCUPATIONAL THERAPIST REGISTERED (OTR), PER AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA) STANDARDS.
PA41	IDENTIFY THE PLACE OF SERVICE AND ITS EFFECT ON SUPPORTING THE DESIRED TREATMENT OUTCOME.
PA42	PLEASE INDICATE THE HOURS OF USE OF OXYGEN PER 24-HOUR PERIOD.
PA43	PROVIDE BASELINE DOCUMENTATION FOR THIS CLIENTS LIMITATIONS USING UNITS OF MEASUREMENT THAT ARE APPLIED CONSISTENTLY WHEN REPORTING STATUS.
PA44	IDENTIFY FUNCTIONAL LIMITATIONS AS THEY ARE RELATED TO IDENTIFIED CONDITIONS.
PA46	CORRELATE PLAN OF CARE TO REQUESTED PROCEDURE CODES.
PA47	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE FREQUENCY/DURATION REQUESTED.
PA48	PLEASE PROVIDE THE NAME AND CREDENTIALS OF THE RENDERING PROVIDER.
PA50	COLORADO MEDICAID RECORDS INDICATE THE CLIENT OWNS A WHEELCHAIR. DOCUMENT THE REASON AND NEED FOR REPLACEMENT AND COST TO REPAIR CURRENT WHEELCHAIR.
PA51	PLEASE DISTINGUISH PRIMARY AND SUPPORTIVE MODALITIES.
PA52	PLEASE SUBMIT A PROGRESS REPORT.
PA53	MULTIPLE FAMILY CLIENTS TREATMENT BY THE SAME PROVIDER REQUIRES FURTHER INFORMATION DOCUMENTING COORDINATION OF TREATMENT PLAN.
PA54	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE MINUTES REQUESTED.
PA55	MEDICAL NECESSITY OF TREATMENT REQUIRES ADDITIONAL DOCUMENTATION.
PA56	GIVEN AGE, DIAGNOSES, CURRENT LEVEL OF FUNCTION, PAST RESPONSE TO TREATMENT, AND LIVING SITUATION, EXPAND ON POTENTIAL FOR SIGNIFICANT FUNCTIONAL PROGRESS WITHIN THE NEXT SIX MONTHS. EMPHASIZE WHY PROGRESS IS EXPECTED WITH SERVICES AT THIS TIME.
PA57	SUBMIT THE INITIAL FINDINGS. INCLUDE A COMPREHENSIVE EVALUATION.
PA58	SUBMIT PROGRESSIVE, OBJECTIVE FINDINGS. INCLUDE A PERTINENT RE-EVALUATION.
PA59	PLEASE SUPPLY INFORMATION REGARDING THE CLIENTS MEDICATION REQUIREMENTS, IF ANY.
PA60	PLEASE SPECIFY IF THE CLIENT IS IN AN EDUCATIONAL SETTING.
PA61	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA62	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
PA63	THE SKILLS OF A THERAPIST ARE PURPOSEFUL AND SKILLED INTERVENTIONS REQUIRED TO CONTINUALLY DESIGN, IMPLEMENT, REASSESS, MODIFY/GRADE, AND/OR DISCONTINUE A PLAN OF CARE IN A TIMELY MANNER, BASED ON THE COMPLEXITY OF THE CLIENTS MEDICAL CONDITION AND/OR CO
PA64	PLEASE SUBMIT A THERAPY PLAN OF CARE, INCLUDING A CURRENT, DATED EVALUATION.
PA65	A PLAN OF CARE SIGNED AND DATED BY THE PHYSICIAN IS REQUIRED.
PA66	THE SKILLS OF A THERAPIST ARE REQUIRED WHEN ONLY THE THERAPIST CAN SAFELY AND EFFECTIVELY DELIVER THE THERAPEUTIC PROCEDURES BECAUSE OF THEIR UNIQUE KNOWLEDGE, TRAINING, AND EXPERTISE. DESCRIBE THE REASON THAT SOMEONE OTHER THAN A THERAPIST CANNOT SAFELY

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PA67	PLEASE SPECIFY IF THE CLIENTS WORK SITE DEMANDS GOOD BINAURAL HEARING.
PA68	DESCRIBE THE REASON, BASED ON THE CLIENTS COGNITIVE, PHYSICAL, COMMUNICATION, OR RESOURCE STATUS, THAT A HOME PROGRAM, EQUIPMENT, OR ENVIRONMENTAL ADAPTATIONS ALONE CANNOT MEET CLIENTS NEEDS.
PA69	PLEASE SPECIFY IF THE CLIENT HAS AN ACCOMPANYING DISABILITY THAT ADDS TO THE HEARING PROBLEM.
PA70	DISTINGUISH REQUESTED PROCEDURES AND GOALS FROM OTHER SERVICES THIS CLIENT RECEIVES. THEY MAY NOT BE DUPLICATIVE.
PA71	PLEASE INDICATE THE NUMBER OF DAYS REQUESTED.
PA73	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA74	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA75	PLEASE DOCUMENT CARRYOVER OF THE THERAPY PROGRAM TO NURSING.
PA76	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA79	PROVIDE EVIDENCE OF SIGNIFICANT FUNCTIONAL PROGRESS IN LAST SIX MONTHS.
PA84	THE GRANT DATE OF THIS REQUEST CANNOT BE PRIOR TO THE SIGNATURE DATE OF THE PRESCRIBING PHYSICIAN.
PA86	PROVIDE EVIDENCE OF SKILLS GAINED IN THERAPY CARRYING OVER TO OTHER SETTINGS WITHIN SIX MONTHS.
PA87	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE NUMBER OF SESSIONS REQUESTED.
PA88	THE REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL SCOPE OF PRACTICE.
PA89	PRIOR AUTHORIZATION IS NOT REQUIRED UNTIL LIMITATION OF SERVICE HAS BEEN REACHED.
PA91	PLEASE SUBMIT REQUIRED X-RAYS.
PA92	PLEASE PROVIDE AN EXPLANATION FOR THE MATERIAL SUBMITTED WITH THE REQUEST.
PA95	PLEASE DESCRIBE HOW THE PROVISION OF THIS SERVICE WOULD PREVENT INSTITUTIONALIZATION OF THE CLIENT.
PA96	COULD THE EXISTING DENTURE(S) BE RELINED OR REBASED? IF NOT, PLEASE EXPLAIN WHY NOT.
PA97	REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL STANDARDS OF PRACTICE.
PA98	PLEASE INDICATE IF THE CLIENT IS CURRENTLY BEING TUBE FED.
PB02	PLEASE PROVIDE THE REQUIRED DATED SIGNATURES ON THE ATTACHMENTS.
PB03	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING THE LOSS/DESTRUCTION/THEFT OF THE HEARING AID.
PB04	DESCRIBE THE CLIENTS ABILITY TO STAND OR AMBULATE SUFFICIENTLY TO ACCOMPLISH SELF-CARE ACTIVITIES.
PB07	PLEASE SUBMIT AN ORTHODONTIC STUDY MODEL OR DIAGNOSTIC CASTS.
PB09	PLEASE PROVIDE A PHOTOGRAPH OF THE INVOLVED AREA(S).
PB10	PLEASE PROVIDE AN ESTIMATION (IN GRAMS) OF THE TOTAL AMOUNT OF TISSUE TO BE RESECTED.
PB11	PLEASE SUBMIT THE PLAN OF CARE FOR CO-TREATMENT.
PB12	FURNISH A DETAILED DESCRIPTION FOR THE PROCEDURE CODE REQUESTED.
PB13	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB15	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB18	PLEASE COMPLETE THE ATTACHED OUT-OF-STATE PROVIDER DATA SHEET, F-11001, AND RESUBMIT.
PB20	A SIGNED AND DATED PRESCRIPTION IS REQUIRED WITHIN THREE MONTHS OF RECEIPT BY COLORADO MEDICAID FOR INITIAL REQUESTS AND WITHIN 12 MONTHS OF RECEIPT BY COLORADO MEDICAID FOR SUBSEQUENT REQUESTS.
PB21	PLEASE COMPLETE THE APPROPRIATE PRIOR AUTHORIZATION ATTACHMENT. CONTACT PROVIDER SERVICES OR THE PRIOR AUTHORIZATION UNIT FOR ASSISTANCE.
PB23	PHYSICAL THERAPY ASSISTANT NOTES AND ALL FORMS SUBMITTED MUST BE COSIGNED BY A REGISTERED PHYSICAL THERAPIST.
PB31	ARE YOU REQUESTING A COMPLETE APPLIANCE, OR REPLACEMENT PARTS?
PB32	THE PROCEDURE CODE INDICATED ON THE REQUEST DOES NOT MATCH THE DESCRIPTION OF SERVICE; PLEASE CORRECT AND RESUBMIT.

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PB35	THE SERVICE REQUESTED DOES NOT REQUIRE PRIOR AUTHORIZATION.
PB41	PLEASE FURNISH A CURRENT MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT, F-11090 (DATED WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID).
PB45	THE CERTIFICATION PERIOD ON THE PLAN OF CARE (POC) DOES NOT COVER THE REQUESTED GRANT/START DATE. PLEASE RESUBMIT YOUR REQUEST WITH A NEW POC.
PB49	A CERTIFIED OCCUPATIONAL THERAPY ASSISTANTS NOTES MUST BE COSIGNED BY AN OCCUPATIONAL THERAPIST REGISTERED.
PB51	ADDITIONAL INFORMATION IS REQUIRED ON PRIOR AUTHORIZATION TO ENABLE PRICING.
PB54	REQUESTED SERVICES DO NOT MATCH SERVICES ON THE PHYSICIANS ORDERS.
PB59	PLEASE PROVIDE AN INDIVIDUAL EDUCATIONAL PLAN (IEP), WHICH HAS BEEN SIGNED BY THE PROVIDER NO EARLIER THAN NINE MONTHS PRIOR TO RECEIPT AT COLORADO MEDICAID; OTHERWISE, DOCUMENT WHY NO IEP EXISTS.
PB65	PLEASE FURNISH THE ANTICIPATED TOTAL CHARGES FOR THIS REQUEST.
PB66	A PHOTOCOPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED; THE DATE MUST BE WITHIN SIX MONTHS OF RECEIPT BY COLORADO MEDICAID.
PB67	THE PRESCRIPTION DATE MUST INCLUDE MONTH, DAY, AND YEAR.
PB68	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID.
PB73	THE SERVICES IDENTIFIED ON THE PLAN OF CARE DO NOT APPEAR APPROPRIATE FOR THE PROCEDURE CODE(S) REQUESTED ON THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018.
PB74	THE CLIENT/PROVIDER DOES NOT HAVE RETROACTIVE ENROLLMENT.
PB75	THE REQUESTED START DATE IS MORE THAN 14 DAYS BEFORE OR 62 DAYS AFTER RECEIPT.
PB82	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
PB83	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A HOME HEALTH AIDE. PLEASE RESUBMIT AS A PERSONAL CARE WORKER OR PROVIDE ADDITIONAL DOCUMENTATION.
PB86	THE SERVICES REQUESTED ARE NOT BEING PROVIDED IN THE CLIENTS RESIDENCE. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL.
PB87	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A NURSE. PLEASE RESUBMIT AS A HOME HEALTH AIDE OR PROVIDE ADDITIONAL DOCUMENTATION.
PB92	PLEASE FURNISH THE CLIENTS COMPLETE ADDRESS.
PB94	IF THE CLIENT IS A RESIDENT OF A NURSING HOME, SUPPLY THE COMPLETE NAME AND ADDRESS OF THE NURSING HOME.
PB99	THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018, MUST BE SIGNED AND DATED.
PC01	PLEASE SUPPLY THE RENDERING PROVIDERS PROVIDER NUMBER.
PC03	THE DRUG ENFORCEMENT ADMINISTRATION NUMBER IS MISSING OR INVALID.
PC06	PLEASE DESCRIBE YOUR PROGRAM; INCLUDE ENTRY DATE, TERMINATION DATE, HOURS PER WEEK, AND NUMBER OF WEEKS OF PRIMARY INTENSIVE SERVICE REQUESTED.
PC07	PLEASE DESCRIBE YOUR "AFTERCARE/FOLLOW-UP" PLANS FOR THIS CLIENT.
PC08	PLEASE SUPPLY DOCUMENTATION OF PREVIOUS SUBSTANCE ABUSE SERVICES WITH DATE(S) AND OUTCOME.
PC09	PLEASE DESCRIBE IN DETAIL THE TREATMENT OBJECTIVES/GOALS FOR THIS CLIENT.
PC10	PLEASE DESCRIBE THE FAMILY SITUATION/DYNAMICS. EXPLAIN HOW THE FAMILY WILL BE INCORPORATED INTO THE CLIENTS PLAN OF CARE.
PC12	PLEASE EXPLAIN IF YOUR SERVICE ENCOURAGES THE CLIENT TO ATTEND SELF-HELP GROUPS.
PC13	PLEASE SUPPLY A SPECIFIC SCHEDULE OF ACTIVITIES, INCLUDING DAY, TIME OF DAY, LENGTH OF SESSION, AND SERVICE TO BE RENDERED DURING THAT TIME.
PC15	PLEASE FURNISH DIAGNOSTIC RATIONALE.
PC17	PLEASE DOCUMENT IF THE CLIENT EVER RECEIVED SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT.
PC19	PLEASE FURNISH MORE EXTENSIVE AND IN-DEPTH HISTORICAL AND PSYCHOSOCIAL DATA.
PC20	PLEASE SUPPLY THE DATE THE CLIENT BECAME TOTALLY ENDENTULOUS.
PC23	PLEASE SUBMIT A PHYSICIANS STATEMENT REGARDING THE MEDICAL NECESSITY OF DENTURES FOR THIS CLIENT. THE PHYSICIANS STATEMENT MUST DOCUMENT THE MEDICAL NEED FOR DENTURES.
PC24	THE SERVICE REQUESTED WAS PREVIOUSLY AUTHORIZED. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT INDICATING THIS FACT IS REQUIRED.

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PC25	PLEASE SUPPLY SUFFICIENT MITIGATING CIRCUMSTANCES TO WARRANT THE CONSTRUCTION OF NEW DENTURES(S).
PC26	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
PC28	PLEASE SUBMIT A PHYSICIANS STATEMENT INDICATING DENTURES ARE NECESSARY FOR THIS NURSING HOME CLIENT.
PC29	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING LOSS OR DESTRUCTION OF DENTURE(S). INCLUDE SIGNED STATEMENT FROM CLIENT OR FACILITY DIRECTOR REGARDING HOW, WHEN AND WHERE LOST.
PC30	PLEASE PROVIDE COMPLETE INTRAORAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PC31	PLEASE DESCRIBE ANY RELATED DEFORMITIES OF THE FEET.
PC34	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD WITH REQUESTED DME ITEM(S) AND DOCUMENT IF THE CLIENT CAN USE SAFELY AND INDEPENDENTLY.
PC35	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD AND DESCRIBE THE RESULTS AND EFFECTIVENESS OF THE SERVICE REQUESTED.
PC39	PLEASE INDICATE LITER FLOW PER MINUTE, HOURS OF USE PER 24 HOUR PERIOD, AND THE EXPECTED DURATION OF NEED.
PC40	THE ITEM DOES NOT REQUIRE PRIOR AUTHORIZATION UNTIL THE LIFE EXPECTANCY HAS BEEN REACHED.
PC41	PLEASE SUPPLY INFORMATION INDICATING THE NECESSITY OF POSITIONING THE CLIENT'S BODY IN MULTIPLE POSITIONS.
PC42	PLEASE INDICATE IF THE BED HEIGHT MUST BE CHANGED TO ALLOW FOR SAFE TRANSFER OR ADEQUATE BED CARE.
PC43	SUPPLY A PHYSICIANS STATEMENT INDICATING TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR UNIT HAS REDUCED PAIN, IMPROVED/INCREASED THE CLIENTS ACTIVITY LEVEL, AND/OR REDUCED CLIENTS USE OF PAIN MEDICATION.
PC44	A CURRENT AUTHORIZATION FOR THIS SERVICE IS ON FILE FOR ANOTHER PROVIDER. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT OF THAT FACT IS REQUIRED BY THE CLIENT OF FIRST PROVIDER.
PC59	DOCUMENT DECLINE OR PROGRESS IN SPECIFIC, MEASURABLE, OBJECTIVE TERMS.
PC60	DOCUMENT IF CLIENT HAS DEMONSTRATED A GOOD APPOINTMENT COMPLIANCE RECORD.
PC61	THE PHYSICIANS SIGNATURE DATE MUST NOT EXCEED 90 DAYS FROM THE DATE OF RECEIPT BY COLORADO MEDICAID.
PC62	REQUESTS FOR A CONTINUATION OF THERAPY SHOULD NOT BE SUBMITTED MORE THAN FOUR WEEKS PRIOR TO THE EXPIRATION DATE OF THE CURRENT AUTHORIZATION.
PC63	PLEASE FURNISH THE STYLE AND MANUFACTURER OF THE FRAME.
PC64	PLEASE FURNISH THE CLIENTS LENS FORMULA.
PC66	ALL REQUESTS FOR TINTS REQUIRE DOCUMENTATION OF THE VISUAL OR MEDICAL CONDITION RELATED TO PHOTOPHOBIA.
PC67	PLEASE DOCUMENT THE REASON AND JUSTIFICATION FOR REPLACEMENT BEYOND THE FIRST LENS/FRAME.
PC68	DOCUMENT IF ALL REMAINING MAXILLARY AND/OR MANDIBULAR TEETH ARE DECAY-FREE, PROPERLY RESTORED, AND PERIODONTICALLY SOUND.
PC72	SUPPLY MORE DETAIL REGARDING PROGRESS (ATTACHMENT OF GOALS, ETC.). CORRELATE PROGRESS TO PREVIOUS GOALS AND IDENTIFIED LIMITATIONS.
PC77	PLEASE SUBMIT A PLAN OF CARE DESCRIBING THE SERVICES THAT WOULD BE PROVIDED.
PC78	PLEASE DOCUMENT SPECIFIC, MEASURABLE GOALS.
PC82	THE PRIOR AUTHORIZATION (PA) SYSTEM CAN PROCESS ONLY 26 DETAILS PER PA REQUEST. PLEASE RESUBMIT YOUR REQUEST WITH NO MORE THAN 26 DETAILS.
PC83	PLEASE SUPPLY A PHYSICIANS PRESCRIPTION DATED WITHIN ONE MONTH OF REQUESTED SUBSTANCE ABUSE DAY TREATMENT.
PC84	PLEASE PROVIDE INFORMATION INDICATING THIS CLIENT IS APPROPRIATELY DETOXIFIED FROM ALCOHOL AND/OR OTHER DRUGS.
PC85	PLEASE PROVIDE INFORMATION TO INDICATE THE CLIENTS ABILITY TO ABSTAIN FROM ALCOHOL OR DRUGS WHILE IN THE SUBSTANCE ABUSE DAY TREATMENT PROGRAM.

Denial Code	Long Description
PC86	PLEASE INDICATE IF THIS CLIENT IS WILLING TO PARTICIPATE IN AFTERCARE OR CONTINUING CARE SERVICES.
PC87	PROVIDE MORE INFORMATION ON TREATMENT HISTORY; INCLUDE SERVICE PROVIDED, DATES, AND OUTCOME. PROVIDE DETAIL OF PREVIOUS TREATMENT.
PC88	PLEASE PROVIDE MORE RATIONALE FOR THE APPROPRIATENESS AND MEDICAL NECESSITY OF SUBSTANCE ABUSE DAY TREATMENT.
PC89	PROVIDE A TREATMENT PLAN THAT CONTAINS MEASURABLE GOALS AND OBJECTIVES CORRESPONDING TO THE IDENTIFIED DEFICIT.
PC91	PLEASE PROVIDE MORE INFORMATION ON FAMILY INVOLVEMENT TREATMENT.
PC92	PLEASE PROVIDE MORE HISTORY AND EXPLANATION ABOUT THE ISSUE OF ABSTINENCE FOR THIS CLIENT.
PC94	PLEASE PROVIDE THE ANTICIPATED BEGINNING DATE AND/OR THE ESTIMATED SUBSTANCE ABUSE DAY TREATMENT DISCHARGE DATE.
PC95	PLEASE SUPPLY JUSTIFICATION FOR BEGINNING CLIENT IN SERVICE PRIOR TO AUTHORIZATION BEING OBTAINED.
PC96	THE INITIAL THREE HOURS OF SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IN A CALENDAR YEAR DO NOT REQUIRE PRIOR AUTHORIZATION.
PC97	REIMBURSEMENT FOR INITIAL SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IS LIMITED TO THREE HOURS IN A CALENDAR YEAR AND DOES NOT REQUIRE PRIOR AUTHORIZATION.
PC98	THIS DRUG IS CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE BILL USING THE APPROPRIATE NATIONAL DRUG CODE (NDC) OR SUBMIT A COMPLETED DRUG ADDITION REQUEST FORM IF THE NDC IS NOT LISTED IN THE DRUG INDEX.
PC99	THIS DRUG IS NOT CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL, CURRENT ADMINISTRATIVE RULE, OR COLORADO DRUG INDEX FOR COVERAGE LIMITATIONS.
PD01	DOCUMENT THAT CLIENT HAS ACHIEVED GOOD ORAL HYGIENE, PERIODONTAL CASE TYPE 1 OR 2, AND IS MOTIVATED TO MAINTAIN SAME.
PD03	PLEASE PROVIDE AN ARTERIAL BLOOD GAS READING OR PULSE OXIMETRY RESULTS DONE ON ROOM AIR SIGNED AND DATED BY A MEDICAL DOCTOR. THIS SHOULD BE DONE WITHIN 60 DAYS OF REQUESTED SERVICE.
PD04	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 30 DAYS OF RECEIPT BY COLORADO MEDICAID.
PD07	SUBMIT A PHOTOCOPY OF A VALID PRESCRIPTION, ISSUED WITHIN THE PAST YEAR, OR COMPLETE SECTION B OF THE PRIOR AUTHORIZATION/DRUG ATTACHMENT (PA/DGA), F-11049.
PD10	BRAND MEDICALLY NECESSARY MUST BE IN THE PRESCRIBERS OWN HANDWRITING AND WRITTEN DIRECTLY ON THE PRESCRIPTION OR A SEPARATE ORDER ATTACHED TO THE ORIGINAL PRESCRIPTION.
PD12	COMPLETE DENTURES, PARTIAL DENTURES, DENTURE RELINES, AND FIXED PROSTHODONTIC SERVICES ARE NOT COVERED SERVICES FOR ADULTS FOR DATES OF SERVICE ON AND AFTER OCTOBER 1, 1995.
PD22	PLEASE COMPLETE ALL REQUIRED ELEMENTS ON THE PERSONAL CARE SCREENING TOOL (PCST), F-11133.
PD24	THIS PRIOR AUTHORIZATION REQUEST IS UNABLE TO BE PROCESSED. PLEASE RESUBMIT WITH ADDITIONAL REQUIRED FORMS, INCLUDING THE ENTIRE PERSONAL CARE SCREENING TOOL (PCST), F-11133; PERSONAL CARE ADDENDUM, F-11136; AND SUPPORTING DOCUMENTATION, AS DIRECTED.
PD25	THERE IS A PERSONAL CARE SCREENING TOOL (PCST), F-11133, COMPLETED BY ANOTHER AGENCY. CONTACT THE AGENCY TO TRANSFER SCREEN.
PD26	THERE IS A LIMITED TERM CARE FUNCTIONAL SCREEN (LTC-FS) COMPLETED BY ANOTHER AGENCY. THE PERSONAL CARE SCREENING TOOL (PCST), F-11133, INFORMATION IS IN CONFLICT WITH LTC-FS.
PD27	ONLY ONE LEVEL OF FUNCTION MAY BE SELECTED FOR ALL ELEMENTS EXCEPT TOILETING. COLORADO MEDICAID IS UNABLE TO PROCESS THE PRIOR AUTHORIZATION REQUEST.
PD28	NO UNITS MAY BE REQUESTED USING THIS PRIOR AUTHORIZATION PROCESS. PLEASE SUBMIT WITH THE APPROPRIATE ATTACHMENTS FOR REQUESTING SPECIFIC PERSONAL CARE WORKER UNITS.
PD29	CLIENT IS NOT ELIGIBLE FOR THE REQUESTED SERVICE(S) AS OF THE REQUESTED START DATE.
PD30	NO TRAVEL TIME MAY BE AUTHORIZED WHEN NO PERSONAL CARE WORKER SERVICE IS AUTHORIZED.
PD32	PROVIDER NOT CERTIFIED TO RENDER THE SERVICE(S) REQUESTED.

Denial Code	Long Description
PD34	BASED ON THE DOCUMENTATION SUBMITTED, THIS REQUEST CAN NOT BE PRIOR AUTHORIZED. REFER TO THE PA MESSAGES FROM THE CONSULTANT FOR COMPLETE EXPLANATION.
PD98	PLEASE DOCUMENT HOW AND WHEN EACH PREVIOUSLY AUTHORIZED PRO RE NATA VISIT WAS USED.

Psychotherapy

Denial Code	Long Description
0201	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
0233	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0235	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0237	CLIENT IDENTIFICATION NUMBER DOES NOT MATCH CLIENTS FIRST NAME.
0238	THE CLIENT IDENTIFICATION NUMBER DOES NOT MATCH THE CLIENTS LAST NAME.
0242	SECONDARY DIAGNOSIS CODE IS INVALID.
0248	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0249	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0251	PROCEDURE CODE MODIFIER IN FIRST POSITION IS INVALID.
0252	THE PROCEDURE CODE MODIFIER IN SECOND POSITION IS INVALID FOR REQUESTED START DATE OR DATE OF RECEIPT.
0253	THE PROCEDURE CODE MODIFIER IN THIRD POSITION IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
0258	THE PRIMARY DIAGNOSIS CODE IS REQUIRED.
0272	THE PRIMARY DIAGNSOSIS CODE IS INVALID.
0400	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0853	HCPCS - ANNUAL UPDATE
0885	NEVER EVENTS MODIFIERS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
0886	NEVER EVENTS DIAGNOSIS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
1000	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
1002	RENDERING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1003	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1007	RENDERING PROVIDER ID IS NOT ON FILE.
1047	THE RENDERING PROVIDERS CERTIFICATION HAS BEEN CANCELLED.
1048	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1801	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
1804	A CERTIFIED SUBSTANCE ABUSE DAY TREATMENT PROVIDER MUST SUBMIT A SUBSTANCE ABUSE DAY TREATMENT PROCEDURE CODE.
1806	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
1808	THE BILLING PROVIDER DOES NOT HAVE THE REQUIRED CERTIFICATION ADDENDUM ON FILE.
1900	THE BILLING PROVIDERS TAXONOMY CODE IS INVALID.
1901	THE RENDERING PROVIDERS TAXONOMY CODE IS INVALID.
1927	A NATIONAL PROVIDER IDENTIFIER IS REQUIRED FOR THE BILLING PROVIDER.
1934	A NATIONAL PROVIDER INDENTIFIER IS REQUIRED FOR THE RENDERING PROVIDER.
1936	THE BILLING PROVIDER NUMBER IS INVALID.
1937	THE RENDERING PROVIDER NUMBER IS INVALID.
1960	INTERNAL PROCESSING IS REQUIRED.
1963	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.
1964	THE BILLING PROVIDER INDICATED IS NOT ALLOWABLE AS A BILLING PROVIDER.

Denial Code	Long Description
1965	RENDERING PROVIDER NUMBER IS MISSING/INVALID FOR THIS PROCEDURE PROVIDER.
1974	PRESCRIBING/REFERRING/ORDERING PROVIDER INDICATED IS NOT CERTIFIED AS A PRESCRIBING/REFERRING/ORDERING PROVIDER.
1975	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
1976	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
2001	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2003	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2017	THE CLIENT IS ENROLLED IN A MEDICAID OR OTHER MANAGED CARE PROGRAM.
2037	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2603	CLIENT LOCKED-IN TO A PROVIDER OR ENROLLED IN A HOSPICE. CONTACT CLIENTS HOSPICE FOR PAYMENT OF SERVICES OR RESUBMIT WITH DOCUMENTATION OF UNRELATED NATURE OF CARE.
3324	THE MODIFIER HAS BEEN DISCONTINUED BY THE CENTERS OF MEDICARE AND MEDICAID SERVICES OR THE AMERICAN MEDICAL ASSOCIATION FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
3337	THE PROCEDURE CODE HAS BEEN TERMINATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AMERICAN MEDICAL ASSOCIATION, OR AMERICAN DENTAL ASSOCIATION FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT. RESUBMIT WITH VALID A PROCEDURE CODE.
3339	THE PROCEDURE BILLED IS NOT PAYABLE ACCORDING TO DEFICIT REDUCTION ACT (DEFRA) GUIDELINES.
3351	THE PROCEDURE IS NOT COVERED FOR CLIENTS WITH A NURSING HOME AUTHORIZATION ON THE REQUESTED START DATE OR DATE OF RECEIPT.
3353	THE PROCEDURE IS NOT A COVERED SERVICE FOR HOME AND COMMUNITY-BASED WAIVER CLIENTS.
4021	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4027	THE DIAGNOSIS CODE IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
4031	THE PROCEDURE SUBMITTED IS NOT APPROPRIATE FOR CLIENTS GENDER.
4032	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4034	THE PROCEDURE CODE HAS AN AGE RESTRICTION.
4036	THE PLACE OF SERVICE CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4040	THE PRIMARY DIAGNOSIS CODE IS NOT ON FILE.
4041	THE SECONDARY DIAGNOSIS IS NOT ON FILE.
4046	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4127	INTERNAL PROCESSING IS REQUIRED.
4131	INTERNAL PROCESSING IS REQUIRED.
4141	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4149	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4150	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4236	ETIOLOGY DIAGNOSIS CODE(S) (E-CODES) ARE INVALID AS THE PRIMARY DIAGNOSIS.
4244	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4245	THE FOURTH POSITION MODIFIER IS INVALID FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT.
4256	THE PROCEDURE CODE AND MODIFIER COMBINATION IS NOT PAYABLE FOR THE CLIENTS BENEFIT PLAN.
4257	THE MODIFIERS SUBMITTED ARE EITHER INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT OR THE MODIFIERS ARE MISSING.
4311	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4315	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4316	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4371	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4372	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4711	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR CLIENTS AGE.
4714	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS AGE.
4731	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS DIAGNOSIS.
4742	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4743	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4744	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.

Denial Code	Long Description
4745	DIAGNOSIS AND/OR PROCEDURE AND/OR PLACE OF SERVICE (POS) CODE IS NOT COVERED FOR EXPRESS ENROLLMENT CLIENTS.
4746	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4801	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4802	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
4821	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
4871	PLEASE REFER TO PA MESSAGES FOR RETURN INFORMATION.
4963	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS GENDER.
4990	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
7500	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
7509	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
P001	THE BILLING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THE SERVICES.
P002	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P003	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P005	THE PRIOR AUTHORIZATION CAN NOT BE END DATED. THE PRIOR AUTHORIZATION STATUS IS NOT APPROVED OR APPROVED WITH REVISIONS.
P006	PLEASE FURNISH THE PROCEDURE CODE AND CORRESPONDING DESCRIPTION.
P008	THE BILLING PROVIDER NUMBER IS INVALID.
P009	THE BILLING PROVIDER NUMBER IS INVALID.
P010	THE REQUESTED END DATE IS INVALID.
P011	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P012	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P013	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P014	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P015	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P016	THE REQUESTED START DATE IS MISSING OR INVALID.
P019	THE REQUESTED START DATE IS MISSING OR INVALID.
P020	THE RENDERING PROVIDER NUMBER IS INVALID.
P021	THE RENDERING PROVIDER NUMBER IS INVALID.
P022	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P023	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P024	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P026	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P027	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P030	FIRST MODIFIER IS INVALID.
P031	FIRST MODIFIER IS INVALID.
P032	SECOND MODIFIER IS INVALID.
P033	SECOND MODIFIER IS INVALID.
P034	THIRD MODIFIER IS INVALID.
P035	THIRD MODIFIER IS INVALID.
P036	FOURTH MODIFIER IS INVALID.
P037	FOURTH MODIFIER IS INVALID.
P038	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P039	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.

Denial Code	Long Description
P040	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P041	CLIENTS FIRST NAME IS MISSING.
P042	CLIENTS LAST NAME IS MISSING.
P043	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P044	BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES REQUESTED.
P045	FIRST MODIFIER IS INVALID.
P046	SECOND MODIFIER IS INVALID.
P047	THIRD MODIFIER IS INVALID.
P048	FOURTH MODIFIER IS INVALID.
P052	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P053	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P054	RENDERING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES FOR THE BENEFIT PLAN.
P055	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P061	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P062	THE CLIENT ID AND/OR NAME INDICATED ON THE PA REQUEST IS INCORRECT. THE CLIENT ID AND/OR NAME HAS BEEN UPDATED. PLEASE VERIFY THE ID AND/OR NAME IS CORRECT.
P064	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
P067	THE FREQUENCY OF HOURS REQUESTED ARE NOT APPROPRIATE FOR THIS CLIENT AND HAVE BEEN MODIFIED ACCORDINGLY.
P079	BILLING PROVIDER IS ON PAYMENT SUSPENSION DUE TO CREDIBLE ALLEGATION OF FRAUD.
P120	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAS BEEN REDUCED.
P121	THE SERVICE/ PROCEDURE REQUESTED IS NOT SUPPORTED BY SUBMITTED DOCUMENTATION.
P126	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
P128	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.
P138	SERVICE(S) DO NOT MEET COLORADO MEDICAID GUIDELINES.
P167	REQUESTED DOCUMENTATION HAS NOT BEEN SUBMITTED.
P178	THE SERVICE REQUESTED IS NOT MEDICALLY NECESSARY.
P179	THE MEDICAL NECESSITY FOR THIS SERVICE IS NOT SUPPORTED BY THE SUBMITTED DOCUMENTATION.
P233	THE DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE ADDITIONAL CARE.
P257	THIS CLIENTS FUNCTIONAL ASSESSMENT SCORES PLACE THIS CLIENT OUTSIDE ELIGIBILITY FOR DAY TREATMENT.
P274	OUR RECORDS INDICATE THIS CLIENT IS INVOLVED IN EFFECTIVE AND APPROPRIATE SERVICE ELSEWHERE.
P292	INTENSIVE REHABILITATION HOURS ARE NO LONGER APPROPRIATE AS INDICATED BY HISTORY, DIAGNOSIS, AND/ OR FUNCTIONAL ASSESSMENT SCORES.
P328	THE SERVICES REQUESTED INCLUDE NON-COVERED SERVICES, AND HOURS ARE REDUCED ACCORDINGLY.
P339	THE CLIENTS PAST HISTORY INDICATES REDUCED TREATMENT HOURS ARE WARRANTED.
P342	THE REQUEST DOES NOT MEET GENERALLY ACCEPTED CONDITIONS REQUIRING FLUORIDE TREATMENTS.
P346	SERVICES EXCEED COLORADO MEDICAID LIMITATION AND DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE MEDICAL NECESSITY OF THE SERVICE.
P349	THE SERVICE REQUESTED WAS PERFORMED LESS THAN FIVE YEARS AGO.
P353	THE EXISTING APPLIANCE HAS NOT BEEN WORN FOR THREE YEARS.
P367	THE CLIENT HAS BEEN TOTALLY WITHOUT TEETH AND AN APPLIANCE FOR FIVE YEARS.
P392	THE CLIENT IS MISSING AN ANTERIOR TOOTH AND/OR HAS TWO OR MORE POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P405	THE SERVICE(S) REQUESTED COULD ADEQUATELY BE PERFORMED IN THE DENTAL OFFICE.
P406	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE OF GOOD PERIODONTAL HEALTH (AMERICAN ACADEMY OF PERIODONTOLOGY PERIODONTAL CLASSIFICATION OF TYPE I OR II).
P407	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE VISIBLE ON RADIOGRAPHS THAT AT LEAST 50 PERCENT OF THE CLINICAL CROWN IS INTACT.

Denial Code	Long Description
P409	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING SIX OR MORE TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED, INCLUDING THIRD MOLARS.
P410	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING ONE OR MORE ANTERIOR TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED.
P411	DOCUMENTATION DOES NOT SUPPORT THE NEED FOR PERIODONTIC SERVICES. POCKETS ARE LESS THAN 4MM AND/OR GREATER THAN 6MM FOR CLIENT AND/OR THE CLIENT IS UNDER THE AGE OF 13.
P412	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA.
P413	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA. THIS PA HAS BEEN GRANTED AS APPROVED NOT APPROVED WITH REVISIONS. THE DURATION REQUESTED MAY HAVE BEEN REDUCED TO REFLECT COVERAGE LIMITATIONS, PRESCRIBER ORDERS, CONFLICTI
P417	THE SERVICE(S) REQUESTED COULD BE ADEQUATELY PERFORMED WITH LOCAL ANESTHESIA.
P437	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO POOR ORAL HYGIENE.
P444	THIS LINE ITEM IS A DUPLICATE OF ANOTHER LINE ITEM ON THIS PRIOR AUTHORIZATION (PA) REQUEST. PLEASE CORRECT.
P446	THIS IS A DUPLICATE OF AN EXISTING PRIOR AUTHORIZATION (PA) REQUEST. YOU MAY CONTACT PROVIDER SERVICES IF YOU REQUIRE ASSISTANCE. DUPLICATE PA REQUEST
P448	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO DECAY HISTORY.
P449	QUESTIONABLE LONG TERM PROGNOSIS DUE TO GUM AND BONE DISEASE.
P456	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO APPARENT ROOT INFECTION.
P457	OUR RECORDS INDICATE THIS CLIENT HAS EXCEEDED ESTABLISHED PROGRAM LIMITATIONS. COLORADO MEDICAID WILL NOT AUTHORIZE NEW DENTURES.
P458	DOCUMENTATION PROVIDED INDICATES A LESS ELABORATE PROCEDURE SHOULD BE CONSIDERED.
P502	RENTAL ONLY ALLOWED; MEDICAL NEED FOR PURCHASE HAS NOT BEEN DOCUMENTED.
P503	PURCHASE ONLY ALLOWED; MEDICAL NEED FOR RENTAL HAS NOT BEEN DOCUMENTED.
P504	OCCUPATIONAL THERAPY GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P505	THE SERVICE REQUESTED IS INCLUDED IN THE NURSING HOME RATE STRUCTURE.
P511	THIS NATIONAL DRUG CODE IS ONLY BILLABLE AS PART OF A COMPOUND DRUG.
P515	THE PRESENCE OF A HANDICAPPING MALOCCLUSION OR HANDICAPPING DENTOFACIAL DEFORMITY IS NOT SUPPORTED BY THE DOCUMENTATION SUBMITTED.
P521	THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVERED BY COLORADO MEDICAID.
P522	GASTRO-INTESTINAL SURGERY FOR THE PURPOSE OF WEIGHT CONTROL IS COVERED ONLY AS A LIFE THREATENING PROCEDURE.
P523	THE TREATMENT REQUEST IS NOT CONSISTENT WITH THE CLIENT'S DIAGNOSIS.
P524	PSYCHOTHERAPY PROVIDED IN THE CLIENTS HOME IS NOT A COVERED BENEFIT OF COLORADO MEDICAID.
P525	THE INFORMATION PROVIDED IS NOT CONSISTENT WITH THE INTENSITY OF SERVICES REQUESTED.
P526	INTENSIVE MULTIPLE MODALITY TREATMENT IS NOT CONSISTENT WITH THE INFORMATION PROVIDED.
P527	MULTIPLE PROVIDERS OF TREATMENT ARE NOT INDICATED FOR THIS CLIENT.
P528	THE DURATION OF TREATMENT SESSIONS EXCEED CURRENT COLORADO MEDICAID GUIDELINES.
P534	DOCUMENTATION OF POOR PHYSICAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P535	OTHER PHYSICAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P536	THE PHYSICAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P537	USE OF PHYSICAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P538	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF A PHYSICAL THERAPIST.
P539	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS AND LIVING ARRANGEMENT.
P540	GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P541	THE PROCEDURE(S) REQUESTED ARE NOT MEDICAL IN NATURE.

Denial Code	Long Description
P542	DOCUMENTATION OF POOR OCCUPATIONAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P543	DOCUMENTATION OF POOR SPEECH THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P544	OTHER OCCUPATIONAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P546	THE OCCUPATIONAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P547	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF PHYSICAL THERAPY.
P548	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P549	ACTIVITIES TO PROMOTE DIVERSION OR GENERAL MOTIVATION ARE NONCOVERED COLORADO MEDICAID SERVICES.
P550	REVISIONS OF THE REQUEST IS NECESSITATED BY THE CLIENTS MINIMAL PROGRESS.
P551	RESTORATIVE NURSING INVOLVEMENT COULD BE INCREASED.
P552	CLIENTS DEMONSTRATED RESPONSE TO CURRENT THERAPY DOES NOT WARRANT THE INTENSE FREQUENCY REQUESTED.
P553	MAINTENANCE IS TWO TIMES PER WEEK OR LESS.
P554	THE SPEECH THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P555	USE OF OCCUPATIONAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P556	USE OF SPEECH THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P557	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF AN OCCUPATIONAL THERAPIST.
P558	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
P559	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P560	THE MATERIALS/ SERVICES REQUESTED ARE PRINCIPALLY COSMETIC IN NATURE.
P561	THE LENS FORMULA DOES NOT JUSTIFY REPLACEMENT.
P562	THE CHANGE IN THE LENS FORMULA DOES NOT WARRANT MULTIPLE REPLACEMENTS.
P563	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P564	LENSES ONLY ARE APPROVED; PLEASE DISPENSE A CONTRACTED FRAME. THE NON-CONTRACTED FRAME IS NOT MEDICALLY JUSTIFIED.
P565	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P566	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P567	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF OCCUPATIONAL THERAPY.
P568	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF SPEECH THERAPY.
P569	LEVEL, INTENSITY, OR EXTENT OF SERVICE(S) REQUESTED HAS BEEN MODIFIED CONSISTENT WITH MEDICAL NEED AS DEFINED IN THE PLAN OF CARE.
P570	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P571	THE SERVICE ASKED FOR IS NOT COVERED BY COLORADO MEDICAID AS THESE TASKS CAN BE DONE BY NURSES OR ACTIVITY STAFF.
P572	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P573	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.
P574	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P575	MEDICAL NEED FOR EQUIPMENT/ SUPPLY REQUESTED IS NOT SUPPORTED BY DOCUMENTATION SUBMITTED.
P576	OTHER SPEECH THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.

Denial Code	Long Description
P577	DOCUMENTATION SUBMITTED IDENTIFIES THAT THE CLIENT HAS FEWER THAN TWO POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P582	LESS EXPENSIVE ALTERNATIVE SERVICES ARE AVAILABLE FOR THIS CLIENT.
P634	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P711	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING PERIODONTAL SCALING AND ROOT PLANNING.
P712	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING GINGIVECTOMY.
P754	AN APPROVED SUBSTANCE ABUSE DAY TREATMENT PROGRAM CANNOT EXCEED A SIX WEEK PERIOD.
P761	THE CLIENT DOES NOT APPEAR TO BE ABLE OR WILLING TO ABSTAIN FROM ALCOHOL/DRUG USAGE WHILE IN TREATMENT. THEREFORE, SUBSTANCE ABUSE DAY TREATMENT SERVICES ARE NOT APPROVED.
P764	THIS CLIENT HAS COMPLETED INTENSIVE SUBSTANCE ABUSE TREATMENT WITHIN THE PAST 12 MONTHS. THE DOCUMENTATION PROVIDED IS NOT ADEQUATE TO JUSTIFY ADDITIONAL INTENSIVE TREATMENT AT THIS TIME.
P785	A LESS THAN SIX-WEEK HEALING PERIOD HAS BEEN SPECIFIED FOR THIS PRIOR AUTHORIZATION. THEREFORE IT IS NOT NECESSARY TO WAIT THE FULL SIX WEEKS AFTER EXTRACTIONS BEFORE TAKING DENTURE IMPRESSIONS.
P818	SIX-WEEK HEALING TIME IS REQUIRED BETWEEN EDENTULATION AND FINAL IMPRESSIONS. PAYMENT FOR DENTURES WILL BE DENIED OR RECOUPED IF HEALING PERIOD IS NOT OBSERVED.
P849	COLORADO MEDICAID HAS DETERMINED THERE WERE (ARE) SEVERAL HOME HEALTH AGENCIES WILLING TO PROVIDE MEDICALLY NECESSARY SKILLED NURSING SERVICES TO THIS CLIENT.
P864	THE DOCUMENTATION YOU HAVE SUBMITTED DOES NOT MEET THE REQUIREMENTS OF COLORADO MEDICAID.
P873	THE MEDICAL NECESSITY FOR THE HOURS REQUESTED IS NOT SUPPORTED BY THE INFORMATION SUBMITTED.
P874	THE DOCUMENTATION SUBMITTED INDICATES THE TASKS SPECIFIED CAN BE COMPLETED DURING THE VISITS APPROVED.
P878	THE DOCUMENTATION SUBMITTED DOES NOT INDICATE THAT MEDICALLY ORIENTED TASKS ARE MEDICALLY NECESSARY; THEREFORE PERSONAL CARE SERVICES HAVE BEEN APPROVED.
P880	THE QUANTITY OF SERVICES AUTHORIZED FOR THIS CLIENTS PERSONAL CARE HAS BEEN AMENDED BASED ON INFORMATION RECEIVED FROM ONE OR MORE OF THESE SOURCES: THE CLIENT, THEIR PHYSICIAN, AND/OR THE IN-HOME VISIT BY STAFF OF THE OIG (OFFICE OF INSPECTOR GENERAL).
P885	THE USE OF THIS DRUG FOR THE INTENDED PURPOSE IS NOT COVERED BY COLORADO MEDICAID, CONSISTENT WITH COLORADO ADMINISTRATIVE CODE AND FEDERAL LAW.
P924	THE MEDICAL RECORDS SUBMITTED WITH THE CURRENT REQUEST CONFLICT OR DISAGREE WITH OUR MEDICAL RECORDS ON THIS CLIENT.
P950	INDEPENDENT NURSES, PLEASE NOTE PAYABLE SERVICES MAY NOT EXCEED 12 HOURS/DAY OR 60 HOURS/WEEK.
P951	SERVICES CAN ONLY BE AUTHORIZED THROUGH ONE YEAR FROM THE PRESCRIPTION DATE.
P952	LEAD INSPECTION IS A COVERED COLORADO MEDICAID SERVICE WHEN THE CHILD HAS BEEN SHOWN TO HAVE LEAD POISONING (E.G., CHILD HAS A BLOOD LEAD LEVEL > 19 UG/DL OR TWO CONSECUTIVE BLOOD LEAD LEVELS OF 15-19 UG/DL DONE AT LEAST 90 DAYS APART). THE INSPECTION MUS
P953	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P954	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P956	THE REQUEST CAN ONLY BE BACKDATED A MAXIMUM OF 14 DAYS FROM FIRST DATE RECEIVED BY COLORADO MEDICAID.
P957	COMPLETE PERIODONTAL CHARTING AT TIME OF SERVICE, AND SUBMIT CHARTING, COPY OF OPERATIVE REPORT, TOGETHER WITH A COPY OF THE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF), F-11035, TO PA UNIT ATTENTION DENTAL CONTSULTANT.
P958	NOTE THAT CODE D4341 HAS BEEN CHANGED. REFER TO THE DECISION NOTICE FOR AUTHORIZED QUANTITY.

Denial Code	Long Description
P960	YOUR PA HAS BEEN APPROVED FOR 90 DAYS. THE 90 DAY APPROVAL DOES NOT IMPLY THE PA REQUEST MEETS PRIOR AUTHORIZATION CRITERIA. AFTER ADDITIONAL INFORMATION IS AVAILABLE IN INTERCHANGE, COLORADO MEDICAID WILL CREATE AN AMENDMENT REQUEST TO EXTEND THE PA FOR
P961	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P962	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
PA10	THE REQUESTED END DATE IS INVALID.
PA12	PLEASE FURNISH A WRITTEN DESCRIPTION OF THE CLIENTS DIAGNOSIS.
PA13	PROVIDE DIAGNOSES WITH DATES OF ONSET.
PA14	IDENTIFY PROBLEMS TO BE TREATED.
PA15	THE AUDIOLOGISTS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1), F-11020, AND PRIOR AUTHORIZATION REQUEST/HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2), F-11021.
PA16	THE PHYSICIANS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION/PHYSICIAN OTOLOGICAL REPORT (PA/POR), F-11019.
PA17	SUBMIT BRIEF HISTORY WITH REFERRAL INFORMATION, LIVING SITUATION, FUNCTIONAL STATUS, AND OTHER PERTINENT INFORMATION. WHAT CHANGE OF STATUS RESULTED IN REFERRAL AT THIS TIME?
PA18	PLEASE FURNISH THE CLIENTS HEIGHT AND WEIGHT.
PA19	PLEASE SUBMIT CLINICAL INFORMATION SUFFICIENT TO VERIFY THE NEED FOR THE REQUESTED SERVICE(S).
PA20	PLEASE RESUBMIT WITH COMPLETE PERIODONTAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PA21	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL EDUCATIONAL PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA22	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL PROGRAM PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA23	REFER TO THE DURABLE MEDICAL EQUIPMENT INDEX FOR APPROPRIATE CODE AND DESCRIPTION. DO NOT USE AN "UNLISTED" CODE.
PA24	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUALIZED FAMILY SERVICE PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA25	INFORMATION ON THE REQUEST FORM IS ILLEGIBLE, AND THE REQUEST CANNOT BE PROCESSED.
PA26	RE-EVALUATE YOUR GOALS. EMPHASIS SHOULD BE ON FUNCTIONAL SELF-CARE. GOALS MUST BE RELATED TO FUNCTIONAL OUTCOME.
PA27	PLEASE CLARIFY THE NUMBER OF HOURS PER WEEK REQUESTED.
PA28	PLEASE CLARIFY THE NUMBER OF HOURS PER DAY REQUESTED.
PA29	PLEASE CLARIFY THE NUMBER OF VISITS PER DAY REQUESTED.
PA30	ATTACH SUPPORTIVE DOCUMENTATION; HOME EXERCISE PROGRAM AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA31	THE DIAGNOSIS CODE INDICATED ON THE REQUEST DOES NOT CORRESPOND TO THE DIAGNOSIS CODE DESCRIPTION.
PA32	PLEASE SUBMIT ADDITIONAL INFORMATION SUFFICIENT TO VERIFY APPROPRIATENESS AND NEED FOR TRANSPLANT.
PA33	PLEASE SUBMIT THE INITIAL AND PROGRESSIVE OBJECTIVE FINDINGS.
PA34	ATTACH SUPPORTIVE DOCUMENTATION, FACILITY PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA35	PLEASE SUBMIT THE CLIENTS ORIGINAL COMPLAINTS AND EXAMINATION FINDINGS.
PA36	ATTACH SUPPORTIVE DOCUMENTATION, IN-HOME AUTISM PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA37	PLEASE SUBMIT YOUR TREATMENT PLAN FOR THIS CLIENT.
PA38	ATTACH SUPPORTIVE DOCUMENTATION AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.

Denial Code	Long Description
PA39	INITIAL EVALUATIONS MUST BE PERFORMED BY AN OCCUPATIONAL THERAPIST REGISTERED (OTR), PER AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA) STANDARDS.
PA41	IDENTIFY THE PLACE OF SERVICE AND ITS EFFECT ON SUPPORTING THE DESIRED TREATMENT OUTCOME.
PA42	PLEASE INDICATE THE HOURS OF USE OF OXYGEN PER 24-HOUR PERIOD.
PA43	PROVIDE BASELINE DOCUMENTATION FOR THIS CLIENTS LIMITATIONS USING UNITS OF MEASUREMENT THAT ARE APPLIED CONSISTENTLY WHEN REPORTING STATUS.
PA44	IDENTIFY FUNCTIONAL LIMITATIONS AS THEY ARE RELATED TO IDENTIFIED CONDITIONS.
PA46	CORRELATE PLAN OF CARE TO REQUESTED PROCEDURE CODES.
PA47	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE FREQUENCY/DURATION REQUESTED.
PA48	PLEASE PROVIDE THE NAME AND CREDENTIALS OF THE RENDERING PROVIDER.
PA50	COLORADO MEDICAID RECORDS INDICATE THE CLIENT OWNS A WHEELCHAIR. DOCUMENT THE REASON AND NEED FOR REPLACEMENT AND COST TO REPAIR CURRENT WHEELCHAIR.
PA51	PLEASE DISTINGUISH PRIMARY AND SUPPORTIVE MODALITIES.
PA52	PLEASE SUBMIT A PROGRESS REPORT.
PA53	MULTIPLE FAMILY CLIENTS TREATMENT BY THE SAME PROVIDER REQUIRES FURTHER INFORMATION DOCUMENTING COORDINATION OF TREATMENT PLAN.
PA54	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE MINUTES REQUESTED.
PA55	MEDICAL NECESSITY OF TREATMENT REQUIRES ADDITIONAL DOCUMENTATION.
PA56	GIVEN AGE, DIAGNOSES, CURRENT LEVEL OF FUNCTION, PAST RESPONSE TO TREATMENT, AND LIVING SITUATION, EXPAND ON POTENTIAL FOR SIGNIFICANT FUNCTIONAL PROGRESS WITHIN THE NEXT SIX MONTHS. EMPHASIZE WHY PROGRESS IS EXPECTED WITH SERVICES AT THIS TIME.
PA57	SUBMIT THE INITIAL FINDINGS. INCLUDE A COMPREHENSIVE EVALUATION.
PA58	SUBMIT PROGRESSIVE, OBJECTIVE FINDINGS. INCLUDE A PERTINENT RE-EVALUATION.
PA59	PLEASE SUPPLY INFORMATION REGARDING THE CLIENTS MEDICATION REQUIREMENTS, IF ANY.
PA60	PLEASE SPECIFY IF THE CLIENT IS IN AN EDUCATIONAL SETTING.
PA61	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA62	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
PA63	THE SKILLS OF A THERAPIST ARE PURPOSEFUL AND SKILLED INTERVENTIONS REQUIRED TO CONTINUALLY DESIGN, IMPLEMENT, REASSESS, MODIFY/GRADE, AND/OR DISCONTINUE A PLAN OF CARE IN A TIMELY MANNER, BASED ON THE COMPLEXITY OF THE CLIENTS MEDICAL CONDITION AND/OR CO
PA64	PLEASE SUBMIT A THERAPY PLAN OF CARE, INCLUDING A CURRENT, DATED EVALUATION.
PA65	A PLAN OF CARE SIGNED AND DATED BY THE PHYSICIAN IS REQUIRED.
PA66	THE SKILLS OF A THERAPIST ARE REQUIRED WHEN ONLY THE THERAPIST CAN SAFELY AND EFFECTIVELY DELIVER THE THERAPEUTIC PROCEDURES BECAUSE OF THEIR UNIQUE KNOWLEDGE, TRAINING, AND EXPERTISE. DESCRIBE THE REASON THAT SOMEONE OTHER THAN A THERAPIST CANNOT SAFELY
PA67	PLEASE SPECIFY IF THE CLIENTS WORK SITE DEMANDS GOOD BINAURAL HEARING.
PA68	DESCRIBE THE REASON, BASED ON THE CLIENTS COGNITIVE, PHYSICAL, COMMUNICATION, OR RESOURCE STATUS, THAT A HOME PROGRAM, EQUIPMENT, OR ENVIRONMENTAL ADAPTATIONS ALONE CANNOT MEET CLIENTS NEEDS.
PA69	PLEASE SPECIFY IF THE CLIENT HAS AN ACCOMPANYING DISABILITY THAT ADDS TO THE HEARING PROBLEM.
PA70	DISTINGUISH REQUESTED PROCEDURES AND GOALS FROM OTHER SERVICES THIS CLIENT RECEIVES. THEY MAY NOT BE DUPLICATIVE.
PA71	PLEASE INDICATE THE NUMBER OF DAYS REQUESTED.
PA73	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA74	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA75	PLEASE DOCUMENT CARRYOVER OF THE THERAPY PROGRAM TO NURSING.
PA76	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).

Denial Code	Long Description
PA79	PROVIDE EVIDENCE OF SIGNIFICANT FUNCTIONAL PROGRESS IN LAST SIX MONTHS.
PA84	THE GRANT DATE OF THIS REQUEST CANNOT BE PRIOR TO THE SIGNATURE DATE OF THE PRESCRIBING PHYSICIAN.
PA86	PROVIDE EVIDENCE OF SKILLS GAINED IN THERAPY CARRYING OVER TO OTHER SETTINGS WITHIN SIX MONTHS.
PA87	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE NUMBER OF SESSIONS REQUESTED.
PA88	THE REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL SCOPE OF PRACTICE.
PA89	PRIOR AUTHORIZATION IS NOT REQUIRED UNTIL LIMITATION OF SERVICE HAS BEEN REACHED.
PA91	PLEASE SUBMIT REQUIRED X-RAYS.
PA92	PLEASE PROVIDE AN EXPLANATION FOR THE MATERIAL SUBMITTED WITH THE REQUEST.
PA95	PLEASE DESCRIBE HOW THE PROVISION OF THIS SERVICE WOULD PREVENT INSTITUTIONALIZATION OF THE CLIENT.
PA96	COULD THE EXISTING DENTURE(S) BE RELINED OR REBASED? IF NOT, PLEASE EXPLAIN WHY NOT.
PA97	REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL STANDARDS OF PRACTICE.
PA98	PLEASE INDICATE IF THE CLIENT IS CURRENTLY BEING TUBE FED.
PB02	PLEASE PROVIDE THE REQUIRED DATED SIGNATURES ON THE ATTACHMENTS.
PB03	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING THE LOSS/DESTRUCTION/THEFT OF THE HEARING AID.
PB04	DESCRIBE THE CLIENTS ABILITY TO STAND OR AMBULATE SUFFICIENTLY TO ACCOMPLISH SELF-CARE ACTIVITIES.
PB07	PLEASE SUBMIT AN ORTHODONTIC STUDY MODEL OR DIAGNOSTIC CASTS.
PB09	PLEASE PROVIDE A PHOTOGRAPH OF THE INVOLVED AREA(S).
PB10	PLEASE PROVIDE AN ESTIMATION (IN GRAMS) OF THE TOTAL AMOUNT OF TISSUE TO BE RESECTED.
PB11	PLEASE SUBMIT THE PLAN OF CARE FOR CO-TREATMENT.
PB12	FURNISH A DETAILED DESCRIPTION FOR THE PROCEDURE CODE REQUESTED.
PB13	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB15	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB18	PLEASE COMPLETE THE ATTACHED OUT-OF-STATE PROVIDER DATA SHEET, F-11001, AND RESUBMIT.
PB20	A SIGNED AND DATED PRESCRIPTION IS REQUIRED WITHIN THREE MONTHS OF RECEIPT BY COLORADO MEDICAID FOR INITIAL REQUESTS AND WITHIN 12 MONTHS OF RECEIPT BY COLORADO MEDICAID FOR SUBSEQUENT REQUESTS.
PB21	PLEASE COMPLETE THE APPROPRIATE PRIOR AUTHORIZATION ATTACHMENT. CONTACT PROVIDER SERVICES OR THE PRIOR AUTHORIZATION UNIT FOR ASSISTANCE.
PB23	PHYSICAL THERAPY ASSISTANT NOTES AND ALL FORMS SUBMITTED MUST BE COSIGNED BY A REGISTERED PHYSICAL THERAPIST.
PB31	ARE YOU REQUESTING A COMPLETE APPLIANCE, OR REPLACEMENT PARTS?
PB32	THE PROCEDURE CODE INDICATED ON THE REQUEST DOES NOT MATCH THE DESCRIPTION OF SERVICE; PLEASE CORRECT AND RESUBMIT.
PB35	THE SERVICE REQUESTED DOES NOT REQUIRE PRIOR AUTHORIZATION.
PB41	PLEASE FURNISH A CURRENT MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT, F-11090 (DATED WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID).
PB45	THE CERTIFICATION PERIOD ON THE PLAN OF CARE (POC) DOES NOT COVER THE REQUESTED GRANT/START DATE. PLEASE RESUBMIT YOUR REQUEST WITH A NEW POC.
PB49	A CERTIFIED OCCUPATIONAL THERAPY ASSISTANTS NOTES MUST BE COSIGNED BY AN OCCUPATIONAL THERAPIST REGISTERED.
PB51	ADDITIONAL INFORMATION IS REQUIRED ON PRIOR AUTHORIZATION TO ENABLE PRICING.
PB54	REQUESTED SERVICES DO NOT MATCH SERVICES ON THE PHYSICIANS ORDERS.
PB59	PLEASE PROVIDE AN INDIVIDUAL EDUCATIONAL PLAN (IEP), WHICH HAS BEEN SIGNED BY THE PROVIDER NO EARLIER THAN NINE MONTHS PRIOR TO RECEIPT AT COLORADO MEDICAID; OTHERWISE, DOCUMENT WHY NO IEP EXISTS.
PB65	PLEASE FURNISH THE ANTICIPATED TOTAL CHARGES FOR THIS REQUEST.
PB66	A PHOTOCOPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED; THE DATE MUST BE WITHIN SIX MONTHS OF RECEIPT BY COLORADO MEDICAID.

Denial Code	Long Description
PB67	THE PRESCRIPTION DATE MUST INCLUDE MONTH, DAY, AND YEAR.
PB68	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID.
PB73	THE SERVICES IDENTIFIED ON THE PLAN OF CARE DO NOT APPEAR APPROPRIATE FOR THE PROCEDURE CODE(S) REQUESTED ON THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018.
PB74	THE CLIENT/PROVIDER DOES NOT HAVE RETROACTIVE ENROLLMENT.
PB75	THE REQUESTED START DATE IS MORE THAN 14 DAYS BEFORE OR 62 DAYS AFTER RECEIPT.
PB82	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
PB83	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A HOME HEALTH AIDE. PLEASE RESUBMIT AS A PERSONAL CARE WORKER OR PROVIDE ADDITIONAL DOCUMENTATION.
PB86	THE SERVICES REQUESTED ARE NOT BEING PROVIDED IN THE CLIENTS RESIDENCE. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL.
PB87	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A NURSE. PLEASE RESUBMIT AS A HOME HEALTH AIDE OR PROVIDE ADDITIONAL DOCUMENTATION.
PB92	PLEASE FURNISH THE CLIENTS COMPLETE ADDRESS.
PB94	IF THE CLIENT IS A RESIDENT OF A NURSING HOME, SUPPLY THE COMPLETE NAME AND ADDRESS OF THE NURSING HOME.
PB99	THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018, MUST BE SIGNED AND DATED.
PC01	PLEASE SUPPLY THE RENDERING PROVIDERS PROVIDER NUMBER.
PC03	THE DRUG ENFORCEMENT ADMINISTRATION NUMBER IS MISSING OR INVALID.
PC06	PLEASE DESCRIBE YOUR PROGRAM; INCLUDE ENTRY DATE, TERMINATION DATE, HOURS PER WEEK, AND NUMBER OF WEEKS OF PRIMARY INTENSIVE SERVICE REQUESTED.
PC07	PLEASE DESCRIBE YOUR "AFTERCARE/FOLLOW-UP" PLANS FOR THIS CLIENT.
PC08	PLEASE SUPPLY DOCUMENTATION OF PREVIOUS SUBSTANCE ABUSE SERVICES WITH DATE(S) AND OUTCOME.
PC09	PLEASE DESCRIBE IN DETAIL THE TREATMENT OBJECTIVES/GOALS FOR THIS CLIENT.
PC10	PLEASE DESCRIBE THE FAMILY SITUATION/DYNAMICS. EXPLAIN HOW THE FAMILY WILL BE INCORPORATED INTO THE CLIENTS PLAN OF CARE.
PC12	PLEASE EXPLAIN IF YOUR SERVICE ENCOURAGES THE CLIENT TO ATTEND SELF-HELP GROUPS.
PC13	PLEASE SUPPLY A SPECIFIC SCHEDULE OF ACTIVITIES, INCLUDING DAY, TIME OF DAY, LENGTH OF SESSION, AND SERVICE TO BE RENDERED DURING THAT TIME.
PC15	PLEASE FURNISH DIAGNOSTIC RATIONALE.
PC17	PLEASE DOCUMENT IF THE CLIENT EVER RECEIVED SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT.
PC19	PLEASE FURNISH MORE EXTENSIVE AND IN-DEPTH HISTORICAL AND PSYCHOSOCIAL DATA.
PC20	PLEASE SUPPLY THE DATE THE CLIENT BECAME TOTALLY ENDENTULOUS.
PC23	PLEASE SUBMIT A PHYSICIANS STATEMENT REGARDING THE MEDICAL NECESSITY OF DENTURES FOR THIS CLIENT. THE PHYSICIANS STATEMENT MUST DOCUMENT THE MEDICAL NEED FOR DENTURES.
PC24	THE SERVICE REQUESTED WAS PREVIOUSLY AUTHORIZED. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT INDICATING THIS FACT IS REQUIRED.
PC25	PLEASE SUPPLY SUFFICIENT MITIGATING CIRCUMSTANCES TO WARRANT THE CONSTRUCTION OF NEW DENTURES(S).
PC26	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
PC28	PLEASE SUBMIT A PHYSICIANS STATEMENT INDICATING DENTURES ARE NECESSARY FOR THIS NURSING HOME CLIENT.
PC29	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING LOSS OR DESTRUCTION OF DENTURE(S). INCLUDE SIGNED STATEMENT FROM CLIENT OR FACILITY DIRECTOR REGARDING HOW, WHEN AND WHERE LOST.
PC30	PLEASE PROVIDE COMPLETE INTRAORAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PC31	PLEASE DESCRIBE ANY RELATED DEFORMITIES OF THE FEET.
PC34	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD WITH REQUESTED DME ITEM(S) AND DOCUMENT IF THE CLIENT CAN USE SAFELY AND INDEPENDENTLY.
PC35	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD AND DESCRIBE THE RESULTS AND EFFECTIVENESS OF THE SERVICE REQUESTED.

Denial Code	Long Description
PC39	PLEASE INDICATE LITER FLOW PER MINUTE, HOURS OF USE PER 24 HOUR PERIOD, AND THE EXPECTED DURATION OF NEED.
PC40	THE ITEM DOES NOT REQUIRE PRIOR AUTHORIZATION UNTIL THE LIFE EXPECTANCY HAS BEEN REACHED.
PC41	PLEASE SUPPLY INFORMATION INDICATING THE NECESSITY OF POSITIONING THE CLIENT'S BODY IN MULTIPLE POSITIONS.
PC42	PLEASE INDICATE IF THE BED HEIGHT MUST BE CHANGED TO ALLOW FOR SAFE TRANSFER OR ADEQUATE BED CARE.
PC43	SUPPLY A PHYSICIANS STATEMENT INDICATING TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR UNIT HAS REDUCED PAIN, IMPROVED/INCREASED THE CLIENTS ACTIVITY LEVEL, AND/OR REDUCED CLIENTS USE OF PAIN MEDICATION.
PC44	A CURRENT AUTHORIZATION FOR THIS SERVICE IS ON FILE FOR ANOTHER PROVIDER. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT OF THAT FACT IS REQUIRED BY THE CLIENT OF FIRST PROVIDER.
PC59	DOCUMENT DECLINE OR PROGRESS IN SPECIFIC, MEASURABLE, OBJECTIVE TERMS.
PC60	DOCUMENT IF CLIENT HAS DEMONSTRATED A GOOD APPOINTMENT COMPLIANCE RECORD.
PC61	THE PHYSICIANS SIGNATURE DATE MUST NOT EXCEED 90 DAYS FROM THE DATE OF RECEIPT BY COLORADO MEDICAID.
PC62	REQUESTS FOR A CONTINUATION OF THERAPY SHOULD NOT BE SUBMITTED MORE THAN FOUR WEEKS PRIOR TO THE EXPIRATION DATE OF THE CURRENT AUTHORIZATION.
PC63	PLEASE FURNISH THE STYLE AND MANUFACTURER OF THE FRAME.
PC64	PLEASE FURNISH THE CLIENTS LENS FORMULA.
PC66	ALL REQUESTS FOR TINTS REQUIRE DOCUMENTATION OF THE VISUAL OR MEDICAL CONDITION RELATED TO PHOTOPHOBIA.
PC67	PLEASE DOCUMENT THE REASON AND JUSTIFICATION FOR REPLACEMENT BEYOND THE FIRST LENS/FRAME.
PC68	DOCUMENT IF ALL REMAINING MAXILLARY AND/OR MANDIBULAR TEETH ARE DECAY-FREE, PROPERLY RESTORED, AND PERIODONTICALLY SOUND.
PC72	SUPPLY MORE DETAIL REGARDING PROGRESS (ATTACHMENT OF GOALS, ETC.). CORRELATE PROGRESS TO PREVIOUS GOALS AND IDENTIFIED LIMITATIONS.
PC77	PLEASE SUBMIT A PLAN OF CARE DESCRIBING THE SERVICES THAT WOULD BE PROVIDED.
PC78	PLEASE DOCUMENT SPECIFIC, MEASURABLE GOALS.
PC82	THE PRIOR AUTHORIZATION (PA) SYSTEM CAN PROCESS ONLY 26 DETAILS PER PA REQUEST. PLEASE RESUBMIT YOUR REQUEST WITH NO MORE THAN 26 DETAILS.
PC83	PLEASE SUPPLY A PHYSICIANS PRESCRIPTION DATED WITHIN ONE MONTH OF REQUESTED SUBSTANCE ABUSE DAY TREATMENT.
PC84	PLEASE PROVIDE INFORMATION INDICATING THIS CLIENT IS APPROPRIATELY DETOXIFIED FROM ALCOHOL AND/OR OTHER DRUGS.
PC85	PLEASE PROVIDE INFORMATION TO INDICATE THE CLIENTS ABILITY TO ABSTAIN FROM ALCOHOL OR DRUGS WHILE IN THE SUBSTANCE ABUSE DAY TREATMENT PROGRAM.
PC86	PLEASE INDICATE IF THIS CLIENT IS WILLING TO PARTICIPATE IN AFTERCARE OR CONTINUING CARE SERVICES.
PC87	PROVIDE MORE INFORMATION ON TREATMENT HISTORY; INCLUDE SERVICE PROVIDED, DATES, AND OUTCOME. PROVIDE DETAIL OF PREVIOUS TREATMENT.
PC88	PLEASE PROVIDE MORE RATIONALE FOR THE APPROPRIATENESS AND MEDICAL NECESSITY OF SUBSTANCE ABUSE DAY TREATMENT.
PC89	PROVIDE A TREATMENT PLAN THAT CONTAINS MEASURABLE GOALS AND OBJECTIVES CORRESPONDING TO THE IDENTIFIED DEFICIT.
PC91	PLEASE PROVIDE MORE INFORMATION ON FAMILY INVOLVEMENT TREATMENT.
PC92	PLEASE PROVIDE MORE HISTORY AND EXPLANATION ABOUT THE ISSUE OF ABSTINENCE FOR THIS CLIENT.
PC94	PLEASE PROVIDE THE ANTICIPATED BEGINNING DATE AND/OR THE ESTIMATED SUBSTANCE ABUSE DAY TREATMENT DISCHARGE DATE.
PC95	PLEASE SUPPLY JUSTIFICATION FOR BEGINNING CLIENT IN SERVICE PRIOR TO AUTHORIZATION BEING OBTAINED.
PC96	THE INITIAL THREE HOURS OF SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IN A CALENDAR YEAR DO NOT REQUIRE PRIOR AUTHORIZATION.

Denial Code	Long Description
PC97	REIMBURSEMENT FOR INITIAL SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IS LIMITED TO THREE HOURS IN A CALENDAR YEAR AND DOES NOT REQUIRE PRIOR AUTHORIZATION.
PC98	THIS DRUG IS CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE BILL USING THE APPROPRIATE NATIONAL DRUG CODE (NDC) OR SUBMIT A COMPLETED DRUG ADDITION REQUEST FORM IF THE NDC IS NOT LISTED IN THE DRUG INDEX.
PC99	THIS DRUG IS NOT CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL, CURRENT ADMINISTRATIVE RULE, OR COLORADO DRUG INDEX FOR COVERAGE LIMITATIONS.
PD01	DOCUMENT THAT CLIENT HAS ACHIEVED GOOD ORAL HYGIENE, PERIODONTAL CASE TYPE 1 OR 2, AND IS MOTIVATED TO MAINTAIN SAME.
PD03	PLEASE PROVIDE AN ARTERIAL BLOOD GAS READING OR PULSE OXIMETRY RESULTS DONE ON ROOM AIR SIGNED AND DATED BY A MEDICAL DOCTOR. THIS SHOULD BE DONE WITHIN 60 DAYS OF REQUESTED SERVICE.
PD04	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 30 DAYS OF RECEIPT BY COLORADO MEDICAID.
PD07	SUBMIT A PHOTOCOPY OF A VALID PRESCRIPTION, ISSUED WITHIN THE PAST YEAR, OR COMPLETE SECTION B OF THE PRIOR AUTHORIZATION/DRUG ATTACHMENT (PA/DGA), F-11049.
PD10	BRAND MEDICALLY NECESSARY MUST BE IN THE PRESCRIBERS OWN HANDWRITING AND WRITTEN DIRECTLY ON THE PRESCRIPTION OR A SEPARATE ORDER ATTACHED TO THE ORIGINAL PRESCRIPTION.
PD12	COMPLETE DENTURES, PARTIAL DENTURES, DENTURE RELINES, AND FIXED PROSTHODONTIC SERVICES ARE NOT COVERED SERVICES FOR ADULTS FOR DATES OF SERVICE ON AND AFTER OCTOBER 1, 1995.
PD22	PLEASE COMPLETE ALL REQUIRED ELEMENTS ON THE PERSONAL CARE SCREENING TOOL (PCST), F-11133.
PD24	THIS PRIOR AUTHORIZATION REQUEST IS UNABLE TO BE PROCESSED. PLEASE RESUBMIT WITH ADDITIONAL REQUIRED FORMS, INCLUDING THE ENTIRE PERSONAL CARE SCREENING TOOL (PCST), F-11133; PERSONAL CARE ADDENDUM, F-11136; AND SUPPORTING DOCUMENTATION, AS DIRECTED.
PD25	THERE IS A PERSONAL CARE SCREENING TOOL (PCST), F-11133, COMPLETED BY ANOTHER AGENCY. CONTACT THE AGENCY TO TRANSFER SCREEN.
PD26	THERE IS A LIMITED TERM CARE FUNCTIONAL SCREEN (LTC-FS) COMPLETED BY ANOTHER AGENCY. THE PERSONAL CARE SCREENING TOOL (PCST), F-11133, INFORMATION IS IN CONFLICT WITH LTC-FS.
PD27	ONLY ONE LEVEL OF FUNCTION MAY BE SELECTED FOR ALL ELEMENTS EXCEPT TOILETING. COLORADO MEDICAID IS UNABLE TO PROCESS THE PRIOR AUTHORIZATION REQUEST.
PD28	NO UNITS MAY BE REQUESTED USING THIS PRIOR AUTHORIZATION PROCESS. PLEASE SUBMIT WITH THE APPROPRIATE ATTACHMENTS FOR REQUESTING SPECIFIC PERSONAL CARE WORKER UNITS.
PD29	CLIENT IS NOT ELIGIBLE FOR THE REQUESTED SERVICE(S) AS OF THE REQUESTED START DATE.
PD30	NO TRAVEL TIME MAY BE AUTHORIZED WHEN NO PERSONAL CARE WORKER SERVICE IS AUTHORIZED.
PD32	PROVIDER NOT CERTIFIED TO RENDER THE SERVICE(S) REQUESTED.
PD34	BASED ON THE DOCUMENTATION SUBMITTED, THIS REQUEST CAN NOT BE PRIOR AUTHORIZED. REFER TO THE PA MESSAGES FROM THE CONSULTANT FOR COMPLETE EXPLANATION.
PD98	PLEASE DOCUMENT HOW AND WHEN EACH PREVIOUSLY AUTHORIZED PRO RE NATA VISIT WAS USED.

Psychotherapy (Hospital)

Denial Code	Long Description
0201	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
0233	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0235	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0237	CLIENT IDENTIFICATION NUMBER DOES NOT MATCH CLIENTS FIRST NAME.
0238	THE CLIENT IDENTIFICATION NUMBER DOES NOT MATCH THE CLIENTS LAST NAME.

Denial Code	Long Description
0242	SECONDARY DIAGNOSIS CODE IS INVALID.
0248	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0249	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0251	PROCEDURE CODE MODIFIER IN FIRST POSITION IS INVALID.
0252	THE PROCEDURE CODE MODIFIER IN SECOND POSITION IS INVALID FOR REQUESTED START DATE OR DATE OF RECEIPT.
0253	THE PROCEDURE CODE MODIFIER IN THIRD POSITION IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
0258	THE PRIMARY DIAGNOSIS CODE IS REQUIRED.
0272	THE PRIMARY DIAGNSOSIS CODE IS INVALID.
0339	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0340	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0400	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0853	HCPCS - ANNUAL UPDATE
0885	NEVER EVENTS MODIFIERS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
0886	NEVER EVENTS DIAGNOSIS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
1000	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
1002	RENDERING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1003	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1007	RENDERING PROVIDER ID IS NOT ON FILE.
1048	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1801	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
1806	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
1900	THE BILLING PROVIDERS TAXONOMY CODE IS INVALID.
1901	THE RENDERING PROVIDERS TAXONOMY CODE IS INVALID.
1927	A NATIONAL PROVIDER IDENTIFIER IS REQUIRED FOR THE BILLING PROVIDER.
1934	A NATIONAL PROVIDER INDENTIFIER IS REQUIRED FOR THE RENDERING PROVIDER.
1936	THE BILLING PROVIDER NUMBER IS INVALID.
1937	THE RENDERING PROVIDER NUMBER IS INVALID.
1960	INTERNAL PROCESSING IS REQUIRED.
1964	THE BILLING PROVIDER INDICATED IS NOT ALLOWABLE AS A BILLING PROVIDER.
1965	RENDERING PROVIDER NUMBER IS MISSING/INVALID FOR THIS PROCEDURE PROVIDER.
1974	PRESCRIBING/REFERRING/ORDERING PROVIDER INDICATED IS NOT CERTIFIED AS A PRESCRIBING/REFERRING/ORDERING PROVIDER.
1975	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
1976	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
2001	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2003	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2017	THE CLIENT IS ENROLLED IN A MEDICAID OR OTHER MANAGED CARE PROGRAM.
2037	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2603	CLIENT LOCKED-IN TO A PROVIDER OR ENROLLED IN A HOSPICE. CONTACT CLIENTS HOSPICE FOR PAYMENT OF SERVICES OR RESUBMIT WITH DOCUMENTATION OF UNRELATED NATURE OF CARE.
3324	THE MODIFIER HAS BEEN DISCONTINUED BY THE CENTERS OF MEDICARE AND MEDICAID SERVICES OR THE AMERICAN MEDICAL ASSOCIATION FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
3337	THE PROCEDURE CODE HAS BEEN TERMINATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AMERICAN MEDICAL ASSOCIATION, OR AMERICAN DENTAL ASSOCIATION FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT. RESUBMIT WITH VALID A PROCEDURE CODE.
4021	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4027	THE DIAGNOSIS CODE IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
4031	THE PROCEDURE SUBMITTED IS NOT APPROPRIATE FOR CLIENTS GENDER.

Denial Code	Long Description
4032	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4040	THE PRIMARY DIAGNOSIS CODE IS NOT ON FILE.
4041	THE SECONDARY DIAGNOSIS IS NOT ON FILE.
4046	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4059	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4127	INTERNAL PROCESSING IS REQUIRED.
4131	INTERNAL PROCESSING IS REQUIRED.
4141	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4149	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4150	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4151	THE PROVIDER IS NOT AUTHORIZED TO PERFORM THE PROCEDURE.
4227	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4236	ETIOLOGY DIAGNOSIS CODE(S) (E-CODES) ARE INVALID AS THE PRIMARY DIAGNOSIS.
4244	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4245	THE FOURTH POSITION MODIFIER IS INVALID FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT.
4256	THE PROCEDURE CODE AND MODIFIER COMBINATION IS NOT PAYABLE FOR THE CLIENTS BENEFIT PLAN.
4257	THE MODIFIERS SUBMITTED ARE EITHER INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT OR THE MODIFIERS ARE MISSING.
4311	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4315	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4316	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4321	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4322	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4371	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4372	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4374	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4711	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR CLIENTS AGE.
4714	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS AGE.
4731	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS DIAGNOSIS.
4733	DIAGNOSIS AND/OR PROCEDURE AND/OR PLACE OF SERVICE (POS) CODE IS NOT COVERED FOR EXPRESS ENROLLMENT CLIENTS.
4742	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4745	DIAGNOSIS AND/OR PROCEDURE AND/OR PLACE OF SERVICE (POS) CODE IS NOT COVERED FOR EXPRESS ENROLLMENT CLIENTS.
4801	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4802	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
4804	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4821	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
4871	PLEASE REFER TO PA MESSAGES FOR RETURN INFORMATION.
4874	PLEASE REFER TO PA MESSAGES FOR RETURN INFORMATION.
4963	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS GENDER.
4975	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4990	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
P001	THE BILLING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THE SERVICES.
P002	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P003	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.

Denial Code	Long Description
P005	THE PRIOR AUTHORIZATION CAN NOT BE END DATED. THE PRIOR AUTHORIZATION STATUS IS NOT APPROVED OR APPROVED WITH REVISIONS.
P006	PLEASE FURNISH THE PROCEDURE CODE AND CORRESPONDING DESCRIPTION.
P008	THE BILLING PROVIDER NUMBER IS INVALID.
P009	THE BILLING PROVIDER NUMBER IS INVALID.
P010	THE REQUESTED END DATE IS INVALID.
P011	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P012	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P013	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P014	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P015	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P016	THE REQUESTED START DATE IS MISSING OR INVALID.
P019	THE REQUESTED START DATE IS MISSING OR INVALID.
P020	THE RENDERING PROVIDER NUMBER IS INVALID.
P021	THE RENDERING PROVIDER NUMBER IS INVALID.
P022	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P023	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P024	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P026	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P027	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P030	FIRST MODIFIER IS INVALID.
P031	FIRST MODIFIER IS INVALID.
P032	SECOND MODIFIER IS INVALID.
P033	SECOND MODIFIER IS INVALID.
P034	THIRD MODIFIER IS INVALID.
P035	THIRD MODIFIER IS INVALID.
P036	FOURTH MODIFIER IS INVALID.
P037	FOURTH MODIFIER IS INVALID.
P038	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P039	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P040	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P041	CLIENTS FIRST NAME IS MISSING.
P042	CLIENTS LAST NAME IS MISSING.
P043	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P044	BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES REQUESTED.
P045	FIRST MODIFIER IS INVALID.
P046	SECOND MODIFIER IS INVALID.
P047	THIRD MODIFIER IS INVALID.
P048	FOURTH MODIFIER IS INVALID.
P052	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P053	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P054	RENDERING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES FOR THE BENEFIT PLAN.
P055	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P057	PLEASE FURNISH THE REVENUE CODE AND CORRESPONDING DESCRIPTION.
P061	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.

Denial Code	Long Description
P062	THE CLIENT ID AND/OR NAME INDICATED ON THE PA REQUEST IS INCORRECT. THE CLIENT ID AND/OR NAME HAS BEEN UPDATED. PLEASE VERIFY THE ID AND/OR NAME IS CORRECT.
P064	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
P067	THE FREQUENCY OF HOURS REQUESTED ARE NOT APPROPRIATE FOR THIS CLIENT AND HAVE BEEN MODIFIED ACCORDINGLY.
P079	BILLING PROVIDER IS ON PAYMENT SUSPENSION DUE TO CREDIBLE ALLEGATION OF FRAUD.
P120	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAS BEEN REDUCED.
P121	THE SERVICE/ PROCEDURE REQUESTED IS NOT SUPPORTED BY SUBMITTED DOCUMENTATION.
P126	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
P128	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.
P138	SERVICE(S) DO NOT MEET COLORADO MEDICAID GUIDELINES.
P167	REQUESTED DOCUMENTATION HAS NOT BEEN SUBMITTED.
P178	THE SERVICE REQUESTED IS NOT MEDICALLY NECESSARY.
P179	THE MEDICAL NECESSITY FOR THIS SERVICE IS NOT SUPPORTED BY THE SUBMITTED DOCUMENTATION.
P233	THE DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE ADDITIONAL CARE.
P257	THIS CLIENTS FUNCTIONAL ASSESSMENT SCORES PLACE THIS CLIENT OUTSIDE ELIGIBILITY FOR DAY TREATMENT.
P274	OUR RECORDS INDICATE THIS CLIENT IS INVOLVED IN EFFECTIVE AND APPROPRIATE SERVICE ELSEWHERE.
P292	INTENSIVE REHABILITATION HOURS ARE NO LONGER APPROPRIATE AS INDICATED BY HISTORY, DIAGNOSIS, AND/ OR FUNCTIONAL ASSESSMENT SCORES.
P328	THE SERVICES REQUESTED INCLUDE NON-COVERED SERVICES, AND HOURS ARE REDUCED ACCORDINGLY.
P339	THE CLIENTS PAST HISTORY INDICATES REDUCED TREATMENT HOURS ARE WARRANTED.
P342	THE REQUEST DOES NOT MEET GENERALLY ACCEPTED CONDITIONS REQUIRING FLUORIDE TREATMENTS.
P346	SERVICES EXCEED COLORADO MEDICAID LIMITATION AND DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE MEDICAL NECESSITY OF THE SERVICE.
P349	THE SERVICE REQUESTED WAS PERFORMED LESS THAN FIVE YEARS AGO.
P353	THE EXISTING APPLIANCE HAS NOT BEEN WORN FOR THREE YEARS.
P367	THE CLIENT HAS BEEN TOTALLY WITHOUT TEETH AND AN APPLIANCE FOR FIVE YEARS.
P392	THE CLIENT IS MISSING AN ANTERIOR TOOTH AND/OR HAS TWO OR MORE POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P405	THE SERVICE(S) REQUESTED COULD ADEQUATELY BE PERFORMED IN THE DENTAL OFFICE.
P406	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE OF GOOD PERIODONTAL HEALTH (AMERICAN ACADEMY OF PERIODONTOLOGY PERIODONTAL CLASSIFICATION OF TYPE I OR II).
P407	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE VISIBLE ON RADIOGRAPHS THAT AT LEAST 50 PERCENT OF THE CLINICAL CROWN IS INTACT.
P409	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING SIX OR MORE TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED, INCLUDING THIRD MOLARS.
P410	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING ONE OR MORE ANTERIOR TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED.
P411	DOCUMENTATION DOES NOT SUPPORT THE NEED FOR PERIODONTIC SERVICES. POCKETS ARE LESS THAN 4MM AND/OR GREATER THAN 6MM FOR CLIENT AND/OR THE CLIENT IS UNDER THE AGE OF 13.
P412	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA.
P413	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA. THIS PA HAS BEEN GRANTED AS APPROVED NOT APPROVED WITH REVISIONS. THE DURATION REQUESTED MAY HAVE BEEN REDUCED TO REFLECT COVERAGE LIMITATIONS, PRESCRIBER ORDERS, CONFLICTI
P417	THE SERVICE(S) REQUESTED COULD BE ADEQUATELY PERFORMED WITH LOCAL ANESTHESIA.
P437	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO POOR ORAL HYGIENE.
P444	THIS LINE ITEM IS A DUPLICATE OF ANOTHER LINE ITEM ON THIS PRIOR AUTHORIZATION (PA) REQUEST. PLEASE CORRECT.
P446	THIS IS A DUPLICATE OF AN EXISTING PRIOR AUTHORIZATION (PA) REQUEST. YOU MAY CONTACT PROVIDER SERVICES IF YOU REQUIRE ASSISTANCE. DUPLICATE PA REQUEST

Denial Code	Long Description
P448	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO DECAY HISTORY.
P449	QUESTIONABLE LONG TERM PROGNOSIS DUE TO GUM AND BONE DISEASE.
P456	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO APPARENT ROOT INFECTION.
P457	OUR RECORDS INDICATE THIS CLIENT HAS EXCEEDED ESTABLISHED PROGRAM LIMITATIONS. COLORADO MEDICAID WILL NOT AUTHORIZE NEW DENTURES.
P458	DOCUMENTATION PROVIDED INDICATES A LESS ELABORATE PROCEDURE SHOULD BE CONSIDERED.
P502	RENTAL ONLY ALLOWED; MEDICAL NEED FOR PURCHASE HAS NOT BEEN DOCUMENTED.
P503	PURCHASE ONLY ALLOWED; MEDICAL NEED FOR RENTAL HAS NOT BEEN DOCUMENTED.
P504	OCCUPATIONAL THERAPY GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P505	THE SERVICE REQUESTED IS INCLUDED IN THE NURSING HOME RATE STRUCTURE.
P511	THIS NATIONAL DRUG CODE IS ONLY BILLABLE AS PART OF A COMPOUND DRUG.
P515	THE PRESENCE OF A HANDICAPPING MALOCCLUSION OR HANDICAPPING DENTOFACIAL DEFORMITY IS NOT SUPPORTED BY THE DOCUMENTATION SUBMITTED.
P521	THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVERED BY COLORADO MEDICAID.
P522	GASTRO-INTESTINAL SURGERY FOR THE PURPOSE OF WEIGHT CONTROL IS COVERED ONLY AS A LIFE THREATENING PROCEDURE.
P523	THE TREATMENT REQUEST IS NOT CONSISTENT WITH THE CLIENT'S DIAGNOSIS.
P524	PSYCHOTHERAPY PROVIDED IN THE CLIENTS HOME IS NOT A COVERED BENEFIT OF COLORADO MEDICAID.
P525	THE INFORMATION PROVIDED IS NOT CONSISTENT WITH THE INTENSITY OF SERVICES REQUESTED.
P526	INTENSIVE MULTIPLE MODALITY TREATMENT IS NOT CONSISTENT WITH THE INFORMATION PROVIDED.
P527	MULTIPLE PROVIDERS OF TREATMENT ARE NOT INDICATED FOR THIS CLIENT.
P528	THE DURATION OF TREATMENT SESSIONS EXCEED CURRENT COLORADO MEDICAID GUIDELINES.
P534	DOCUMENTATION OF POOR PHYSICAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P535	OTHER PHYSICAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P536	THE PHYSICAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P537	USE OF PHYSICAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P538	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF A PHYSICAL THERAPIST.
P539	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS AND LIVING ARRANGEMENT.
P540	GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P541	THE PROCEDURE(S) REQUESTED ARE NOT MEDICAL IN NATURE.
P542	DOCUMENTATION OF POOR OCCUPATIONAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P543	DOCUMENTATION OF POOR SPEECH THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P544	OTHER OCCUPATIONAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P546	THE OCCUPATIONAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P547	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF PHYSICAL THERAPY.
P548	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P549	ACTIVITIES TO PROMOTE DIVERSION OR GENERAL MOTIVATION ARE NONCOVERED COLORADO MEDICAID SERVICES.
P550	REVISIONS OF THE REQUEST IS NECESSITATED BY THE CLIENTS MINIMAL PROGRESS.
P551	RESTORATIVE NURSING INVOLVEMENT COULD BE INCREASED.

Denial Code	Long Description
P552	CLIENTS DEMONSTRATED RESPONSE TO CURRENT THERAPY DOES NOT WARRANT THE INTENSE FREQUENCY REQUESTED.
P553	MAINTENANCE IS TWO TIMES PER WEEK OR LESS.
P554	THE SPEECH THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P555	USE OF OCCUPATIONAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P556	USE OF SPEECH THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P557	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF AN OCCUPATIONAL THERAPIST.
P558	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
P559	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P560	THE MATERIALS/ SERVICES REQUESTED ARE PRINCIPALLY COSMETIC IN NATURE.
P561	THE LENS FORMULA DOES NOT JUSTIFY REPLACEMENT.
P562	THE CHANGE IN THE LENS FORMULA DOES NOT WARRANT MULTIPLE REPLACEMENTS.
P563	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P564	LENSES ONLY ARE APPROVED; PLEASE DISPENSE A CONTRACTED FRAME. THE NON-CONTRACTED FRAME IS NOT MEDICALLY JUSTIFIED.
P565	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P566	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P567	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF OCCUPATIONAL THERAPY.
P568	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF SPEECH THERAPY.
P569	LEVEL, INTENSITY, OR EXTENT OF SERVICE(S) REQUESTED HAS BEEN MODIFIED CONSISTENT WITH MEDICAL NEED AS DEFINED IN THE PLAN OF CARE.
P570	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P571	THE SERVICE ASKED FOR IS NOT COVERED BY COLORADO MEDICAID AS THESE TASKS CAN BE DONE BY NURSES OR ACTIVITY STAFF.
P572	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P573	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.
P574	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P575	MEDICAL NEED FOR EQUIPMENT/ SUPPLY REQUESTED IS NOT SUPPORTED BY DOCUMENTATION SUBMITTED.
P576	OTHER SPEECH THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P577	DOCUMENTATION SUBMITTED IDENTIFIES THAT THE CLIENT HAS FEWER THAN TWO POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P582	LESS EXPENSIVE ALTERNATIVE SERVICES ARE AVAILABLE FOR THIS CLIENT.
P634	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P711	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING PERIODONTAL SCALING AND ROOT PLANNING.
P712	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING GINGIVECTOMY.
P754	AN APPROVED SUBSTANCE ABUSE DAY TREATMENT PROGRAM CANNOT EXCEED A SIX WEEK PERIOD.
P761	THE CLIENT DOES NOT APPEAR TO BE ABLE OR WILLING TO ABSTAIN FROM ALCOHOL/DRUG USAGE WHILE IN TREATMENT. THEREFORE, SUBSTANCE ABUSE DAY TREATMENT SERVICES ARE NOT APPROVED.
P764	THIS CLIENT HAS COMPLETED INTENSIVE SUBSTANCE ABUSE TREATMENT WITHIN THE PAST 12 MONTHS. THE DOCUMENTATION PROVIDED IS NOT ADEQUATE TO JUSTIFY ADDITIONAL INTENSIVE TREATMENT AT THIS TIME.
P785	A LESS THAN SIX-WEEK HEALING PERIOD HAS BEEN SPECIFIED FOR THIS PRIOR AUTHORIZATION. THEREFORE IT IS NOT NECESSARY TO WAIT THE FULL SIX WEEKS AFTER EXTRACTIONS BEFORE TAKING DENTURE IMPRESSIONS.

Denial Code	Long Description
P818	SIX-WEEK HEALING TIME IS REQUIRED BETWEEN EDENTULATION AND FINAL IMPRESSIONS. PAYMENT FOR DENTURES WILL BE DENIED OR RECOUPED IF HEALING PERIOD IS NOT OBSERVED.
P849	COLORADO MEDICAID HAS DETERMINED THERE WERE (ARE) SEVERAL HOME HEALTH AGENCIES WILLING TO PROVIDE MEDICALLY NECESSARY SKILLED NURSING SERVICES TO THIS CLIENT.
P864	THE DOCUMENTATION YOU HAVE SUBMITTED DOES NOT MEET THE REQUIREMENTS OF COLORADO MEDICAID.
P873	THE MEDICAL NECESSITY FOR THE HOURS REQUESTED IS NOT SUPPORTED BY THE INFORMATION SUBMITTED.
P874	THE DOCUMENTATION SUBMITTED INDICATES THE TASKS SPECIFIED CAN BE COMPLETED DURING THE VISITS APPROVED.
P878	THE DOCUMENTATION SUBMITTED DOES NOT INDICATE THAT MEDICALLY ORIENTED TASKS ARE MEDICALLY NECESSARY; THEREFORE PERSONAL CARE SERVICES HAVE BEEN APPROVED.
P880	THE QUANTITY OF SERVICES AUTHORIZED FOR THIS CLIENTS PERSONAL CARE HAS BEEN AMENDED BASED ON INFORMATION RECEIVED FROM ONE OR MORE OF THESE SOURCES: THE CLIENT, THEIR PHYSICIAN, AND/OR THE IN-HOME VISIT BY STAFF OF THE OIG (OFFICE OF INSPECTOR GENERAL).
P885	THE USE OF THIS DRUG FOR THE INTENDED PURPOSE IS NOT COVERED BY COLORADO MEDICAID, CONSISTENT WITH COLORADO ADMINISTRATIVE CODE AND FEDERAL LAW.
P924	THE MEDICAL RECORDS SUBMITTED WITH THE CURRENT REQUEST CONFLICT OR DISAGREE WITH OUR MEDICAL RECORDS ON THIS CLIENT.
P950	INDEPENDENT NURSES, PLEASE NOTE PAYABLE SERVICES MAY NOT EXCEED 12 HOURS/DAY OR 60 HOURS/WEEK.
P951	SERVICES CAN ONLY BE AUTHORIZED THROUGH ONE YEAR FROM THE PRESCRIPTION DATE.
P952	LEAD INSPECTION IS A COVERED COLORADO MEDICAID SERVICE WHEN THE CHILD HAS BEEN SHOWN TO HAVE LEAD POISONING (E.G., CHILD HAS A BLOOD LEAD LEVEL > 19 UG/DL OR TWO CONSECUTIVE BLOOD LEAD LEVELS OF 15-19 UG/DL DONE AT LEAST 90 DAYS APART). THE INSPECTION MUS
P953	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P954	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P956	THE REQUEST CAN ONLY BE BACKDATED A MAXIMUM OF 14 DAYS FROM FIRST DATE RECEIVED BY COLORADO MEDICAID.
P957	COMPLETE PERIODONTAL CHARTING AT TIME OF SERVICE, AND SUBMIT CHARTING, COPY OF OPERATIVE REPORT, TOGETHER WITH A COPY OF THE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF), F-11035, TO PA UNIT ATTENTION DENTAL CONTSULTANT.
P958	NOTE THAT CODE D4341 HAS BEEN CHANGED. REFER TO THE DECISION NOTICE FOR AUTHORIZED QUANTITY.
P960	YOUR PA HAS BEEN APPROVED FOR 90 DAYS. THE 90 DAY APPROVAL DOES NOT IMPLY THE PA REQUEST MEETS PRIOR AUTHORIZATION CRITERIA. AFTER ADDITIONAL INFORMATION IS AVAILABLE IN INTERCHANGE, COLORADO MEDICAID WILL CREATE AN AMENDMENT REQUEST TO EXTEND THE PA FOR
P961	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P962	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
PA10	THE REQUESTED END DATE IS INVALID.
PA12	PLEASE FURNISH A WRITTEN DESCRIPTION OF THE CLIENTS DIAGNOSIS.
PA13	PROVIDE DIAGNOSES WITH DATES OF ONSET.
PA14	IDENTIFY PROBLEMS TO BE TREATED.
PA15	THE AUDIOLOGISTS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1), F-11020, AND PRIOR AUTHORIZATION REQUEST/HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2), F-11021.
PA16	THE PHYSICIANS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION/PHYSICIAN OTOLOGICAL REPORT (PA/POR), F-11019.

Denial Code	Long Description
PA17	SUBMIT BRIEF HISTORY WITH REFERRAL INFORMATION, LIVING SITUATION, FUNCTIONAL STATUS, AND OTHER PERTINENT INFORMATION. WHAT CHANGE OF STATUS RESULTED IN REFERRAL AT THIS TIME?
PA18	PLEASE FURNISH THE CLIENTS HEIGHT AND WEIGHT.
PA19	PLEASE SUBMIT CLINICAL INFORMATION SUFFICIENT TO VERIFY THE NEED FOR THE REQUESTED SERVICE(S).
PA20	PLEASE RESUBMIT WITH COMPLETE PERIODONTAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PA21	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL EDUCATIONAL PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA22	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL PROGRAM PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA23	REFER TO THE DURABLE MEDICAL EQUIPMENT INDEX FOR APPROPRIATE CODE AND DESCRIPTION. DO NOT USE AN "UNLISTED" CODE.
PA24	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUALIZED FAMILY SERVICE PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA25	INFORMATION ON THE REQUEST FORM IS ILLEGIBLE, AND THE REQUEST CANNOT BE PROCESSED.
PA26	RE-EVALUATE YOUR GOALS. EMPHASIS SHOULD BE ON FUNCTIONAL SELF-CARE. GOALS MUST BE RELATED TO FUNCTIONAL OUTCOME.
PA27	PLEASE CLARIFY THE NUMBER OF HOURS PER WEEK REQUESTED.
PA28	PLEASE CLARIFY THE NUMBER OF HOURS PER DAY REQUESTED.
PA29	PLEASE CLARIFY THE NUMBER OF VISITS PER DAY REQUESTED.
PA30	ATTACH SUPPORTIVE DOCUMENTATION; HOME EXERCISE PROGRAM AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA31	THE DIAGNOSIS CODE INDICATED ON THE REQUEST DOES NOT CORRESPOND TO THE DIAGNOSIS CODE DESCRIPTION.
PA32	PLEASE SUBMIT ADDITIONAL INFORMATION SUFFICIENT TO VERIFY APPROPRIATENESS AND NEED FOR TRANSPLANT.
PA33	PLEASE SUBMIT THE INITIAL AND PROGRESSIVE OBJECTIVE FINDINGS.
PA34	ATTACH SUPPORTIVE DOCUMENTATION, FACILITY PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA35	PLEASE SUBMIT THE CLIENTS ORIGINAL COMPLAINTS AND EXAMINATION FINDINGS.
PA36	ATTACH SUPPORTIVE DOCUMENTATION, IN-HOME AUTISM PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA37	PLEASE SUBMIT YOUR TREATMENT PLAN FOR THIS CLIENT.
PA38	ATTACH SUPPORTIVE DOCUMENTATION AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA39	INITIAL EVALUATIONS MUST BE PERFORMED BY AN OCCUPATIONAL THERAPIST REGISTERED (OTR), PER AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA) STANDARDS.
PA41	IDENTIFY THE PLACE OF SERVICE AND ITS EFFECT ON SUPPORTING THE DESIRED TREATMENT OUTCOME.
PA42	PLEASE INDICATE THE HOURS OF USE OF OXYGEN PER 24-HOUR PERIOD.
PA43	PROVIDE BASELINE DOCUMENTATION FOR THIS CLIENTS LIMITATIONS USING UNITS OF MEASUREMENT THAT ARE APPLIED CONSISTENTLY WHEN REPORTING STATUS.
PA44	IDENTIFY FUNCTIONAL LIMITATIONS AS THEY ARE RELATED TO IDENTIFIED CONDITIONS.
PA46	CORRELATE PLAN OF CARE TO REQUESTED PROCEDURE CODES.
PA47	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE FREQUENCY/DURATION REQUESTED.
PA48	PLEASE PROVIDE THE NAME AND CREDENTIALS OF THE RENDERING PROVIDER.
PA50	COLORADO MEDICAID RECORDS INDICATE THE CLIENT OWNS A WHEELCHAIR. DOCUMENT THE REASON AND NEED FOR REPLACEMENT AND COST TO REPAIR CURRENT WHEELCHAIR.
PA51	PLEASE DISTINGUISH PRIMARY AND SUPPORTIVE MODALITIES.
PA52	PLEASE SUBMIT A PROGRESS REPORT.
PA53	MULTIPLE FAMILY CLIENTS TREATMENT BY THE SAME PROVIDER REQUIRES FURTHER INFORMATION DOCUMENTING COORDINATION OF TREATMENT PLAN.

Denial Code	Long Description
PA54	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE MINUTES REQUESTED.
PA55	MEDICAL NECESSITY OF TREATMENT REQUIRES ADDITIONAL DOCUMENTATION.
PA56	GIVEN AGE, DIAGNOSES, CURRENT LEVEL OF FUNCTION, PAST RESPONSE TO TREATMENT, AND LIVING SITUATION, EXPAND ON POTENTIAL FOR SIGNIFICANT FUNCTIONAL PROGRESS WITHIN THE NEXT SIX MONTHS. EMPHASIZE WHY PROGRESS IS EXPECTED WITH SERVICES AT THIS TIME.
PA57	SUBMIT THE INITIAL FINDINGS. INCLUDE A COMPREHENSIVE EVALUATION.
PA58	SUBMIT PROGRESSIVE, OBJECTIVE FINDINGS. INCLUDE A PERTINENT RE-EVALUATION.
PA59	PLEASE SUPPLY INFORMATION REGARDING THE CLIENTS MEDICATION REQUIREMENTS, IF ANY.
PA60	PLEASE SPECIFY IF THE CLIENT IS IN AN EDUCATIONAL SETTING.
PA61	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA62	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
PA63	THE SKILLS OF A THERAPIST ARE PURPOSEFUL AND SKILLED INTERVENTIONS REQUIRED TO CONTINUALLY DESIGN, IMPLEMENT, REASSESS, MODIFY/GRADE, AND/OR DISCONTINUE A PLAN OF CARE IN A TIMELY MANNER, BASED ON THE COMPLEXITY OF THE CLIENTS MEDICAL CONDITION AND/OR CO
PA64	PLEASE SUBMIT A THERAPY PLAN OF CARE, INCLUDING A CURRENT, DATED EVALUATION.
PA65	A PLAN OF CARE SIGNED AND DATED BY THE PHYSICIAN IS REQUIRED.
PA66	THE SKILLS OF A THERAPIST ARE REQUIRED WHEN ONLY THE THERAPIST CAN SAFELY AND EFFECTIVELY DELIVER THE THERAPEUTIC PROCEDURES BECAUSE OF THEIR UNIQUE KNOWLEDGE, TRAINING, AND EXPERTISE. DESCRIBE THE REASON THAT SOMEONE OTHER THAN A THERAPIST CANNOT SAFELY
PA67	PLEASE SPECIFY IF THE CLIENTS WORK SITE DEMANDS GOOD BINAURAL HEARING.
PA68	DESCRIBE THE REASON, BASED ON THE CLIENTS COGNITIVE, PHYSICAL, COMMUNICATION, OR RESOURCE STATUS, THAT A HOME PROGRAM, EQUIPMENT, OR ENVIRONMENTAL ADAPTATIONS ALONE CANNOT MEET CLIENTS NEEDS.
PA69	PLEASE SPECIFY IF THE CLIENT HAS AN ACCOMPANYING DISABILITY THAT ADDS TO THE HEARING PROBLEM.
PA70	DISTINGUISH REQUESTED PROCEDURES AND GOALS FROM OTHER SERVICES THIS CLIENT RECEIVES. THEY MAY NOT BE DUPLICATIVE.
PA71	PLEASE INDICATE THE NUMBER OF DAYS REQUESTED.
PA73	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA74	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA75	PLEASE DOCUMENT CARRYOVER OF THE THERAPY PROGRAM TO NURSING.
PA76	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA79	PROVIDE EVIDENCE OF SIGNIFICANT FUNCTIONAL PROGRESS IN LAST SIX MONTHS.
PA84	THE GRANT DATE OF THIS REQUEST CANNOT BE PRIOR TO THE SIGNATURE DATE OF THE PRESCRIBING PHYSICIAN.
PA86	PROVIDE EVIDENCE OF SKILLS GAINED IN THERAPY CARRYING OVER TO OTHER SETTINGS WITHIN SIX MONTHS.
PA87	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE NUMBER OF SESSIONS REQUESTED.
PA88	THE REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL SCOPE OF PRACTICE.
PA89	PRIOR AUTHORIZATION IS NOT REQUIRED UNTIL LIMITATION OF SERVICE HAS BEEN REACHED.
PA91	PLEASE SUBMIT REQUIRED X-RAYS.
PA92	PLEASE PROVIDE AN EXPLANATION FOR THE MATERIAL SUBMITTED WITH THE REQUEST.
PA95	PLEASE DESCRIBE HOW THE PROVISION OF THIS SERVICE WOULD PREVENT INSTITUTIONALIZATION OF THE CLIENT.
PA96	COULD THE EXISTING DENTURE(S) BE RELINED OR REBASED? IF NOT, PLEASE EXPLAIN WHY NOT.
PA97	REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL STANDARDS OF PRACTICE.
PA98	PLEASE INDICATE IF THE CLIENT IS CURRENTLY BEING TUBE FED.
PB02	PLEASE PROVIDE THE REQUIRED DATED SIGNATURES ON THE ATTACHMENTS.

Denial Code	Long Description
PB03	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING THE LOSS/DESTRUCTION/THEFT OF THE HEARING AID.
PB04	DESCRIBE THE CLIENTS ABILITY TO STAND OR AMBULATE SUFFICIENTLY TO ACCOMPLISH SELF-CARE ACTIVITIES.
PB07	PLEASE SUBMIT AN ORTHODONTIC STUDY MODEL OR DIAGNOSTIC CASTS.
PB09	PLEASE PROVIDE A PHOTOGRAPH OF THE INVOLVED AREA(S).
PB10	PLEASE PROVIDE AN ESTIMATION (IN GRAMS) OF THE TOTAL AMOUNT OF TISSUE TO BE RESECTED.
PB11	PLEASE SUBMIT THE PLAN OF CARE FOR CO-TREATMENT.
PB12	FURNISH A DETAILED DESCRIPTION FOR THE PROCEDURE CODE REQUESTED.
PB13	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB15	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB18	PLEASE COMPLETE THE ATTACHED OUT-OF-STATE PROVIDER DATA SHEET, F-11001, AND RESUBMIT.
PB20	A SIGNED AND DATED PRESCRIPTION IS REQUIRED WITHIN THREE MONTHS OF RECEIPT BY COLORADO MEDICAID FOR INITIAL REQUESTS AND WITHIN 12 MONTHS OF RECEIPT BY COLORADO MEDICAID FOR SUBSEQUENT REQUESTS.
PB21	PLEASE COMPLETE THE APPROPRIATE PRIOR AUTHORIZATION ATTACHMENT. CONTACT PROVIDER SERVICES OR THE PRIOR AUTHORIZATION UNIT FOR ASSISTANCE.
PB23	PHYSICAL THERAPY ASSISTANT NOTES AND ALL FORMS SUBMITTED MUST BE COSIGNED BY A REGISTERED PHYSICAL THERAPIST.
PB31	ARE YOU REQUESTING A COMPLETE APPLIANCE, OR REPLACEMENT PARTS?
PB32	THE PROCEDURE CODE INDICATED ON THE REQUEST DOES NOT MATCH THE DESCRIPTION OF SERVICE; PLEASE CORRECT AND RESUBMIT.
PB35	THE SERVICE REQUESTED DOES NOT REQUIRE PRIOR AUTHORIZATION.
PB41	PLEASE FURNISH A CURRENT MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT, F-11090 (DATED WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID).
PB45	THE CERTIFICATION PERIOD ON THE PLAN OF CARE (POC) DOES NOT COVER THE REQUESTED GRANT/START DATE. PLEASE RESUBMIT YOUR REQUEST WITH A NEW POC.
PB49	A CERTIFIED OCCUPATIONAL THERAPY ASSISTANTS NOTES MUST BE COSIGNED BY AN OCCUPATIONAL THERAPIST REGISTERED.
PB51	ADDITIONAL INFORMATION IS REQUIRED ON PRIOR AUTHORIZATION TO ENABLE PRICING.
PB54	REQUESTED SERVICES DO NOT MATCH SERVICES ON THE PHYSICIANS ORDERS.
PB59	PLEASE PROVIDE AN INDIVIDUAL EDUCATIONAL PLAN (IEP), WHICH HAS BEEN SIGNED BY THE PROVIDER NO EARLIER THAN NINE MONTHS PRIOR TO RECEIPT AT COLORADO MEDICAID; OTHERWISE, DOCUMENT WHY NO IEP EXISTS.
PB65	PLEASE FURNISH THE ANTICIPATED TOTAL CHARGES FOR THIS REQUEST.
PB66	A PHOTOCOPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED; THE DATE MUST BE WITHIN SIX MONTHS OF RECEIPT BY COLORADO MEDICAID.
PB67	THE PRESCRIPTION DATE MUST INCLUDE MONTH, DAY, AND YEAR.
PB68	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID.
PB73	THE SERVICES IDENTIFIED ON THE PLAN OF CARE DO NOT APPEAR APPROPRIATE FOR THE PROCEDURE CODE(S) REQUESTED ON THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018.
PB74	THE CLIENT/PROVIDER DOES NOT HAVE RETROACTIVE ENROLLMENT.
PB75	THE REQUESTED START DATE IS MORE THAN 14 DAYS BEFORE OR 62 DAYS AFTER RECEIPT.
PB82	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
PB83	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A HOME HEALTH AIDE. PLEASE RESUBMIT AS A PERSONAL CARE WORKER OR PROVIDE ADDITIONAL DOCUMENTATION.
PB86	THE SERVICES REQUESTED ARE NOT BEING PROVIDED IN THE CLIENTS RESIDENCE. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL.
PB87	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A NURSE. PLEASE RESUBMIT AS A HOME HEALTH AIDE OR PROVIDE ADDITIONAL DOCUMENTATION.
PB92	PLEASE FURNISH THE CLIENTS COMPLETE ADDRESS.
PB94	IF THE CLIENT IS A RESIDENT OF A NURSING HOME, SUPPLY THE COMPLETE NAME AND ADDRESS OF THE NURSING HOME.

Denial Code	Long Description
PB99	THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018, MUST BE SIGNED AND DATED.
PC01	PLEASE SUPPLY THE RENDERING PROVIDERS PROVIDER NUMBER.
PC03	THE DRUG ENFORCEMENT ADMINISTRATION NUMBER IS MISSING OR INVALID.
PC06	PLEASE DESCRIBE YOUR PROGRAM; INCLUDE ENTRY DATE, TERMINATION DATE, HOURS PER WEEK, AND NUMBER OF WEEKS OF PRIMARY INTENSIVE SERVICE REQUESTED.
PC07	PLEASE DESCRIBE YOUR "AFTERCARE/FOLLOW-UP" PLANS FOR THIS CLIENT.
PC08	PLEASE SUPPLY DOCUMENTATION OF PREVIOUS SUBSTANCE ABUSE SERVICES WITH DATE(S) AND OUTCOME.
PC09	PLEASE DESCRIBE IN DETAIL THE TREATMENT OBJECTIVES/GOALS FOR THIS CLIENT.
PC10	PLEASE DESCRIBE THE FAMILY SITUATION/DYNAMICS. EXPLAIN HOW THE FAMILY WILL BE INCORPORATED INTO THE CLIENTS PLAN OF CARE.
PC12	PLEASE EXPLAIN IF YOUR SERVICE ENCOURAGES THE CLIENT TO ATTEND SELF-HELP GROUPS.
PC13	PLEASE SUPPLY A SPECIFIC SCHEDULE OF ACTIVITIES, INCLUDING DAY, TIME OF DAY, LENGTH OF SESSION, AND SERVICE TO BE RENDERED DURING THAT TIME.
PC15	PLEASE FURNISH DIAGNOSTIC RATIONALE.
PC17	PLEASE DOCUMENT IF THE CLIENT EVER RECEIVED SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT.
PC19	PLEASE FURNISH MORE EXTENSIVE AND IN-DEPTH HISTORICAL AND PSYCHOSOCIAL DATA.
PC20	PLEASE SUPPLY THE DATE THE CLIENT BECAME TOTALLY ENDENTULOUS.
PC23	PLEASE SUBMIT A PHYSICIANS STATEMENT REGARDING THE MEDICAL NECESSITY OF DENTURES FOR THIS CLIENT. THE PHYSICIANS STATEMENT MUST DOCUMENT THE MEDICAL NEED FOR DENTURES.
PC24	THE SERVICE REQUESTED WAS PREVIOUSLY AUTHORIZED. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT INDICATING THIS FACT IS REQUIRED.
PC25	PLEASE SUPPLY SUFFICIENT MITIGATING CIRCUMSTANCES TO WARRANT THE CONSTRUCTION OF NEW DENTURES(S).
PC26	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
PC28	PLEASE SUBMIT A PHYSICIANS STATEMENT INDICATING DENTURES ARE NECESSARY FOR THIS NURSING HOME CLIENT.
PC29	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING LOSS OR DESTRUCTION OF DENTURE(S). INCLUDE SIGNED STATEMENT FROM CLIENT OR FACILITY DIRECTOR REGARDING HOW, WHEN AND WHERE LOST.
PC30	PLEASE PROVIDE COMPLETE INTRAORAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PC31	PLEASE DESCRIBE ANY RELATED DEFORMITIES OF THE FEET.
PC34	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD WITH REQUESTED DME ITEM(S) AND DOCUMENT IF THE CLIENT CAN USE SAFELY AND INDEPENDENTLY.
PC35	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD AND DESCRIBE THE RESULTS AND EFFECTIVENESS OF THE SERVICE REQUESTED.
PC39	PLEASE INDICATE LITER FLOW PER MINUTE, HOURS OF USE PER 24 HOUR PERIOD, AND THE EXPECTED DURATION OF NEED.
PC40	THE ITEM DOES NOT REQUIRE PRIOR AUTHORIZATION UNTIL THE LIFE EXPECTANCY HAS BEEN REACHED.
PC41	PLEASE SUPPLY INFORMATION INDICATING THE NECESSITY OF POSITIONING THE CLIENT'S BODY IN MULTIPLE POSITIONS.
PC42	PLEASE INDICATE IF THE BED HEIGHT MUST BE CHANGED TO ALLOW FOR SAFE TRANSFER OR ADEQUATE BED CARE.
PC43	SUPPLY A PHYSICIANS STATEMENT INDICATING TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR UNIT HAS REDUCED PAIN, IMPROVED/INCREASED THE CLIENTS ACTIVITY LEVEL, AND/OR REDUCED CLIENTS USE OF PAIN MEDICATION.
PC44	A CURRENT AUTHORIZATION FOR THIS SERVICE IS ON FILE FOR ANOTHER PROVIDER. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT OF THAT FACT IS REQUIRED BY THE CLIENT OF FIRST PROVIDER.
PC59	DOCUMENT DECLINE OR PROGRESS IN SPECIFIC, MEASURABLE, OBJECTIVE TERMS.
PC60	DOCUMENT IF CLIENT HAS DEMONSTRATED A GOOD APPOINTMENT COMPLIANCE RECORD.
PC61	THE PHYSICIANS SIGNATURE DATE MUST NOT EXCEED 90 DAYS FROM THE DATE OF RECEIPT BY COLORADO MEDICAID.

Denial Code	Long Description
PC62	REQUESTS FOR A CONTINUATION OF THERAPY SHOULD NOT BE SUBMITTED MORE THAN FOUR WEEKS PRIOR TO THE EXPIRATION DATE OF THE CURRENT AUTHORIZATION.
PC63	PLEASE FURNISH THE STYLE AND MANUFACTURER OF THE FRAME.
PC64	PLEASE FURNISH THE CLIENTS LENS FORMULA.
PC66	ALL REQUESTS FOR TINTS REQUIRE DOCUMENTATION OF THE VISUAL OR MEDICAL CONDITION RELATED TO PHOTOPHOBIA.
PC67	PLEASE DOCUMENT THE REASON AND JUSTIFICATION FOR REPLACEMENT BEYOND THE FIRST LENS/FRAME.
PC68	DOCUMENT IF ALL REMAINING MAXILLARY AND/OR MANDIBULAR TEETH ARE DECAY-FREE, PROPERLY RESTORED, AND PERIODONTICALLY SOUND.
PC72	SUPPLY MORE DETAIL REGARDING PROGRESS (ATTACHMENT OF GOALS, ETC.). CORRELATE PROGRESS TO PREVIOUS GOALS AND IDENTIFIED LIMITATIONS.
PC77	PLEASE SUBMIT A PLAN OF CARE DESCRIBING THE SERVICES THAT WOULD BE PROVIDED.
PC78	PLEASE DOCUMENT SPECIFIC, MEASURABLE GOALS.
PC82	THE PRIOR AUTHORIZATION (PA) SYSTEM CAN PROCESS ONLY 26 DETAILS PER PA REQUEST. PLEASE RESUBMIT YOUR REQUEST WITH NO MORE THAN 26 DETAILS.
PC83	PLEASE SUPPLY A PHYSICIANS PRESCRIPTION DATED WITHIN ONE MONTH OF REQUESTED SUBSTANCE ABUSE DAY TREATMENT.
PC84	PLEASE PROVIDE INFORMATION INDICATING THIS CLIENT IS APPROPRIATELY DETOXIFIED FROM ALCOHOL AND/OR OTHER DRUGS.
PC85	PLEASE PROVIDE INFORMATION TO INDICATE THE CLIENTS ABILITY TO ABSTAIN FROM ALCOHOL OR DRUGS WHILE IN THE SUBSTANCE ABUSE DAY TREATMENT PROGRAM.
PC86	PLEASE INDICATE IF THIS CLIENT IS WILLING TO PARTICIPATE IN AFTERCARE OR CONTINUING CARE SERVICES.
PC87	PROVIDE MORE INFORMATION ON TREATMENT HISTORY; INCLUDE SERVICE PROVIDED, DATES, AND OUTCOME. PROVIDE DETAIL OF PREVIOUS TREATMENT.
PC88	PLEASE PROVIDE MORE RATIONALE FOR THE APPROPRIATENESS AND MEDICAL NECESSITY OF SUBSTANCE ABUSE DAY TREATMENT.
PC89	PROVIDE A TREATMENT PLAN THAT CONTAINS MEASURABLE GOALS AND OBJECTIVES CORRESPONDING TO THE IDENTIFIED DEFICIT.
PC91	PLEASE PROVIDE MORE INFORMATION ON FAMILY INVOLVEMENT TREATMENT.
PC92	PLEASE PROVIDE MORE HISTORY AND EXPLANATION ABOUT THE ISSUE OF ABSTINENCE FOR THIS CLIENT.
PC94	PLEASE PROVIDE THE ANTICIPATED BEGINNING DATE AND/OR THE ESTIMATED SUBSTANCE ABUSE DAY TREATMENT DISCHARGE DATE.
PC95	PLEASE SUPPLY JUSTIFICATION FOR BEGINNING CLIENT IN SERVICE PRIOR TO AUTHORIZATION BEING OBTAINED.
PC96	THE INITIAL THREE HOURS OF SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IN A CALENDAR YEAR DO NOT REQUIRE PRIOR AUTHORIZATION.
PC97	REIMBURSEMENT FOR INITIAL SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IS LIMITED TO THREE HOURS IN A CALENDAR YEAR AND DOES NOT REQUIRE PRIOR AUTHORIZATION.
PC98	THIS DRUG IS CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE BILL USING THE APPROPRIATE NATIONAL DRUG CODE (NDC) OR SUBMIT A COMPLETED DRUG ADDITION REQUEST FORM IF THE NDC IS NOT LISTED IN THE DRUG INDEX.
PC99	THIS DRUG IS NOT CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL, CURRENT ADMINISTRATIVE RULE, OR COLORADO DRUG INDEX FOR COVERAGE LIMITATIONS.
PD01	DOCUMENT THAT CLIENT HAS ACHIEVED GOOD ORAL HYGIENE, PERIODONTAL CASE TYPE 1 OR 2, AND IS MOTIVATED TO MAINTAIN SAME.
PD03	PLEASE PROVIDE AN ARTERIAL BLOOD GAS READING OR PULSE OXIMETRY RESULTS DONE ON ROOM AIR SIGNED AND DATED BY A MEDICAL DOCTOR. THIS SHOULD BE DONE WITHIN 60 DAYS OF REQUESTED SERVICE.
PD04	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 30 DAYS OF RECEIPT BY COLORADO MEDICAID.

Denial Code	Long Description
PD07	SUBMIT A PHOTOCOPY OF A VALID PRESCRIPTION, ISSUED WITHIN THE PAST YEAR, OR COMPLETE SECTION B OF THE PRIOR AUTHORIZATION/DRUG ATTACHMENT (PA/DGA), F-11049.
PD10	BRAND MEDICALLY NECESSARY MUST BE IN THE PRESCRIBERS OWN HANDWRITING AND WRITTEN DIRECTLY ON THE PRESCRIPTION OR A SEPARATE ORDER ATTACHED TO THE ORIGINAL PRESCRIPTION.
PD12	COMPLETE DENTURES, PARTIAL DENTURES, DENTURE RELINES, AND FIXED PROSTHODONTIC SERVICES ARE NOT COVERED SERVICES FOR ADULTS FOR DATES OF SERVICE ON AND AFTER OCTOBER 1, 1995.
PD22	PLEASE COMPLETE ALL REQUIRED ELEMENTS ON THE PERSONAL CARE SCREENING TOOL (PCST), F-11133.
PD24	THIS PRIOR AUTHORIZATION REQUEST IS UNABLE TO BE PROCESSED. PLEASE RESUBMIT WITH ADDITIONAL REQUIRED FORMS, INCLUDING THE ENTIRE PERSONAL CARE SCREENING TOOL (PCST), F-11133; PERSONAL CARE ADDENDUM, F-11136; AND SUPPORTING DOCUMENTATION, AS DIRECTED.
PD25	THERE IS A PERSONAL CARE SCREENING TOOL (PCST), F-11133, COMPLETED BY ANOTHER AGENCY. CONTACT THE AGENCY TO TRANSFER SCREEN.
PD26	THERE IS A LIMITED TERM CARE FUNCTIONAL SCREEN (LTC-FS) COMPLETED BY ANOTHER AGENCY. THE PERSONAL CARE SCREENING TOOL (PCST), F-11133, INFORMATION IS IN CONFLICT WITH LTC-FS.
PD27	ONLY ONE LEVEL OF FUNCTION MAY BE SELECTED FOR ALL ELEMENTS EXCEPT TOILETING. COLORADO MEDICAID IS UNABLE TO PROCESS THE PRIOR AUTHORIZATION REQUEST.
PD28	NO UNITS MAY BE REQUESTED USING THIS PRIOR AUTHORIZATION PROCESS. PLEASE SUBMIT WITH THE APPROPRIATE ATTACHMENTS FOR REQUESTING SPECIFIC PERSONAL CARE WORKER UNITS.
PD29	CLIENT IS NOT ELIGIBLE FOR THE REQUESTED SERVICE(S) AS OF THE REQUESTED START DATE.
PD30	NO TRAVEL TIME MAY BE AUTHORIZED WHEN NO PERSONAL CARE WORKER SERVICE IS AUTHORIZED.
PD32	PROVIDER NOT CERTIFIED TO RENDER THE SERVICE(S) REQUESTED.
PD34	BASED ON THE DOCUMENTATION SUBMITTED, THIS REQUEST CAN NOT BE PRIOR AUTHORIZED. REFER TO THE PA MESSAGES FROM THE CONSULTANT FOR COMPLETE EXPLANATION.
PD98	PLEASE DOCUMENT HOW AND WHEN EACH PREVIOUSLY AUTHORIZED PRO RE NATA VISIT WAS USED.

Personal Care

Denial Code	Long Description
0201	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
0233	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0235	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0237	CLIENT IDENTIFICATION NUMBER DOES NOT MATCH CLIENTS FIRST NAME.
0238	THE CLIENT IDENTIFICATION NUMBER DOES NOT MATCH THE CLIENTS LAST NAME.
0242	SECONDARY DIAGNOSIS CODE IS INVALID.
0248	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0249	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0251	PROCEDURE CODE MODIFIER IN FIRST POSITION IS INVALID.
0252	THE PROCEDURE CODE MODIFIER IN SECOND POSITION IS INVALID FOR REQUESTED START DATE OR DATE OF RECEIPT.
0253	THE PROCEDURE CODE MODIFIER IN THIRD POSITION IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
0258	THE PRIMARY DIAGNOSIS CODE IS REQUIRED.
0272	THE PRIMARY DIAGNSOSIS CODE IS INVALID.
0339	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0340	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0400	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0853	HCPCS - ANNUAL UPDATE
0885	NEVER EVENTS MODIFIERS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
0886	NEVER EVENTS DIAGNOSIS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.

Denial Code	Long Description
1000	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
1002	RENDERING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1003	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1007	RENDERING PROVIDER ID IS NOT ON FILE.
1047	THE RENDERING PROVIDERS CERTIFICATION HAS BEEN CANCELLED.
1048	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1801	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
1804	A CERTIFIED SUBSTANCE ABUSE DAY TREATMENT PROVIDER MUST SUBMIT A SUBSTANCE ABUSE DAY TREATMENT PROCEDURE CODE.
1806	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
1808	THE BILLING PROVIDER DOES NOT HAVE THE REQUIRED CERTIFICATION ADDENDUM ON FILE.
1900	THE BILLING PROVIDERS TAXONOMY CODE IS INVALID.
1901	THE RENDERING PROVIDERS TAXONOMY CODE IS INVALID.
1927	A NATIONAL PROVIDER IDENTIFIER IS REQUIRED FOR THE BILLING PROVIDER.
1934	A NATIONAL PROVIDER INDENTIFIER IS REQUIRED FOR THE RENDERING PROVIDER.
1936	THE BILLING PROVIDER NUMBER IS INVALID.
1937	THE RENDERING PROVIDER NUMBER IS INVALID.
1960	INTERNAL PROCESSING IS REQUIRED.
1963	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.
1964	THE BILLING PROVIDER INDICATED IS NOT ALLOWABLE AS A BILLING PROVIDER.
1965	RENDERING PROVIDER NUMBER IS MISSING/INVALID FOR THIS PROCEDURE PROVIDER.
1974	PRESCRIBING/REFERRING/ORDERING PROVIDER INDICATED IS NOT CERTIFIED AS A PRESCRIBING/REFERRING/ORDERING PROVIDER.
1975	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
1976	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
2001	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2003	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2017	THE CLIENT IS ENROLLED IN A MEDICAID OR OTHER MANAGED CARE PROGRAM.
2037	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2603	CLIENT LOCKED-IN TO A PROVIDER OR ENROLLED IN A HOSPICE. CONTACT CLIENTS HOSPICE FOR PAYMENT OF SERVICES OR RESUBMIT WITH DOCUMENTATION OF UNRELATED NATURE OF CARE.
3324	THE MODIFIER HAS BEEN DISCONTINUED BY THE CENTERS OF MEDICARE AND MEDICAID SERVICES OR THE AMERICAN MEDICAL ASSOCIATION FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
3337	THE PROCEDURE CODE HAS BEEN TERMINATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AMERICAN MEDICAL ASSOCIATION, OR AMERICAN DENTAL ASSOCIATION FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT. RESUBMIT WITH VALID A PROCEDURE CODE.
3339	THE PROCEDURE BILLED IS NOT PAYABLE ACCORDING TO DEFICIT REDUCTION ACT (DEFRA) GUIDELINES.
3351	THE PROCEDURE IS NOT COVERED FOR CLIENTS WITH A NURSING HOME AUTHORIZATION ON THE REQUESTED START DATE OR DATE OF RECEIPT.
3353	THE PROCEDURE IS NOT A COVERED SERVICE FOR HOME AND COMMUNITY-BASED WAIVER CLIENTS.
4021	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4027	THE DIAGNOSIS CODE IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
4031	THE PROCEDURE SUBMITTED IS NOT APPROPRIATE FOR CLIENTS GENDER.
4032	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4034	THE PROCEDURE CODE HAS AN AGE RESTRICTION.
4036	THE PLACE OF SERVICE CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4040	THE PRIMARY DIAGNOSIS CODE IS NOT ON FILE.
4041	THE SECONDARY DIAGNOSIS IS NOT ON FILE.
4046	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4059	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4077	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4127	INTERNAL PROCESSING IS REQUIRED.

Denial Code	Long Description
4131	INTERNAL PROCESSING IS REQUIRED.
4141	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4149	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4150	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4236	ETIOLOGY DIAGNOSIS CODE(S) (E-CODES) ARE INVALID AS THE PRIMARY DIAGNOSIS.
4244	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4245	THE FOURTH POSITION MODIFIER IS INVALID FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT.
4256	THE PROCEDURE CODE AND MODIFIER COMBINATION IS NOT PAYABLE FOR THE CLIENTS BENEFIT PLAN.
4257	THE MODIFIERS SUBMITTED ARE EITHER INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT OR THE MODIFIERS ARE MISSING.
4311	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4315	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4316	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4371	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4372	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4711	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR CLIENTS AGE.
4714	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS AGE.
4731	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS DIAGNOSIS.
4742	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4743	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4744	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4745	DIAGNOSIS AND/OR PROCEDURE AND/OR PLACE OF SERVICE (POS) CODE IS NOT COVERED FOR EXPRESS ENROLLMENT CLIENTS.
4746	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4801	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4802	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
4821	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
4871	PLEASE REFER TO PA MESSAGES FOR RETURN INFORMATION.
4963	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS GENDER.
4990	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
7500	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
7509	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
P001	THE BILLING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THE SERVICES.
P002	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P003	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P005	THE PRIOR AUTHORIZATION CAN NOT BE END DATED. THE PRIOR AUTHORIZATION STATUS IS NOT APPROVED OR APPROVED WITH REVISIONS.
P006	PLEASE FURNISH THE PROCEDURE CODE AND CORRESPONDING DESCRIPTION.
P008	THE BILLING PROVIDER NUMBER IS INVALID.
P009	THE BILLING PROVIDER NUMBER IS INVALID.
P010	THE REQUESTED END DATE IS INVALID.
P011	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P012	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P013	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P014	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.

Denial Code	Long Description
P015	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P016	THE REQUESTED START DATE IS MISSING OR INVALID.
P019	THE REQUESTED START DATE IS MISSING OR INVALID.
P020	THE RENDERING PROVIDER NUMBER IS INVALID.
P021	THE RENDERING PROVIDER NUMBER IS INVALID.
P022	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P023	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P024	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P026	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P027	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P030	FIRST MODIFIER IS INVALID.
P031	FIRST MODIFIER IS INVALID.
P032	SECOND MODIFIER IS INVALID.
P033	SECOND MODIFIER IS INVALID.
P034	THIRD MODIFIER IS INVALID.
P035	THIRD MODIFIER IS INVALID.
P036	FOURTH MODIFIER IS INVALID.
P037	FOURTH MODIFIER IS INVALID.
P038	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P039	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P040	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P041	CLIENTS FIRST NAME IS MISSING.
P042	CLIENTS LAST NAME IS MISSING.
P043	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P044	BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES REQUESTED.
P045	FIRST MODIFIER IS INVALID.
P046	SECOND MODIFIER IS INVALID.
P047	THIRD MODIFIER IS INVALID.
P048	FOURTH MODIFIER IS INVALID.
P052	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P053	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P054	RENDERING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES FOR THE BENEFIT PLAN.
P055	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P061	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P062	THE CLIENT ID AND/OR NAME INDICATED ON THE PA REQUEST IS INCORRECT. THE CLIENT ID AND/OR NAME HAS BEEN UPDATED. PLEASE VERIFY THE ID AND/OR NAME IS CORRECT.
P064	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
P067	THE FREQUENCY OF HOURS REQUESTED ARE NOT APPROPRIATE FOR THIS CLIENT AND HAVE BEEN MODIFIED ACCORDINGLY.
P079	BILLING PROVIDER IS ON PAYMENT SUSPENSION DUE TO CREDIBLE ALLEGATION OF FRAUD.
P120	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAS BEEN REDUCED.
P121	THE SERVICE/ PROCEDURE REQUESTED IS NOT SUPPORTED BY SUBMITTED DOCUMENTATION.
P126	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
P128	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.
P138	SERVICE(S) DO NOT MEET COLORADO MEDICAID GUIDELINES.
P167	REQUESTED DOCUMENTATION HAS NOT BEEN SUBMITTED.

Denial Code	Long Description
P178	THE SERVICE REQUESTED IS NOT MEDICALLY NECESSARY.
P179	THE MEDICAL NECESSITY FOR THIS SERVICE IS NOT SUPPORTED BY THE SUBMITTED DOCUMENTATION.
P233	THE DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE ADDITIONAL CARE.
P257	THIS CLIENTS FUNCTIONAL ASSESSMENT SCORES PLACE THIS CLIENT OUTSIDE ELIGIBILITY FOR DAY TREATMENT.
P274	OUR RECORDS INDICATE THIS CLIENT IS INVOLVED IN EFFECTIVE AND APPROPRIATE SERVICE ELSEWHERE.
P292	INTENSIVE REHABILITATION HOURS ARE NO LONGER APPROPRIATE AS INDICATED BY HISTORY, DIAGNOSIS, AND/ OR FUNCTIONAL ASSESSMENT SCORES.
P328	THE SERVICES REQUESTED INCLUDE NON-COVERED SERVICES, AND HOURS ARE REDUCED ACCORDINGLY.
P339	THE CLIENTS PAST HISTORY INDICATES REDUCED TREATMENT HOURS ARE WARRANTED.
P342	THE REQUEST DOES NOT MEET GENERALLY ACCEPTED CONDITIONS REQUIRING FLUORIDE TREATMENTS.
P346	SERVICES EXCEED COLORADO MEDICAID LIMITATION AND DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE MEDICAL NECESSITY OF THE SERVICE.
P349	THE SERVICE REQUESTED WAS PERFORMED LESS THAN FIVE YEARS AGO.
P353	THE EXISTING APPLIANCE HAS NOT BEEN WORN FOR THREE YEARS.
P367	THE CLIENT HAS BEEN TOTALLY WITHOUT TEETH AND AN APPLIANCE FOR FIVE YEARS.
P392	THE CLIENT IS MISSING AN ANTERIOR TOOTH AND/OR HAS TWO OR MORE POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P405	THE SERVICE(S) REQUESTED COULD ADEQUATELY BE PERFORMED IN THE DENTAL OFFICE.
P406	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE OF GOOD PERIODONTAL HEALTH (AMERICAN ACADEMY OF PERIODONTOLOGY PERIODONTAL CLASSIFICATION OF TYPE I OR II).
P407	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE VISIBLE ON RADIOGRAPHS THAT AT LEAST 50 PERCENT OF THE CLINICAL CROWN IS INTACT.
P409	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING SIX OR MORE TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED, INCLUDING THIRD MOLARS.
P410	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING ONE OR MORE ANTERIOR TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED.
P411	DOCUMENTATION DOES NOT SUPPORT THE NEED FOR PERIODONTIC SERVICES. POCKETS ARE LESS THAN 4MM AND/OR GREATER THAN 6MM FOR CLIENT AND/OR THE CLIENT IS UNDER THE AGE OF 13.
P412	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA.
P413	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA. THIS PA HAS BEEN GRANTED AS APPROVED NOT APPROVED WITH REVISIONS. THE DURATION REQUESTED MAY HAVE BEEN REDUCED TO REFLECT COVERAGE LIMITATIONS, PRESCRIBER ORDERS, CONFLICTI
P417	THE SERVICE(S) REQUESTED COULD BE ADEQUATELY PERFORMED WITH LOCAL ANESTHESIA.
P437	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO POOR ORAL HYGIENE.
P444	THIS LINE ITEM IS A DUPLICATE OF ANOTHER LINE ITEM ON THIS PRIOR AUTHORIZATION (PA) REQUEST. PLEASE CORRECT.
P446	THIS IS A DUPLICATE OF AN EXISTING PRIOR AUTHORIZATION (PA) REQUEST. YOU MAY CONTACT PROVIDER SERVICES IF YOU REQUIRE ASSISTANCE. DUPLICATE PA REQUEST
P448	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO DECAY HISTORY.
P449	QUESTIONABLE LONG TERM PROGNOSIS DUE TO GUM AND BONE DISEASE.
P456	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO APPARENT ROOT INFECTION.
P457	OUR RECORDS INDICATE THIS CLIENT HAS EXCEEDED ESTABLISHED PROGRAM LIMITATIONS. COLORADO MEDICAID WILL NOT AUTHORIZE NEW DENTURES.
P458	DOCUMENTATION PROVIDED INDICATES A LESS ELABORATE PROCEDURE SHOULD BE CONSIDERED.
P502	RENTAL ONLY ALLOWED; MEDICAL NEED FOR PURCHASE HAS NOT BEEN DOCUMENTED.
P503	PURCHASE ONLY ALLOWED; MEDICAL NEED FOR RENTAL HAS NOT BEEN DOCUMENTED.
P504	OCCUPATIONAL THERAPY GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P505	THE SERVICE REQUESTED IS INCLUDED IN THE NURSING HOME RATE STRUCTURE.
P511	THIS NATIONAL DRUG CODE IS ONLY BILLABLE AS PART OF A COMPOUND DRUG.
P515	THE PRESENCE OF A HANDICAPPING MALOCCLUSION OR HANDICAPPING DENTOFACIAL DEFORMITY IS NOT SUPPORTED BY THE DOCUMENTATION SUBMITTED.

Denial Code	Long Description
P521	THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVERED BY COLORADO MEDICAID.
P522	GASTRO-INTESTINAL SURGERY FOR THE PURPOSE OF WEIGHT CONTROL IS COVERED ONLY AS A LIFE THREATENING PROCEDURE.
P523	THE TREATMENT REQUEST IS NOT CONSISTENT WITH THE CLIENT'S DIAGNOSIS.
P524	PSYCHOTHERAPY PROVIDED IN THE CLIENTS HOME IS NOT A COVERED BENEFIT OF COLORADO MEDICAID.
P525	THE INFORMATION PROVIDED IS NOT CONSISTENT WITH THE INTENSITY OF SERVICES REQUESTED.
P526	INTENSIVE MULTIPLE MODALITY TREATMENT IS NOT CONSISTENT WITH THE INFORMATION PROVIDED.
P527	MULTIPLE PROVIDERS OF TREATMENT ARE NOT INDICATED FOR THIS CLIENT.
P528	THE DURATION OF TREATMENT SESSIONS EXCEED CURRENT COLORADO MEDICAID GUIDELINES.
P534	DOCUMENTATION OF POOR PHYSICAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P535	OTHER PHYSICAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P536	THE PHYSICAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P537	USE OF PHYSICAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P538	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF A PHYSICAL THERAPIST.
P539	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS AND LIVING ARRANGEMENT.
P540	GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P541	THE PROCEDURE(S) REQUESTED ARE NOT MEDICAL IN NATURE.
P542	DOCUMENTATION OF POOR OCCUPATIONAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P543	DOCUMENTATION OF POOR SPEECH THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P544	OTHER OCCUPATIONAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P546	THE OCCUPATIONAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P547	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF PHYSICAL THERAPY.
P548	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P549	ACTIVITIES TO PROMOTE DIVERSION OR GENERAL MOTIVATION ARE NONCOVERED COLORADO MEDICAID SERVICES.
P550	REVISIONS OF THE REQUEST IS NECESSITATED BY THE CLIENTS MINIMAL PROGRESS.
P551	RESTORATIVE NURSING INVOLVEMENT COULD BE INCREASED.
P552	CLIENTS DEMONSTRATED RESPONSE TO CURRENT THERAPY DOES NOT WARRANT THE INTENSE FREQUENCY REQUESTED.
P553	MAINTENANCE IS TWO TIMES PER WEEK OR LESS.
P554	THE SPEECH THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P555	USE OF OCCUPATIONAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P556	USE OF SPEECH THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P557	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF AN OCCUPATIONAL THERAPIST.
P558	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
P559	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P560	THE MATERIALS/ SERVICES REQUESTED ARE PRINCIPALLY COSMETIC IN NATURE.
P561	THE LENS FORMULA DOES NOT JUSTIFY REPLACEMENT.
P562	THE CHANGE IN THE LENS FORMULA DOES NOT WARRANT MULTIPLE REPLACEMENTS.
P563	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.

Denial Code	Long Description
P564	LENSES ONLY ARE APPROVED; PLEASE DISPENSE A CONTRACTED FRAME. THE NON-CONTRACTED FRAME IS NOT MEDICALLY JUSTIFIED.
P565	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P566	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P567	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF OCCUPATIONAL THERAPY.
P568	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF SPEECH THERAPY.
P569	LEVEL, INTENSITY, OR EXTENT OF SERVICE(S) REQUESTED HAS BEEN MODIFIED CONSISTENT WITH MEDICAL NEED AS DEFINED IN THE PLAN OF CARE.
P570	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P571	THE SERVICE ASKED FOR IS NOT COVERED BY COLORADO MEDICAID AS THESE TASKS CAN BE DONE BY NURSES OR ACTIVITY STAFF.
P572	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P573	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.
P574	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P575	MEDICAL NEED FOR EQUIPMENT/ SUPPLY REQUESTED IS NOT SUPPORTED BY DOCUMENTATION SUBMITTED.
P576	OTHER SPEECH THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P577	DOCUMENTATION SUBMITTED IDENTIFIES THAT THE CLIENT HAS FEWER THAN TWO POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P582	LESS EXPENSIVE ALTERNATIVE SERVICES ARE AVAILABLE FOR THIS CLIENT.
P634	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P711	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING PERIODONTAL SCALING AND ROOT PLANNING.
P712	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING GINGIVECTOMY.
P754	AN APPROVED SUBSTANCE ABUSE DAY TREATMENT PROGRAM CANNOT EXCEED A SIX WEEK PERIOD.
P761	THE CLIENT DOES NOT APPEAR TO BE ABLE OR WILLING TO ABSTAIN FROM ALCOHOL/DRUG USAGE WHILE IN TREATMENT. THEREFORE, SUBSTANCE ABUSE DAY TREATMENT SERVICES ARE NOT APPROVED.
P764	THIS CLIENT HAS COMPLETED INTENSIVE SUBSTANCE ABUSE TREATMENT WITHIN THE PAST 12 MONTHS. THE DOCUMENTATION PROVIDED IS NOT ADEQUATE TO JUSTIFY ADDITIONAL INTENSIVE TREATMENT AT THIS TIME.
P785	A LESS THAN SIX-WEEK HEALING PERIOD HAS BEEN SPECIFIED FOR THIS PRIOR AUTHORIZATION. THEREFORE IT IS NOT NECESSARY TO WAIT THE FULL SIX WEEKS AFTER EXTRACTIONS BEFORE TAKING DENTURE IMPRESSIONS.
P818	SIX-WEEK HEALING TIME IS REQUIRED BETWEEN EDENTULATION AND FINAL IMPRESSIONS. PAYMENT FOR DENTURES WILL BE DENIED OR RECOUPED IF HEALING PERIOD IS NOT OBSERVED.
P849	COLORADO MEDICAID HAS DETERMINED THERE WERE (ARE) SEVERAL HOME HEALTH AGENCIES WILLING TO PROVIDE MEDICALLY NECESSARY SKILLED NURSING SERVICES TO THIS CLIENT.
P864	THE DOCUMENTATION YOU HAVE SUBMITTED DOES NOT MEET THE REQUIREMENTS OF COLORADO MEDICAID.
P873	THE MEDICAL NECESSITY FOR THE HOURS REQUESTED IS NOT SUPPORTED BY THE INFORMATION SUBMITTED.
P874	THE DOCUMENTATION SUBMITTED INDICATES THE TASKS SPECIFIED CAN BE COMPLETED DURING THE VISITS APPROVED.
P878	THE DOCUMENTATION SUBMITTED DOES NOT INDICATE THAT MEDICALLY ORIENTED TASKS ARE MEDICALLY NECESSARY; THEREFORE PERSONAL CARE SERVICES HAVE BEEN APPROVED.
P880	THE QUANTITY OF SERVICES AUTHORIZED FOR THIS CLIENTS PERSONAL CARE HAS BEEN AMENDED BASED ON INFORMATION RECEIVED FROM ONE OR MORE OF THESE SOURCES: THE CLIENT, THEIR PHYSICIAN, AND/OR THE IN-HOME VISIT BY STAFF OF THE OIG (OFFICE OF INSPECTOR GENERAL).

Denial Code	Long Description
P885	THE USE OF THIS DRUG FOR THE INTENDED PURPOSE IS NOT COVERED BY COLORADO MEDICAID, CONSISTENT WITH COLORADO ADMINISTRATIVE CODE AND FEDERAL LAW.
P924	THE MEDICAL RECORDS SUBMITTED WITH THE CURRENT REQUEST CONFLICT OR DISAGREE WITH OUR MEDICAL RECORDS ON THIS CLIENT.
P950	INDEPENDENT NURSES, PLEASE NOTE PAYABLE SERVICES MAY NOT EXCEED 12 HOURS/DAY OR 60 HOURS/WEEK.
P951	SERVICES CAN ONLY BE AUTHORIZED THROUGH ONE YEAR FROM THE PRESCRIPTION DATE.
P952	LEAD INSPECTION IS A COVERED COLORADO MEDICAID SERVICE WHEN THE CHILD HAS BEEN SHOWN TO HAVE LEAD POISONING (E.G., CHILD HAS A BLOOD LEAD LEVEL > 19 UG/DL OR TWO CONSECUTIVE BLOOD LEAD LEVELS OF 15-19 UG/DL DONE AT LEAST 90 DAYS APART). THE INSPECTION MUS
P953	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P954	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P956	THE REQUEST CAN ONLY BE BACKDATED A MAXIMUM OF 14 DAYS FROM FIRST DATE RECEIVED BY COLORADO MEDICAID.
P957	COMPLETE PERIODONTAL CHARTING AT TIME OF SERVICE, AND SUBMIT CHARTING, COPY OF OPERATIVE REPORT, TOGETHER WITH A COPY OF THE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF), F-11035, TO PA UNIT ATTENTION DENTAL CONTSULTANT.
P958	NOTE THAT CODE D4341 HAS BEEN CHANGED. REFER TO THE DECISION NOTICE FOR AUTHORIZED QUANTITY.
P960	YOUR PA HAS BEEN APPROVED FOR 90 DAYS. THE 90 DAY APPROVAL DOES NOT IMPLY THE PA REQUEST MEETS PRIOR AUTHORIZATION CRITERIA. AFTER ADDITIONAL INFORMATION IS AVAILABLE IN INTERCHANGE, COLORADO MEDICAID WILL CREATE AN AMENDMENT REQUEST TO EXTEND THE PA FOR
P961	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P962	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P989	YOUR PRIOR AUTHORIZATION REQUEST FOR PERSONAL CARE SERVICES HAS BEEN APPROVED AS REQUESTED, WHICH IS EQUAL TO OR LESS THAN THE TOTAL ANNUAL UNITS ALLOCATED ON THE PERSONAL CARE SCREENING TOOL SUMMARY SHEET.
PA10	THE REQUESTED END DATE IS INVALID.
PA12	PLEASE FURNISH A WRITTEN DESCRIPTION OF THE CLIENTS DIAGNOSIS.
PA13	PROVIDE DIAGNOSES WITH DATES OF ONSET.
PA14	IDENTIFY PROBLEMS TO BE TREATED.
PA15	THE AUDIOLOGISTS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1), F-11020, AND PRIOR AUTHORIZATION REQUEST/HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2), F-11021.
PA16	THE PHYSICIANS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION/PHYSICIAN OTOLOGICAL REPORT (PA/POR), F-11019.
PA17	SUBMIT BRIEF HISTORY WITH REFERRAL INFORMATION, LIVING SITUATION, FUNCTIONAL STATUS, AND OTHER PERTINENT INFORMATION. WHAT CHANGE OF STATUS RESULTED IN REFERRAL AT THIS TIME?
PA18	PLEASE FURNISH THE CLIENTS HEIGHT AND WEIGHT.
PA19	PLEASE SUBMIT CLINICAL INFORMATION SUFFICIENT TO VERIFY THE NEED FOR THE REQUESTED SERVICE(S).
PA20	PLEASE RESUBMIT WITH COMPLETE PERIODONTAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PA21	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL EDUCATIONAL PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA22	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL PROGRAM PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA23	REFER TO THE DURABLE MEDICAL EQUIPMENT INDEX FOR APPROPRIATE CODE AND DESCRIPTION. DO NOT USE AN "UNLISTED" CODE.

Denial Code	Long Description
PA24	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUALIZED FAMILY SERVICE PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA25	INFORMATION ON THE REQUEST FORM IS ILLEGIBLE, AND THE REQUEST CANNOT BE PROCESSED.
PA26	RE-EVALUATE YOUR GOALS. EMPHASIS SHOULD BE ON FUNCTIONAL SELF-CARE. GOALS MUST BE RELATED TO FUNCTIONAL OUTCOME.
PA27	PLEASE CLARIFY THE NUMBER OF HOURS PER WEEK REQUESTED.
PA28	PLEASE CLARIFY THE NUMBER OF HOURS PER DAY REQUESTED.
PA29	PLEASE CLARIFY THE NUMBER OF VISITS PER DAY REQUESTED.
PA30	ATTACH SUPPORTIVE DOCUMENTATION; HOME EXERCISE PROGRAM AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA31	THE DIAGNOSIS CODE INDICATED ON THE REQUEST DOES NOT CORRESPOND TO THE DIAGNOSIS CODE DESCRIPTION.
PA32	PLEASE SUBMIT ADDITIONAL INFORMATION SUFFICIENT TO VERIFY APPROPRIATENESS AND NEED FOR TRANSPLANT.
PA33	PLEASE SUBMIT THE INITIAL AND PROGRESSIVE OBJECTIVE FINDINGS.
PA34	ATTACH SUPPORTIVE DOCUMENTATION, FACILITY PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA35	PLEASE SUBMIT THE CLIENTS ORIGINAL COMPLAINTS AND EXAMINATION FINDINGS.
PA36	ATTACH SUPPORTIVE DOCUMENTATION, IN-HOME AUTISM PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA37	PLEASE SUBMIT YOUR TREATMENT PLAN FOR THIS CLIENT.
PA38	ATTACH SUPPORTIVE DOCUMENTATION AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA39	INITIAL EVALUATIONS MUST BE PERFORMED BY AN OCCUPATIONAL THERAPIST REGISTERED (OTR), PER AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA) STANDARDS.
PA41	IDENTIFY THE PLACE OF SERVICE AND ITS EFFECT ON SUPPORTING THE DESIRED TREATMENT OUTCOME.
PA42	PLEASE INDICATE THE HOURS OF USE OF OXYGEN PER 24-HOUR PERIOD.
PA43	PROVIDE BASELINE DOCUMENTATION FOR THIS CLIENTS LIMITATIONS USING UNITS OF MEASUREMENT THAT ARE APPLIED CONSISTENTLY WHEN REPORTING STATUS.
PA44	IDENTIFY FUNCTIONAL LIMITATIONS AS THEY ARE RELATED TO IDENTIFIED CONDITIONS.
PA46	CORRELATE PLAN OF CARE TO REQUESTED PROCEDURE CODES.
PA47	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE FREQUENCY/DURATION REQUESTED.
PA48	PLEASE PROVIDE THE NAME AND CREDENTIALS OF THE RENDERING PROVIDER.
PA50	COLORADO MEDICAID RECORDS INDICATE THE CLIENT OWNS A WHEELCHAIR. DOCUMENT THE REASON AND NEED FOR REPLACEMENT AND COST TO REPAIR CURRENT WHEELCHAIR.
PA51	PLEASE DISTINGUISH PRIMARY AND SUPPORTIVE MODALITIES.
PA52	PLEASE SUBMIT A PROGRESS REPORT.
PA53	MULTIPLE FAMILY CLIENTS TREATMENT BY THE SAME PROVIDER REQUIRES FURTHER INFORMATION DOCUMENTING COORDINATION OF TREATMENT PLAN.
PA54	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE MINUTES REQUESTED.
PA55	MEDICAL NECESSITY OF TREATMENT REQUIRES ADDITIONAL DOCUMENTATION.
PA56	GIVEN AGE, DIAGNOSES, CURRENT LEVEL OF FUNCTION, PAST RESPONSE TO TREATMENT, AND LIVING SITUATION, EXPAND ON POTENTIAL FOR SIGNIFICANT FUNCTIONAL PROGRESS WITHIN THE NEXT SIX MONTHS. EMPHASIZE WHY PROGRESS IS EXPECTED WITH SERVICES AT THIS TIME.
PA57	SUBMIT THE INITIAL FINDINGS. INCLUDE A COMPREHENSIVE EVALUATION.
PA58	SUBMIT PROGRESSIVE, OBJECTIVE FINDINGS. INCLUDE A PERTINENT RE-EVALUATION.
PA59	PLEASE SUPPLY INFORMATION REGARDING THE CLIENTS MEDICATION REQUIREMENTS, IF ANY.
PA60	PLEASE SPECIFY IF THE CLIENT IS IN AN EDUCATIONAL SETTING.
PA61	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA62	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.

Denial Code	Long Description
PA63	THE SKILLS OF A THERAPIST ARE PURPOSEFUL AND SKILLED INTERVENTIONS REQUIRED TO CONTINUALLY DESIGN, IMPLEMENT, REASSESS, MODIFY/GRADE, AND/OR DISCONTINUE A PLAN OF CARE IN A TIMELY MANNER, BASED ON THE COMPLEXITY OF THE CLIENTS MEDICAL CONDITION AND/OR CO
PA64	PLEASE SUBMIT A THERAPY PLAN OF CARE, INCLUDING A CURRENT, DATED EVALUATION.
PA65	A PLAN OF CARE SIGNED AND DATED BY THE PHYSICIAN IS REQUIRED.
PA66	THE SKILLS OF A THERAPIST ARE REQUIRED WHEN ONLY THE THERAPIST CAN SAFELY AND EFFECTIVELY DELIVER THE THERAPEUTIC PROCEDURES BECAUSE OF THEIR UNIQUE KNOWLEDGE, TRAINING, AND EXPERTISE. DESCRIBE THE REASON THAT SOMEONE OTHER THAN A THERAPIST CANNOT SAFELY
PA67	PLEASE SPECIFY IF THE CLIENTS WORK SITE DEMANDS GOOD BINAURAL HEARING.
PA68	DESCRIBE THE REASON, BASED ON THE CLIENTS COGNITIVE, PHYSICAL, COMMUNICATION, OR RESOURCE STATUS, THAT A HOME PROGRAM, EQUIPMENT, OR ENVIRONMENTAL ADAPTATIONS ALONE CANNOT MEET CLIENTS NEEDS.
PA69	PLEASE SPECIFY IF THE CLIENT HAS AN ACCOMPANYING DISABILITY THAT ADDS TO THE HEARING PROBLEM.
PA70	DISTINGUISH REQUESTED PROCEDURES AND GOALS FROM OTHER SERVICES THIS CLIENT RECEIVES. THEY MAY NOT BE DUPLICATIVE.
PA71	PLEASE INDICATE THE NUMBER OF DAYS REQUESTED.
PA73	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA74	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA75	PLEASE DOCUMENT CARRYOVER OF THE THERAPY PROGRAM TO NURSING.
PA76	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA79	PROVIDE EVIDENCE OF SIGNIFICANT FUNCTIONAL PROGRESS IN LAST SIX MONTHS.
PA84	THE GRANT DATE OF THIS REQUEST CANNOT BE PRIOR TO THE SIGNATURE DATE OF THE PRESCRIBING PHYSICIAN.
PA86	PROVIDE EVIDENCE OF SKILLS GAINED IN THERAPY CARRYING OVER TO OTHER SETTINGS WITHIN SIX MONTHS.
PA87	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE NUMBER OF SESSIONS REQUESTED.
PA88	THE REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL SCOPE OF PRACTICE.
PA89	PRIOR AUTHORIZATION IS NOT REQUIRED UNTIL LIMITATION OF SERVICE HAS BEEN REACHED.
PA91	PLEASE SUBMIT REQUIRED X-RAYS.
PA92	PLEASE PROVIDE AN EXPLANATION FOR THE MATERIAL SUBMITTED WITH THE REQUEST.
PA95	PLEASE DESCRIBE HOW THE PROVISION OF THIS SERVICE WOULD PREVENT INSTITUTIONALIZATION OF THE CLIENT.
PA96	COULD THE EXISTING DENTURE(S) BE RELINED OR REBASED? IF NOT, PLEASE EXPLAIN WHY NOT.
PA97	REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL STANDARDS OF PRACTICE.
PA98	PLEASE INDICATE IF THE CLIENT IS CURRENTLY BEING TUBE FED.
PB02	PLEASE PROVIDE THE REQUIRED DATED SIGNATURES ON THE ATTACHMENTS.
PB03	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING THE LOSS/DESTRUCTION/THEFT OF THE HEARING AID.
PB04	DESCRIBE THE CLIENTS ABILITY TO STAND OR AMBULATE SUFFICIENTLY TO ACCOMPLISH SELF-CARE ACTIVITIES.
PB07	PLEASE SUBMIT AN ORTHODONTIC STUDY MODEL OR DIAGNOSTIC CASTS.
PB09	PLEASE PROVIDE A PHOTOGRAPH OF THE INVOLVED AREA(S).
PB10	PLEASE PROVIDE AN ESTIMATION (IN GRAMS) OF THE TOTAL AMOUNT OF TISSUE TO BE RESECTED.
PB11	PLEASE SUBMIT THE PLAN OF CARE FOR CO-TREATMENT.
PB12	FURNISH A DETAILED DESCRIPTION FOR THE PROCEDURE CODE REQUESTED.
PB13	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB15	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB18	PLEASE COMPLETE THE ATTACHED OUT-OF-STATE PROVIDER DATA SHEET, F-11001, AND RESUBMIT.

Denial Code	Long Description
PB20	A SIGNED AND DATED PRESCRIPTION IS REQUIRED WITHIN THREE MONTHS OF RECEIPT BY COLORADO MEDICAID FOR INITIAL REQUESTS AND WITHIN 12 MONTHS OF RECEIPT BY COLORADO MEDICAID FOR SUBSEQUENT REQUESTS.
PB21	PLEASE COMPLETE THE APPROPRIATE PRIOR AUTHORIZATION ATTACHMENT. CONTACT PROVIDER SERVICES OR THE PRIOR AUTHORIZATION UNIT FOR ASSISTANCE.
PB23	PHYSICAL THERAPY ASSISTANT NOTES AND ALL FORMS SUBMITTED MUST BE COSIGNED BY A REGISTERED PHYSICAL THERAPIST.
PB31	ARE YOU REQUESTING A COMPLETE APPLIANCE, OR REPLACEMENT PARTS?
PB32	THE PROCEDURE CODE INDICATED ON THE REQUEST DOES NOT MATCH THE DESCRIPTION OF SERVICE; PLEASE CORRECT AND RESUBMIT.
PB35	THE SERVICE REQUESTED DOES NOT REQUIRE PRIOR AUTHORIZATION.
PB41	PLEASE FURNISH A CURRENT MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT, F-11090 (DATED WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID).
PB45	THE CERTIFICATION PERIOD ON THE PLAN OF CARE (POC) DOES NOT COVER THE REQUESTED GRANT/START DATE. PLEASE RESUBMIT YOUR REQUEST WITH A NEW POC.
PB49	A CERTIFIED OCCUPATIONAL THERAPY ASSISTANTS NOTES MUST BE COSIGNED BY AN OCCUPATIONAL THERAPIST REGISTERED.
PB51	ADDITIONAL INFORMATION IS REQUIRED ON PRIOR AUTHORIZATION TO ENABLE PRICING.
PB54	REQUESTED SERVICES DO NOT MATCH SERVICES ON THE PHYSICIANS ORDERS.
PB59	PLEASE PROVIDE AN INDIVIDUAL EDUCATIONAL PLAN (IEP), WHICH HAS BEEN SIGNED BY THE PROVIDER NO EARLIER THAN NINE MONTHS PRIOR TO RECEIPT AT COLORADO MEDICAID; OTHERWISE, DOCUMENT WHY NO IEP EXISTS.
PB65	PLEASE FURNISH THE ANTICIPATED TOTAL CHARGES FOR THIS REQUEST.
PB66	A PHOTOCOPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED; THE DATE MUST BE WITHIN SIX MONTHS OF RECEIPT BY COLORADO MEDICAID.
PB67	THE PRESCRIPTION DATE MUST INCLUDE MONTH, DAY, AND YEAR.
PB68	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID.
PB73	THE SERVICES IDENTIFIED ON THE PLAN OF CARE DO NOT APPEAR APPROPRIATE FOR THE PROCEDURE CODE(S) REQUESTED ON THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018.
PB74	THE CLIENT/PROVIDER DOES NOT HAVE RETROACTIVE ENROLLMENT.
PB75	THE REQUESTED START DATE IS MORE THAN 14 DAYS BEFORE OR 62 DAYS AFTER RECEIPT.
PB82	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
PB83	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A HOME HEALTH AIDE. PLEASE RESUBMIT AS A PERSONAL CARE WORKER OR PROVIDE ADDITIONAL DOCUMENTATION.
PB86	THE SERVICES REQUESTED ARE NOT BEING PROVIDED IN THE CLIENTS RESIDENCE. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL.
PB87	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A NURSE. PLEASE RESUBMIT AS A HOME HEALTH AIDE OR PROVIDE ADDITIONAL DOCUMENTATION.
PB92	PLEASE FURNISH THE CLIENTS COMPLETE ADDRESS.
PB94	IF THE CLIENT IS A RESIDENT OF A NURSING HOME, SUPPLY THE COMPLETE NAME AND ADDRESS OF THE NURSING HOME.
PB99	THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018, MUST BE SIGNED AND DATED.
PC01	PLEASE SUPPLY THE RENDERING PROVIDERS PROVIDER NUMBER.
PC03	THE DRUG ENFORCEMENT ADMINISTRATION NUMBER IS MISSING OR INVALID.
PC06	PLEASE DESCRIBE YOUR PROGRAM; INCLUDE ENTRY DATE, TERMINATION DATE, HOURS PER WEEK, AND NUMBER OF WEEKS OF PRIMARY INTENSIVE SERVICE REQUESTED.
PC07	PLEASE DESCRIBE YOUR "AFTERCARE/FOLLOW-UP" PLANS FOR THIS CLIENT.
PC08	PLEASE SUPPLY DOCUMENTATION OF PREVIOUS SUBSTANCE ABUSE SERVICES WITH DATE(S) AND OUTCOME.
PC09	PLEASE DESCRIBE IN DETAIL THE TREATMENT OBJECTIVES/GOALS FOR THIS CLIENT.
PC10	PLEASE DESCRIBE THE FAMILY SITUATION/DYNAMICS. EXPLAIN HOW THE FAMILY WILL BE INCORPORATED INTO THE CLIENTS PLAN OF CARE.
PC12	PLEASE EXPLAIN IF YOUR SERVICE ENCOURAGES THE CLIENT TO ATTEND SELF-HELP GROUPS.

Denial Code	Long Description
PC13	PLEASE SUPPLY A SPECIFIC SCHEDULE OF ACTIVITIES, INCLUDING DAY, TIME OF DAY, LENGTH OF SESSION, AND SERVICE TO BE RENDERED DURING THAT TIME.
PC15	PLEASE FURNISH DIAGNOSTIC RATIONALE.
PC17	PLEASE DOCUMENT IF THE CLIENT EVER RECEIVED SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT.
PC19	PLEASE FURNISH MORE EXTENSIVE AND IN-DEPTH HISTORICAL AND PSYCHOSOCIAL DATA.
PC20	PLEASE SUPPLY THE DATE THE CLIENT BECAME TOTALLY ENDENTULOUS.
PC23	PLEASE SUBMIT A PHYSICIANS STATEMENT REGARDING THE MEDICAL NECESSITY OF DENTURES FOR THIS CLIENT. THE PHYSICIANS STATEMENT MUST DOCUMENT THE MEDICAL NEED FOR DENTURES.
PC24	THE SERVICE REQUESTED WAS PREVIOUSLY AUTHORIZED. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT INDICATING THIS FACT IS REQUIRED.
PC25	PLEASE SUPPLY SUFFICIENT MITIGATING CIRCUMSTANCES TO WARRANT THE CONSTRUCTION OF NEW DENTURES(S).
PC26	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
PC28	PLEASE SUBMIT A PHYSICIANS STATEMENT INDICATING DENTURES ARE NECESSARY FOR THIS NURSING HOME CLIENT.
PC29	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING LOSS OR DESTRUCTION OF DENTURE(S). INCLUDE SIGNED STATEMENT FROM CLIENT OR FACILITY DIRECTOR REGARDING HOW, WHEN AND WHERE LOST.
PC30	PLEASE PROVIDE COMPLETE INTRAORAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PC31	PLEASE DESCRIBE ANY RELATED DEFORMITIES OF THE FEET.
PC34	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD WITH REQUESTED DME ITEM(S) AND DOCUMENT IF THE CLIENT CAN USE SAFELY AND INDEPENDENTLY.
PC35	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD AND DESCRIBE THE RESULTS AND EFFECTIVENESS OF THE SERVICE REQUESTED.
PC39	PLEASE INDICATE LITER FLOW PER MINUTE, HOURS OF USE PER 24 HOUR PERIOD, AND THE EXPECTED DURATION OF NEED.
PC40	THE ITEM DOES NOT REQUIRE PRIOR AUTHORIZATION UNTIL THE LIFE EXPECTANCY HAS BEEN REACHED.
PC41	PLEASE SUPPLY INFORMATION INDICATING THE NECESSITY OF POSITIONING THE CLIENT'S BODY IN MULTIPLE POSITIONS.
PC42	PLEASE INDICATE IF THE BED HEIGHT MUST BE CHANGED TO ALLOW FOR SAFE TRANSFER OR ADEQUATE BED CARE.
PC43	SUPPLY A PHYSICIANS STATEMENT INDICATING TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR UNIT HAS REDUCED PAIN, IMPROVED/INCREASED THE CLIENTS ACTIVITY LEVEL, AND/OR REDUCED CLIENTS USE OF PAIN MEDICATION.
PC44	A CURRENT AUTHORIZATION FOR THIS SERVICE IS ON FILE FOR ANOTHER PROVIDER. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT OF THAT FACT IS REQUIRED BY THE CLIENT OF FIRST PROVIDER.
PC59	DOCUMENT DECLINE OR PROGRESS IN SPECIFIC, MEASURABLE, OBJECTIVE TERMS.
PC60	DOCUMENT IF CLIENT HAS DEMONSTRATED A GOOD APPOINTMENT COMPLIANCE RECORD.
PC61	THE PHYSICIANS SIGNATURE DATE MUST NOT EXCEED 90 DAYS FROM THE DATE OF RECEIPT BY COLORADO MEDICAID.
PC62	REQUESTS FOR A CONTINUATION OF THERAPY SHOULD NOT BE SUBMITTED MORE THAN FOUR WEEKS PRIOR TO THE EXPIRATION DATE OF THE CURRENT AUTHORIZATION.
PC63	PLEASE FURNISH THE STYLE AND MANUFACTURER OF THE FRAME.
PC64	PLEASE FURNISH THE CLIENTS LENS FORMULA.
PC66	ALL REQUESTS FOR TINTS REQUIRE DOCUMENTATION OF THE VISUAL OR MEDICAL CONDITION RELATED TO PHOTOPHOBIA.
PC67	PLEASE DOCUMENT THE REASON AND JUSTIFICATION FOR REPLACEMENT BEYOND THE FIRST LENS/FRAME.
PC68	DOCUMENT IF ALL REMAINING MAXILLARY AND/OR MANDIBULAR TEETH ARE DECAY-FREE, PROPERLY RESTORED, AND PERIODONTICALLY SOUND.
PC72	SUPPLY MORE DETAIL REGARDING PROGRESS (ATTACHMENT OF GOALS, ETC.). CORRELATE PROGRESS TO PREVIOUS GOALS AND IDENTIFIED LIMITATIONS.
PC77	PLEASE SUBMIT A PLAN OF CARE DESCRIBING THE SERVICES THAT WOULD BE PROVIDED.

Denial Code	Long Description
PC78	PLEASE DOCUMENT SPECIFIC, MEASURABLE GOALS.
PC82	THE PRIOR AUTHORIZATION (PA) SYSTEM CAN PROCESS ONLY 26 DETAILS PER PA REQUEST. PLEASE RESUBMIT YOUR REQUEST WITH NO MORE THAN 26 DETAILS.
PC83	PLEASE SUPPLY A PHYSICIANS PRESCRIPTION DATED WITHIN ONE MONTH OF REQUESTED SUBSTANCE ABUSE DAY TREATMENT.
PC84	PLEASE PROVIDE INFORMATION INDICATING THIS CLIENT IS APPROPRIATELY DETOXIFIED FROM ALCOHOL AND/OR OTHER DRUGS.
PC85	PLEASE PROVIDE INFORMATION TO INDICATE THE CLIENTS ABILITY TO ABSTAIN FROM ALCOHOL OR DRUGS WHILE IN THE SUBSTANCE ABUSE DAY TREATMENT PROGRAM.
PC86	PLEASE INDICATE IF THIS CLIENT IS WILLING TO PARTICIPATE IN AFTERCARE OR CONTINUING CARE SERVICES.
PC87	PROVIDE MORE INFORMATION ON TREATMENT HISTORY; INCLUDE SERVICE PROVIDED, DATES, AND OUTCOME. PROVIDE DETAIL OF PREVIOUS TREATMENT.
PC88	PLEASE PROVIDE MORE RATIONALE FOR THE APPROPRIATENESS AND MEDICAL NECESSITY OF SUBSTANCE ABUSE DAY TREATMENT.
PC89	PROVIDE A TREATMENT PLAN THAT CONTAINS MEASURABLE GOALS AND OBJECTIVES CORRESPONDING TO THE IDENTIFIED DEFICIT.
PC91	PLEASE PROVIDE MORE INFORMATION ON FAMILY INVOLVEMENT TREATMENT.
PC92	PLEASE PROVIDE MORE HISTORY AND EXPLANATION ABOUT THE ISSUE OF ABSTINENCE FOR THIS CLIENT.
PC94	PLEASE PROVIDE THE ANTICIPATED BEGINNING DATE AND/OR THE ESTIMATED SUBSTANCE ABUSE DAY TREATMENT DISCHARGE DATE.
PC95	PLEASE SUPPLY JUSTIFICATION FOR BEGINNING CLIENT IN SERVICE PRIOR TO AUTHORIZATION BEING OBTAINED.
PC96	THE INITIAL THREE HOURS OF SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IN A CALENDAR YEAR DO NOT REQUIRE PRIOR AUTHORIZATION.
PC97	REIMBURSEMENT FOR INITIAL SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IS LIMITED TO THREE HOURS IN A CALENDAR YEAR AND DOES NOT REQUIRE PRIOR AUTHORIZATION.
PC98	THIS DRUG IS CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE BILL USING THE APPROPRIATE NATIONAL DRUG CODE (NDC) OR SUBMIT A COMPLETED DRUG ADDITION REQUEST FORM IF THE NDC IS NOT LISTED IN THE DRUG INDEX.
PC99	THIS DRUG IS NOT CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL, CURRENT ADMINISTRATIVE RULE, OR COLORADO DRUG INDEX FOR COVERAGE LIMITATIONS.
PD01	DOCUMENT THAT CLIENT HAS ACHIEVED GOOD ORAL HYGIENE, PERIODONTAL CASE TYPE 1 OR 2, AND IS MOTIVATED TO MAINTAIN SAME.
PD03	PLEASE PROVIDE AN ARTERIAL BLOOD GAS READING OR PULSE OXIMETRY RESULTS DONE ON ROOM AIR SIGNED AND DATED BY A MEDICAL DOCTOR. THIS SHOULD BE DONE WITHIN 60 DAYS OF REQUESTED SERVICE.
PD04	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 30 DAYS OF RECEIPT BY COLORADO MEDICAID.
PD07	SUBMIT A PHOTOCOPY OF A VALID PRESCRIPTION, ISSUED WITHIN THE PAST YEAR, OR COMPLETE SECTION B OF THE PRIOR AUTHORIZATION/DRUG ATTACHMENT (PA/DGA), F-11049.
PD10	BRAND MEDICALLY NECESSARY MUST BE IN THE PRESCRIBERS OWN HANDWRITING AND WRITTEN DIRECTLY ON THE PRESCRIPTION OR A SEPARATE ORDER ATTACHED TO THE ORIGINAL PRESCRIPTION.
PD12	COMPLETE DENTURES, PARTIAL DENTURES, DENTURE RELINES, AND FIXED PROSTHODONTIC SERVICES ARE NOT COVERED SERVICES FOR ADULTS FOR DATES OF SERVICE ON AND AFTER OCTOBER 1, 1995.
PD22	PLEASE COMPLETE ALL REQUIRED ELEMENTS ON THE PERSONAL CARE SCREENING TOOL (PCST), F-11133.
PD24	THIS PRIOR AUTHORIZATION REQUEST IS UNABLE TO BE PROCESSED. PLEASE RESUBMIT WITH ADDITIONAL REQUIRED FORMS, INCLUDING THE ENTIRE PERSONAL CARE SCREENING TOOL (PCST), F-11133; PERSONAL CARE ADDENDUM, F-11136; AND SUPPORTING DOCUMENTATION, AS DIRECTED.
PD25	THERE IS A PERSONAL CARE SCREENING TOOL (PCST), F-11133, COMPLETED BY ANOTHER AGENCY. CONTACT THE AGENCY TO TRANSFER SCREEN.

Denial Code	Long Description
PD26	THERE IS A LIMITED TERM CARE FUNCTIONAL SCREEN (LTC-FS) COMPLETED BY ANOTHER AGENCY. THE PERSONAL CARE SCREENING TOOL (PCST), F-11133, INFORMATION IS IN CONFLICT WITH LTC-FS.
PD27	ONLY ONE LEVEL OF FUNCTION MAY BE SELECTED FOR ALL ELEMENTS EXCEPT TOILETING. COLORADO MEDICAID IS UNABLE TO PROCESS THE PRIOR AUTHORIZATION REQUEST.
PD28	NO UNITS MAY BE REQUESTED USING THIS PRIOR AUTHORIZATION PROCESS. PLEASE SUBMIT WITH THE APPROPRIATE ATTACHMENTS FOR REQUESTING SPECIFIC PERSONAL CARE WORKER UNITS.
PD29	CLIENT IS NOT ELIGIBLE FOR THE REQUESTED SERVICE(S) AS OF THE REQUESTED START DATE.
PD30	NO TRAVEL TIME MAY BE AUTHORIZED WHEN NO PERSONAL CARE WORKER SERVICE IS AUTHORIZED.
PD32	PROVIDER NOT CERTIFIED TO RENDER THE SERVICE(S) REQUESTED.
PD34	BASED ON THE DOCUMENTATION SUBMITTED, THIS REQUEST CAN NOT BE PRIOR AUTHORIZED. REFER TO THE PA MESSAGES FROM THE CONSULTANT FOR COMPLETE EXPLANATION.
PD98	PLEASE DOCUMENT HOW AND WHEN EACH PREVIOUSLY AUTHORIZED PRO RE NATA VISIT WAS USED.

Physical Therapy

Denial Code	Long Description
0201	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
0233	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0235	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0237	CLIENT IDENTIFICATION NUMBER DOES NOT MATCH CLIENTS FIRST NAME.
0238	THE CLIENT IDENTIFICATION NUMBER DOES NOT MATCH THE CLIENTS LAST NAME.
0242	SECONDARY DIAGNOSIS CODE IS INVALID.
0248	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0249	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0251	PROCEDURE CODE MODIFIER IN FIRST POSITION IS INVALID.
0252	THE PROCEDURE CODE MODIFIER IN SECOND POSITION IS INVALID FOR REQUESTED START DATE OR DATE OF RECEIPT.
0253	THE PROCEDURE CODE MODIFIER IN THIRD POSITION IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
0258	THE PRIMARY DIAGNOSIS CODE IS REQUIRED.
0272	THE PRIMARY DIAGNSOSIS CODE IS INVALID.
0400	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0853	HCPCS - ANNUAL UPDATE
0885	NEVER EVENTS MODIFIERS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
0886	NEVER EVENTS DIAGNOSIS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
1000	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
1002	RENDERING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1003	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1007	RENDERING PROVIDER ID IS NOT ON FILE.
1047	THE RENDERING PROVIDERS CERTIFICATION HAS BEEN CANCELLED.
1048	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1801	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
1804	A CERTIFIED SUBSTANCE ABUSE DAY TREATMENT PROVIDER MUST SUBMIT A SUBSTANCE ABUSE DAY TREATMENT PROCEDURE CODE.
1806	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
1808	THE BILLING PROVIDER DOES NOT HAVE THE REQUIRED CERTIFICATION ADDENDUM ON FILE.
1900	THE BILLING PROVIDERS TAXONOMY CODE IS INVALID.

Denial Code	Long Description
1901	THE RENDERING PROVIDERS TAXONOMY CODE IS INVALID.
1927	A NATIONAL PROVIDER IDENTIFIER IS REQUIRED FOR THE BILLING PROVIDER.
1934	A NATIONAL PROVIDER INDENTIFIER IS REQUIRED FOR THE RENDERING PROVIDER.
1936	THE BILLING PROVIDER NUMBER IS INVALID.
1937	THE RENDERING PROVIDER NUMBER IS INVALID.
1960	INTERNAL PROCESSING IS REQUIRED.
1963	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.
1964	THE BILLING PROVIDER INDICATED IS NOT ALLOWABLE AS A BILLING PROVIDER.
1965	RENDERING PROVIDER NUMBER IS MISSING/INVALID FOR THIS PROCEDURE PROVIDER.
1974	PRESCRIBING/REFERRING/ORDERING PROVIDER INDICATED IS NOT CERTIFIED AS A PRESCRIBING/REFERRING/ORDERING PROVIDER.
1975	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
1976	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
2001	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2003	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2017	THE CLIENT IS ENROLLED IN A MEDICAID OR OTHER MANAGED CARE PROGRAM.
2037	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2603	CLIENT LOCKED-IN TO A PROVIDER OR ENROLLED IN A HOSPICE. CONTACT CLIENTS HOSPICE FOR PAYMENT OF SERVICES OR RESUBMIT WITH DOCUMENTATION OF UNRELATED NATURE OF CARE.
3324	THE MODIFIER HAS BEEN DISCONTINUED BY THE CENTERS OF MEDICARE AND MEDICAID SERVICES OR THE AMERICAN MEDICAL ASSOCIATION FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
3337	THE PROCEDURE CODE HAS BEEN TERMINATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AMERICAN MEDICAL ASSOCIATION, OR AMERICAN DENTAL ASSOCIATION FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT. RESUBMIT WITH VALID A PROCEDURE CODE.
3339	THE PROCEDURE BILLED IS NOT PAYABLE ACCORDING TO DEFICIT REDUCTION ACT (DEFRA) GUIDELINES.
3351	THE PROCEDURE IS NOT COVERED FOR CLIENTS WITH A NURSING HOME AUTHORIZATION ON THE REQUESTED START DATE OR DATE OF RECEIPT.
3353	THE PROCEDURE IS NOT A COVERED SERVICE FOR HOME AND COMMUNITY-BASED WAIVER CLIENTS.
4021	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4027	THE DIAGNOSIS CODE IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
4031	THE PROCEDURE SUBMITTED IS NOT APPROPRIATE FOR CLIENTS GENDER.
4032	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4034	THE PROCEDURE CODE HAS AN AGE RESTRICTION.
4036	THE PLACE OF SERVICE CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4040	THE PRIMARY DIAGNOSIS CODE IS NOT ON FILE.
4041	THE SECONDARY DIAGNOSIS IS NOT ON FILE.
4046	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4127	INTERNAL PROCESSING IS REQUIRED.
4131	INTERNAL PROCESSING IS REQUIRED.
4141	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4149	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4150	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4236	ETIOLOGY DIAGNOSIS CODE(S) (E-CODES) ARE INVALID AS THE PRIMARY DIAGNOSIS.
4244	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4245	THE FOURTH POSITION MODIFIER IS INVALID FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT.
4256	THE PROCEDURE CODE AND MODIFIER COMBINATION IS NOT PAYABLE FOR THE CLIENTS BENEFIT PLAN.
4257	THE MODIFIERS SUBMITTED ARE EITHER INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT OR THE MODIFIERS ARE MISSING.
4311	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4315	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4316	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4371	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.

Denial Code	Long Description
4372	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4711	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR CLIENTS AGE.
4714	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS AGE.
4731	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS DIAGNOSIS.
4742	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4743	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4744	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4745	DIAGNOSIS AND/OR PROCEDURE AND/OR PLACE OF SERVICE (POS) CODE IS NOT COVERED FOR EXPRESS ENROLLMENT CLIENTS.
4746	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4801	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4802	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
4821	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
4871	PLEASE REFER TO PA MESSAGES FOR RETURN INFORMATION.
4963	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS GENDER.
4990	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
7500	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
7509	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
C001	This prior authorization was denied because the prior authorization form was not completed or the necessary attachment was not included.
C002	This prior authorization was denied because the client does not meet the criteria to receive a non-preferred product on the Colorado Medicaid Preferred Drug List.
C003	This prior authorization was denied because of a non-approved diagnosis. See Prior Authorization criteria (APPENDIX P) for approved diagnoses for this drug at http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1201542571132.
C004	This prior authorization was denied because the quantity limits have been exceeded. See Drug Limits for the allowable quantities for this medication at http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1201542571132.
C005	This prior authorization was denied because of the dosing schedule. See Prior Authorization criteria (APPENDIX P) for the approved dosing schedule for this drug at http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1201542571132.
C006	This prior authorization was denied because medications administered in a hospital, physician office or dialysis unit should be billed directly by those facilities as a medical item. These medications are not a pharmacy benefit under Colorado Medicaid.
C007	This prior authorization was denied because DESI drugs (medications determined not to be safe and effective by the FDA) and non-rebate able drugs (medications that have not signed a rebate agreement with the Centers for Medicare and Medicaid Services) are not a benefit of Colorado Medicaid.
C008	This prior authorization (PA) was denied because a pain evaluation was not submitted to the Prior Authorization Helpdesk with the PA form. Please fax a pain evaluation to the PA Helpdesk for reconsideration.
C009	This prior authorization was denied because the client has exceeded the 90 day lifetime benefit for smoking cessation products
C010	This prior authorization was denied because durable medical equipment (DME) and supplies are a medical benefit of Colorado Medicaid and need to be billed as a medical cl DME are not a pharmacy benefit.
C011	This prior authorization was denied because the client does not meet the criteria for approval. See Prior Authorization criteria (APPENDIX P) at http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1201542571132.
C01Z	This is not a final denial. Please do not submit an appeal request. The required Client State Id number is missing or invalid. Please resubmit PAR request with the corrected information to CFMC via FAX at: 303-790-4643.
C02Z	*INACTIVE* This is not a final denial. Please do not submit an appeal request. The required Client State Id number does not match the Client Name. Please resubmit PAR request with the corrected information to CFMC via FAX at: 303-790-4643.

Denial Code	Long Description
C03Z	*INACTIVE* This is not a final denial. Please do not submit an appeal request. The required Client date of birth is missing or invalid. Please resubmit PAR request with the corrected information to CFMC via FAX at: 303-790-4643.
C04Z	*INACTIVE* This is not a final denial. Please do not submit an appeal request. The required Requesting Provider Number is missing or invalid. Please resubmit PAR request with the corrected information to CFMC via FAX at: 303-790-4643.
C05Z	*INACTIVE* This is not a final denial. Please do not submit an appeal request. The required Billing Provider Number is missing or invalid. Please resubmit PAR request with the corrected information to CFMC via FAX at: 303-790-4643.
C100	The item or service requested is not a Medicaid benefit.
C101	*INACTIVE* DENIAL 1 The procedure is not a benefit of the Colorado Medicaid program.
C102	*INACTIVE* Denial 2 The procedure is not a benefit for children, recipients age birth through age 20.
C103	*INACTIVE* Denial 3 The procedure is not a benefit for adults, recipients age 21 and older.
C104	*INACTIVE* Denial 4 A report of the dental condition which supports the need for service was not submitted. ELECTRONIC PAR: 1. You can re-submit this PAR. 2. Click on the PROVIDER TAB during electronic dental prior authorization. 3. Describe the DENTAL CONDITION that supports the need for service. PAPER PAR: 1. You can re-submit this PAR. 2. On the ADA claim in area 32 "remarks for unusual services" 3. Describe the DENTAL CONDITION that supports the need for service.
C105	*INACTIVE* Denial 5 Report of dental condition/concurrent med condition which supports need not submitted. ELECTRONIC PAR 1. Re-submit PAR. 2. Click PROVIDER TAB during electronic dental PAR, 3. Describe DENTAL CONDITION supporting need for service. 4. Describe CONCURRENT MEDICAL CONDITION supporting need for service. PAPER PAR 1. You can re-submit this PAR. 2. On the ADA claim in area 32 "remarks for unusual services" 3. Describe DENTAL CONDITION supporting need for service. 4. Describe CONCURRENT MEDICAL CONDITION supporting need for service.
C106	*INACTIVE* Denial 6 The procedure code is not valid for the described procedure. ELECTRONIC AND PAPER PAR 1. You can re-submit this PAR. 2. Please refer to the DECEMBER 1998 Medicaid bulletin 3. See current codes and their descriptions. 4. You may submit ADA or Medicaid codes.
C107	*INACTIVE* Denial 07 The procedure code is not a benefit for this tooth number. ELECTRONIC AND PAPER 1. You can re-submit this PAR. 2. Please refer to the DECEMBER 1998 Medicaid bulletin 3. See procedure code tooth number limitations.
C108	*INACTIVE* Denial 8 The tooth surface designation submitted is not valid for this tooth number.
C109	*INACTIVE* Denial 9 The procedure is a duplicate service.
C110	*INACTIVE* Denial 10 Info required for PAR review not submitted. ELECTRONIC PAR 1. Re-submit this PAR. 2. Click on PROVIDER TAB during electronic dental PAR, 3. See the December 1998 Medicaid bulletin for this procedure code. 4. Briefly describe the information required as listed in the last column. PAPER PAR 1. You can resubmit this PAR. 2. On the ADA claim in area 32 " remarks for unusual services" 3. See the December 1998 Medicaid bulletin for the procedure code. 4. Briefly describe the information required as listed in the last column.
C111	*INACTIVE* Denial 11 Periodontal diag and class not submitted. ELECTRONIC PAR 1. Re-submit this PAR. 2. Click on PROVIDER TAB during electronic dental PAR, 3. Briefly describe PERIODONTAL DIAGNOSIS supporting need for service. 4. Write the PERIODONTAL CLASSIFICATION supporting need for service. PAPER PAR 1. Re-submit this PAR. 2. On the ADA claim in are 32 "remarks for unusual services" 3. Briefly describe PERIODONTAL DIAGNOSIS supporting need for service. 4. Write the PERIODONTAL CLASSIFICATION supporting need for service.
C112	*INACTIVE* Denial 12 The orthodontic diagnosis which supports the need for the procedure was not submitted. ELECTRONIC PAR 1. You can re-submit this PAR. 2. Click on the PROVIDER TAB during electronic dental prior authorization. 3. Describe the ORTHODONTIC DIAGNOSIS supporting need for service. PAPER PAR 1. You can re-submit this PAR. 2. On the ADA claim in area 32 "remarks for unusual services" 3. Describe the ORTHODONTIC DIAGNOSIS supporting need for service.
C113	*INACTIVE* Denial 13 The info submitted does not support need for procedure. ELECTRONIC PAR 1. Re-submit this PAR. 2. Click on PROVIDER TAB during electronic dental PAR. 3. Describe in more detail DENTAL CONDITION supporting need for service. 4. Describe in more detail CONCURRENT MEDICAL CONDITION supporting need for service. PAPER PAR 1. Re-submit PAR. 2. On ADA claim in 32 "remarks for unusual services" 3. Describe in more detail DENTAL CONDITION need for service. 4. Describe in more detail CONCURRENT MEDICAL CONDITION need for service.

Denial Code	Long Description
C114	*INACTIVE* Denial 14 Submitted information does not support a favorable prognosis.
C115	*INACTIVE* Denial 15 The "TMJ Pre-surgical evaluation form" for primary surgeon was not submitted. PAPER PAR 1. You can re-submit this PAR. 2. This prior authorization must be submitted on paper. 3. We need the ADA claim form and TMJ Pre-surgical evaluation form. 4. Contact ACS at 534-0109, ext 724 request a copy of the TMJ Pre-surgical evaluation form. 5. This is the only attachment in addition to the ADA claim form which is required for review.
C116	*INACTIVE* 16 PAR cannot be approved after the service has been started.
C117	Client ID is missing or invalid. Please resubmit with a correct client ID.
C120	*INACTIVE* The PAR that you sent directly to ACS is being denied. Please send this PAR to the authorizing agent: CFMC, P.O. Box 17300, Denver, CO 80217. Upon approval, CFMC will forward the PAR to ACS for PAR entry.
C121	*INACTIVE* The item or service requested is not a Medicaid Home Health benefit.
C122	*INACTIVE* The item or service requested is available under other Colorado Medicaid benefits for which the client is eligible. (eg. Private Duty Nursing, HCBS Personal Care, School Health and Related Services, outpatient therapy)
C123	*INACTIVE* The information submitted does not support the need for the services requested, you may re-submit the PAR describing in more detail current medical conditions supporting the need for services.
C124	*INACTIVE* The requested information has not been submitted. You may submit a new PAR with the requested information-Home Health plan of care and/or therapy assessments, current clinical summary.
C125	*INACTIVE* The requested information has not been submitted. You may submit a new PAR with the requested information-Written documentation of the results of the EPSDT medical screening, or other equivalent examination results provided by the client's third-party insurance.
C126	*INACTIVE* This service does not require prior authorization. Submit charges on the appropriate claim form.
C127	*INACTIVE* The revenue code is already authorized for this client, this provider, this date span. Please bill using the information on the original PAR, or submit a new PAR for revision to increase services.
C128	*INACTIVE* The clinical information does not substantiate medical necessity.
C129	*INACTIVE* The information submitted is insufficient. Completion of the prior authorization request information is required to review this Prior Authorization.
C130	*INACTIVE* The agency is not a Medicaid Provider.
C131	*INACTIVE* No services shall be approved for dates of service prior to the date of receipt of the complete prior authorization request by the State or its agent.
C132	*INACTIVE* Extended Home Health Aide visits requested without submitting sufficient information about services on each visit.
C133	*INACTIVE* Therapy services requested are not included in the plan of care, which does not list the specific procedures and modalities to be used nor the amount, duration, and frequency.
C134	*INACTIVE* Detailed information on each planned Home Health visit, including the times in and out, all tasks to be performed on each visit, and the place of service for each service is not included on the prior authorization request.
C135	Nursing visits solely for psychiatric counseling are not reimbursable.
C136	*INACTIVE* Any visit made solely for supervision of the Home Health Aide shall not be reimbursed.
C151	*INACTIVE* This item or service requested is not a Home and Community Based Services-Brain Injury program/ Medicaid benefit.
C152	*INACTIVE* The requested clinical information does not substantiate how the device or service will result in enhancement of the clients ability to perform activities of daily living, or to perceive, control or communicate with the environment in which they live.
C153	Item is not of direct medical or remedial benefit to the client.
C154	This item is primarily for a vocational or education application. Funding must first be pursued through the Division of Vocational Rehabilitation/Dept. of Education.
C155	Home modification request/environmental modification does not contain supporting documentation, which substantiates the necessity of the modification.
C156	*INACTIVE* The requested modification is not a direct medical or remedial benefit to the client.
C157	*INACTIVE* The Prior Authorization Request does not contain the required documentation of an Occupational Therapist or Physical Therapist in home assessment.

Denial Code	Long Description
C158	Home modification request is not reasonable in cost when compared to usual and customary charges.
C159	*INACTIVE* Non-medical transportation request does not provide transportation for services, which prevent institutionalization.
C160	Transitional living prior authorization was requested for a client who does not meet the definition of "in need" according to 10 C.C.R. 2505-10, Sec. 8.516.30.B.2-3.
C161	Prior authorization period exceeds benefit defined in 10 C.C.R. 2505-10, sec.8.516.30.C.5.
C162	Prior authorization period exceeds benefit defined in 10 C.C.R. 2505-10, sec.8.516.30.C.5.
C163	The prior authorization request must include: a medical prescription, the name and Medicaid identification number of the client, the clinic name, business address, phone number, and Medicaid provider number, the referring physician name, business address, phone number, the rendering therapist name, provider number, business address, and phone number, Billing Provider information, a service plan for the client, Physical therapy history (including home health program involvement). Medicaid Bulletin B0200140.
C164	The prior authorization request is not needed. The original prior authorization is still in effect. Medicaid Bulletin B0200139.
C165	The service requested for this client is covered under another program (i.e., Home Health or Hospital Services, DME, etc.).
C166	Therapy services for this client have been authorized to a different provider. Medicaid Bulletin B0200139.
C167	*INACTIVE* Category of Handicapping Malocclusion not checked.
C168	Procedure does not require Prior Authorization approval for this client.
C169	Outpatient individual and individual brief counseling visits are limited to 35 visits per state fiscal year.
C170	Documentation supporting medical necessity is not sufficient.
C171	The Prior authorization request shall include: * a medical prescription, * client name and Medicaid identification * clinic name, business address, phone number and Medicaid provider number, * the rendering therapist name, provider number, business address and phone number, * billing provider information, * a service plan for the client, * mental health history (including the Mental Health Capitation Program (MHASA) or Home Health Program Involvement).
C172	Service requested for this client is covered under another program (i.e. 10 C.C.R. 2505-10, section 8.212 Mental Health Capitation Program).
C173	Mental Health visits for this client have been authorized to a different provider.
C174	This client is exempted from prefabricated crown services if the client was scheduled for hospitalization for dental services before May 13, 2004.
C175	Procedure does not require a prior authorization.
C176	*INACTIVE* The PAR that you sent directly to ACS is being denied. Please send this PAR to the authorizing agent: CFMC, Attention Medicaid/DME PARS, 23 Inverness Way East, Suite 100, Englewood, CO 80112-5708.
C177	*INACTIVE* The PAR that you sent directly to ACS is being denied. Please send this PAR to the authorizing agent: CFMC, Attention Medicaid/DME PARs, to the fax server number at 303 695-3377.
C190	Item or service requested is not a benefit of the Home and Community Based Services Persons with Brain Injury Waiver.
C191	Alternative funding for modification has not been considered.
C192	Modification did not include two bids.
C193	Cost of modification exceeds lifetime cap.
C194	Requested clinical information does not substantiate how the device or service will result in enhancement of the client's ability to perform activities of daily living, or to perceive, control or communicate within the client's environment.
C195	Modification is not a direct medical or remedial benefit to the client.
C196	Documentation was not provided from an Occupational Therapist or Physical Therapist.
C197	Request for non-medical transportation request is not required by care plan to prevent institutionalization.
C200	The Diagnosis/clinical information does not substantiate medical necessity.
C201	*INACTIVE* Client has not utilized the equipment in the manner for which it was intended. Repairs and/or replacement of equipment will not be allowed in cases of repeated misuse.
C202	*INACTIVE* This product cannot be approved as its primary purpose is to either enhance the personal comfort of the client or provide Convenience for the client caregiver.

Denial Code	Long Description
C203	*INACTIVE* The information submitted does not meet the Colorado Medicaid Program guidelines for medical necessity.
C204	*INACTIVE* This product has been provided in the recent past. Please submit additional information documenting the reason for its being requested once again.
C205	*INACTIVE* This request is for a WHEELCHAIR. The Colorado Medicaid Program has provided a similar product within the last few years. It is Medicaid policy that the original wheelchair should be utilized for a minimum of 5 years. Please submit additional information documenting the need for a new wheelchair at this point in time.
C206	*INACTIVE* It is the responsibility of the provider to service, repair and supply necessary parts for any Durable Medical Equipment product covered by a warranty during the warranty period. No replacement parts or repairs will be reimbursed by Colorado Medicaid during the warranty period.
C207	*INACTIVE* This product would more appropriately be provided on a rental basis.
C208	*INACTIVE* This product intended usage is for exercise. Colorado Medicaid does not cover products that are prescribed primarily for exercise.
C209	*INACTIVE* This product has been requested for a client who is currently residing in a nursing facility or hospital setting. Therefore, it will not be reimbursed through the Durable Medical Equipment program of Colorado Medicaid. It is the responsibility of the facility to provide this product.
C210	*INACTIVE* Please resubmit on paper. Prior Authorization Requests (PARS) must be submitted on paper for the following items: Electric Wheelchairs, Scooters, Orthotics and Prosthetics, Augmentative Communication Devices. Medicaid Bulletin B9900014, May 1999, Front Page Send paper PARS for these items directly to: CFMC, Attention: Medicaid/DME PARS, PO Box 17300, Denver, Colorado 80217 - 0300
C211	*INACTIVE* This product is not a benefit of the Durable Medical Equipment program. However, it may be covered under one of the Department waiver programs
C212	*INACTIVE* The information submitted does not support the need for the equipment requested. You may re-submit the Prior Authorization Request describing in more detail the current medical conditions that support the need for the equipment.
C213	*INACTIVE* The information submitted does not support the need for the medical supplies requested. You may re-submit the Prior Authorization Request describing in more detail the current medical conditions that support the need for the supplies.
C214	*INACTIVE* The requested information has not been submitted.
C215	*INACTIVE* The requested additional information is insufficient. Completion of the requested information is required to review this Prior Authorization Request.
C216	*INACTIVE* This product does not require prior authorization. Submit charges on the appropriate claim form.
C217	*INACTIVE* Serial number is required for all repairs. Please resubmit Prior Authorization Request with the serial number. Medicaid Bulletin B0100089, January 2001, Page 3
C218	*INACTIVE* Please send invoiced acquisition cost for this item.
C219	*INACTIVE* Following info needed to review request for SPECIALIZED BED. 1. Hours a day client in bed? 2. What bed does client have now? 3. Why does current bed not meet needs? 3. Other alternatives tried? 4. Can client work controls, change positions independently? 5. Does client have caregiver assistant? 6. Medical necessity semi-electric or total electric bed will meet? 7. Explain why manual hospital bed will not meet needs. Submit letter with info requested and return to ACS, PARS Unit, P.O. Box 30, Denver, Colorado 80201-0030.
C220	*INACTIVE* WHEELCHAIR purchases must have the manufacturer, brand name, model name and serial number. Medicaid Bulletin B0100089, January 2001, Page 3. Please submit this letter with the information requested and return to ACS, PARS Unit, P.O. Box 30, Denver, Colorado 80201-0030.
C221	*INACTIVE* Following info needed to review request for SEAT LIFT. 1. Does client have severe hip arthritis/knee or severe neuromuscular disease? 2. Is seat lift mechanism part of physician course of treatment and prescribed to effect improvement or arrest or retard deterioration in patient condition? 3. Is client completely incapable of standing from any chair in home? 4. Once standing, can client ambulate independently? Submit this letter with info requested and return to ACS, PARS Unit, P.O. Box 30, Denver, Colorado 80201-0030.
C222	*INACTIVE* Info needed to review request for PATIENT LIFT. 1. Does transfer between bed, chair, wheelchair or commode require assistance of more than one person? 2. Without use of lift will client be confined to bed? 3. Other alternatives tried? 4. How long will client require use of lift? 5. Provide info about physical dimensions of home environment that should be taken into consideration. 10 C.C.R. 2505-10, Sec. 8.593.02 (A) - (G). Submit this letter with info requested and return to ACS, PARS Unit, P.O. Box 30, Denver, Colorado 80201-0030

Denial Code	Long Description
C223	*INACTIVE* Info needed to review request for ELECTRIC/POWER LIFT. 1. Identify spasticity of patient. 2. How lift allow approp position of patient with one caregiver? 3. Caregiver need for proximity or physical contact during transfer for safety reasons. 4. Desc how lift will provide safe method of transfer for caregivers with restrictions/dysfunctions. 5. Info about physical dimensions of home environ. 10 C.C.R. 2505-10, Sec. 8.593.02 (A) - (G). Submit letter with info requested to ACS, PARS Unit, P.O. Box 30, Denver, Colorado 80201-0030.
C224	*INACTIVE* The following information is needed to review this request for the MATTRESS. 1. Does the client have a history of skin breakdown or currently have skin breakdown? Please explain? 2. What other alternatives have been tried? 3. What is the length of necessity of the mattress? 10 C.C.R. 2505-10, Sec. 8.593.02 (A) - (G). Please submit this letter with the information requested and return to ACS, PARS Unit, P.O. Box 30, Denver, Colorado 80201-0030.
C225	*INACTIVE* The following information is needed to review this request for the BLOOD PRESSURE MONITOR. 1. Please send the latest three blood pressure readings, the dates of the readings, medication and how frequently the blood pressure needs to be monitored. 2. If ordering an automatic monitor, please explain why a manual monitor will not meet the client needs. 10 C.C.R. 2505-10, Sec. 8.593.02 (A) - (G). Please submit this letter with the information requested and return to ACS, PARS Unit, P.O. Box 30, Denver, Colorado 80201-0030.
C226	*INACTIVE* The following information is needed to review this request for the FORMULA. Please provide the brand name being requested and the number of calories required per day from the formula. Specialty Provider Manual, Supply/DME, Page 2. Please submit this letter with the information requested and return to ACS, PARS Unit, P.O. Box 30, Denver, Colorado 80201-0030.
C227	*INACTIVE* Prior Authorization does not indicate a physician signature. A physician signature is required.
C228	*INACTIVE* Info is needed: 1. During trial period, did TENS: A. Produce no relief? B. Produce greater discomfort? C. Alleviate pain? 2. List pain med/dosage prior to treatment? 3. Was pain med/dosage reduced after application? 4. Degree of mobility prior to treatment? 5. Did degree of mobility improve? 6. Did patient derive significant therapeutic benefit? 7. Does patient own TENS unit or owned/used TENS unit in past? 8. Alternative treatments and/or clinical results. A. Traction B. Trigger point injections C. Surgery D. Drugs.
C229	*INACTIVE* Prior Authorization Requests must be submitted on paper for the following items: electric wheelchairs, scooters, orthotics and prosthetics, augmentative communication devices. Please send the Prior Authorization Request for these items directly to CFMC, Attention Medicaid/DME PARs, 23 Inverness Way East, Suite 100, Englewood, CO 80112-5708.
C230	*INACTIVE* This product is not a benefit of the Durable Medical Equipment program.
C231	*INACTIVE* The information submitted does not support the need for the equipment requested. You may re-submit the Prior Authorization Request describing in more detail the current medical conditions that support the need for the equipment.
C232	*INACTIVE* The information submitted does not support the need for the medical supplies or equipment requested. You may resubmit the Prior Authorization Request describing in more detail the current medical conditions that support the need for the supplies.
C233	*INACTIVE* This product does not require prior authorization. Submit charges on the appropriate claim form.
C234	*INACTIVE* Serial number is required for all repairs. Please resubmit Prior Authorization Request with the serial number. Medicaid Bulletin B0100089, January 2001, Page 3.
C235	*INACTIVE* Hospital Bed Questionnaire #1 is needed to review this request. Please submit this letter with the information requested.
C236	*INACTIVE* Wheelchair purchases must have the manufacturer, brand name and model name. Please submit this letter with the information requested.
C237	*INACTIVE* Seat Lift Questionnaire #4 is needed to review this request. Please submit this letter with the information requested.
C238	*INACTIVE* Patient Lift Questionnaire #3 is needed to review this request. Please submit this letter with the information requested.
C239	*INACTIVE* Electric/Power Lift Questionnaire #3 is needed to review this request. Please submit this letter with the information requested.
C240	*INACTIVE* Pressure Relief Mattress Questionnaire #2 is needed to review this request. Please submit this letter with the information requested.
C241	*INACTIVE* Blood Pressure Unit/Monitor Questionnaire #5 is needed to review this request. Please submit this letter with the information requested.

Denial Code	Long Description
C242	*INACTIVE* Oral and Enteral Nutrition Formula Questionnaire #10 (with particular attention to the number of calories per day) is needed to review this request. Please submit this letter with the information requested.
C243	*INACTIVE* The Prior Authorization Request does not indicate a physician signature. A physician signature is required.
C244	*INACTIVE* TENS or NMES Questionnaire #9 is needed to review this request. Please submit this letter with the information requested.
C245	*INACTIVE* Service previously authorized to this provider or another provider. The procedure code is already authorized for this client, this date span.
C246	*INACTIVE* Service previously authorized to this provider. The procedure code is already authorized for this client, this provider, and this date span. Please bill using the information on the original PAR.
C247	*INACTIVE* Services authorized to another provider.
C248	*INACTIVE* Please send product information on this item.
C249	*INACTIVE* A serial number is required for all repairs. Please resubmit PAR with the serial number.
C250	*INACTIVE* The dates entered either on the Header or Detail lines are invalid. Please review the dates and submit a new Prior Authorization Request with valid dates, including correct dates.
C251	This individual is not a Medicaid-eligible individual under age 21.
C252	The item or service requested is not a Medicaid benefit.
C253	The requested information has not been submitted. You may submit a new Prior Authorization Request with the requested information-Early and Periodic Screening, Diagnosis and Treatment screen and additional documentation indicating medical necessity.
C254	The information submitted does not support the medical need for the services requested, you may re-submit the Prior Authorization Request describing in more detail current medical necessity supporting the need for services.
C255	The clinical information does not substantiate medical necessity.
C256	*INACTIVE* This agency/individual is not a Medicaid Provider.
C257	*INACTIVE* This audiological service is not a benefit of the Health Care Program for Children with Special Needs.
C258	*INACTIVE* This audiological service is not a benefit of the Health Care Program for Children with Special Needs.
C259	This vision service was not provided by an ophthalmologist, optometrist or optician.
C260	These eyeglasses were not ordered by an ophthalmologist or an optometrist.
C261	These eyeglasses were not dispensed by an optician.
C262	There is no prior authorization for these orthoptic vision treatment services.
C263	There is no prior authorization for these contact lenses.
C264	Service previously authorized to this provider. The procedure code is already authorized for this client, this provider, this date span. Please bill using the information on the original PAR.
C265	Services authorized to another provider.
C266	The dates entered either on the Header or Detail lines are invalid. Please review the dates and submit a new Prior Authorization Request with valid dates.
C271	Client is not eligible for all or part of the dates covered in this prior authorization. Verify eligibility prior to performing services.
C290	Modification did not include two bids.
C291	Request for non-medical transportation is not required by care plan to prevent institutionalization.
C292	Item or service requested is not a benefit of the Home and Community Based Services for the Elderly, Blind, and Disabled Waiver.
C315	*INACTIVE* Info needed to complete PAR review: 1. During trial period did TENS: A. Produce no relief? B. Produce greater discomfort? C. Significantly alleviate pain? 2. Was patient on pain med before treatment? List med/dosage. 3. Was med/dosage reduced? 4. Degree of mobility prior to treatment? 5. Did mobility improve? 6. Do therapeutic benefits warrant continued use? 7. Does patient own or owned/used TENS unit? 8. Appropriateness of alternative treatments and/or the clinical results. A. Traction B. Trigger point injections C. Surgery D. Drugs
C316	*INACTIVE* The procedure code requested has been changed. Please note the new procedure code.
C317	*INACTIVE* Please review the dates and submit a new PAR with valid dates, including correct year. The dates entered either on the header or detail lines are invalid.
C318	*INACTIVE* Please provide the Medicaid Provider ID number of the Pharmacy or DME Supply company supplying the requested items

Denial Code	Long Description
C351	*INACTIVE* The item or service requested is not a Medicaid Home Health benefit.
C352	The information submitted does not support the need for the services requested, you may re-submit the PAR describing in more detail current medical conditions supporting the need for services.
C353	*INACTIVE* The requested information has not been submitted. You may submit a new PAR with the requested information-Home Health plan of care and/or therapy assessments, current clinical summary.
C354	*INACTIVE* This service does not require prior authorization. Submit charges on the appropriate claim form (Acute Home Health or Long Term Home Health with Acute Episode).
C355	*INACTIVE* The revenue code is already authorized for this client, this provider, this date span. Please bill using the information on the original PAR, or submit a new PAR for revision to increase services.
C356	*INACTIVE* The PAR that you sent directly to ACS is being denied. Please send this PAR to the authorizing agent: Single Entry Point Agency in county of client residence.
C357	*INACTIVE* The clinical information does not substantiate medical necessity.
C358	*INACTIVE* The requested additional information is insufficient. Completion of the requested information is required to review this Prior Authorization.
C359	*INACTIVE* The agency is not a Medicaid Provider.
C360	*INACTIVE* Nursing visits solely for the purpose of assess and teach are not billable in this case.
C361	Nursing visits are unreasonable in amount, frequency, or duration.
C362	*INACTIVE* Home health Aide units are requested, no skilled tasks are identified.
C363	*INACTIVE* Health Aide visits are not medically necessary.
C364	*INACTIVE* Home Health services shall be provided at the client place of residence except for EPSDT extraordinary HH which is prior authorized using a different process and form.
C365	*INACTIVE* The client is 18 years old or over and skilled therapies are not a benefit under Long Term Home Health.
C366	*INACTIVE* Extended Home Health Aide visits requested without submitting sufficient information about services on each visit.
C367	*INACTIVE* Documentation to support PRN visits has not been submitted.
C368	*INACTIVE* Written instructions from the therapist or other medical professional are required to support the need for ROM when it is the only skilled service performed by a Home Health Aide.
C369	*INACTIVE* Medication set-up by a nurse is the only reason for visits and documentation that the pharmacy was contacted is missing.
C370	*INACTIVE* Documentation does not support the need for two Home Health Aides at the same time for a two-person transfer.
C371	*INACTIVE* Client PAR is sent to the wrong authorizing agent, EPSDT HH, PDN, and Outpatient Therapy should be submitted to CFMC at PO Box 17300, Denver, CO, 80217.
C372	*INACTIVE* Based on the needs of the client, authorization is being given for a lesser amount of services than requested.
C373	*INACTIVE* PAR form has been submitted later than 10 days from the HCFA-485 "from" date. PAR dates have been adjusted.
C374	*INACTIVE* Revisions for increases in services shall be submitted and processed according to the same requirements as for new PARs, with a current written assessment/physician orders pertaining to the increase.
C377	*INACTIVE* Nursing visits solely for foot care shall be reimbursed only if the client has a documented diagnosis that supports the need for a nurse, and the client or family caregiver is not able or willing to provide the foot care.
C378	To be eligible for Long Term Home Health services, as set forth at Section 8.523.11K, Medicaid clients 18 years and over shall meet the level of care screening guidelines for Long Term Care Services at Section 10CCR 2505-10/8.401; 10CCR 2505-10/8.522.10.
C379	*INACTIVE* The PAR that you sent directly to the SEP is being denied. Please send this PAR to the authorizing agent: ACS.
C380	*INACTIVE* Client PAR is sent to the wrong authorizing agent, EPSDT HH, or Outpatient Therapy should be submitted to CFMC.
C381	*INACTIVE* Based on the needs of the client, authorization is being given for a lesser amount of services than requested.
C382	*INACTIVE* Any visit made solely for supervision of the Home Health Aide shall not be reimbursed.

Denial Code	Long Description
C383	*INACTIVE* The requested information has not been submitted. You may submit a new PAR with the requested information-Home Health plan of care and/or therapy assessments, current clinical summary.
C384	*INACTIVE* Client PAR is sent to the wrong authorizing agent, Private Duty Nursing PARs and application paperwork should be submitted do DDM Ascend via fax to 877-431-9568.
C385	*INACTIVE* Improper billing may result from visits that are unreasonable in amount, frequency and duration or visits performed when skilled tasks performed are not medically necessary.
C386	*INACTIVE* Service previously authorized to this provider. The procedure code is already authorized for this client, this provider, this date span. Please bill using the information on the original PAR.
C387	*INACTIVE* Services authorized to another provider.
C390	*INACTIVE* Extended Home Health Aide visits requested without submitting sufficient information about services on each visit.
C391	*INACTIVE* Client PAR is sent to the wrong authorizing agent, EPSDT HH, and Outpatient Therapy should be submitted to CFMC.
C392	*INACTIVE* Based on the needs of the client, authorization is being given for a lesser amount of services than requested.
C393	*INACTIVE* PAR form has been submitted later than 10 days from the PAR start date. PAR units have been adjusted.
C394	*INACTIVE* The requested information has not been submitted. You may submit a new PAR with the requested information-Home Health plan of care and/or therapy assessments, current clinical summary.
C395	*INACTIVE* The PAR that you sent directly to ACS is being denied. Please send this PAR to the authorizing agent: Single Entry Point Agency in county of client residence.
C396	*INACTIVE* Service previously authorized to this provider. The procedure code is already authorized for this client, this provider, this date span. Please bill using the information on the original PAR.
C397	The dates entered either on the Header or Detail lines are invalid. Please review the dates and submit a new Prior Authorization Request with valid dates.
C400	The requested information has not been submitted. You may submit a new PAR with the requested information.
C401	*INACTIVE* The service is not a benefit of the Colorado Medicaid medical transportation program. 10 C.C.R. 2505-10, Sec. 8.680-8.691 OTHER HEALTH SERVICES - TRANSPORTATION (As of February 1, 2002, the citations will be: 10 C.C.R. 2505-10, Sec. 8.680-8.688 NON-EMERGENT MEDICAL TRANSPORTATION
C402	Transportation to medical treatment located on or at military facilities is excluded from the Colorado Medicaid medical transportation program. (As of February 1, 2002, the citation will be: 10 C.C.R. 2505-10, Sec. 8.682 BENEFITS/EXCLUSIONS.)
C403	Transportation to medical treatment to providers not enrolled in the Medicaid program when Medicaid is the primary payer is excluded from the Colorado Medicaid medical transportation program. (As of February 1, 2002, the citation will be: 10 C.C.R. 2505-10, Sec. 8.682 BENEFITS/EXCLUSIONS.)
C404	Transportation to medical treatment to providers not enrolled in the Medicaid program when Medicaid is the primary payer is excluded from the Colorado Medicaid medical transportation program. (As of February 1, 2002, the citation will be: 10 C.C.R. 2505-10, Sec. 8.682 BENEFITS/EXCLUSIONS.)
C405	Transportation to pick up or deliver prescriptions, medical supplies, or durable medical equipment is excluded from the Colorado Medicaid medical transportation program. (As of February 1, 2002, the citation will be: 10 C.C.R. 2505-10, Sec. 8.682 BENEFITS/EXCLUSIONS.)
C406	Transportation for nursing facility or group home residents to any medical or rehabilitative services required to be part of the facility program by Federal or State law is excluded from the Colorado Medicaid medical transportation program. (As of February 1, 2002, the citation will be: 10 C.C.R. 2505-10, Sec. 8.682 BENEFITS/EXCLUSIONS.)
C407	Charges when the client is not in the vehicle is excluded from the Colorado Medicaid medical transportation program. (As of February 1, 2002, the citation will be: 10 C.C.R. 2505-10, Sec. 8.682 BENEFITS/EXCLUSIONS.)
C408	Transportation to court-ordered medical services that are not a benefit of Medicaid is excluded from the Colorado Medicaid medical transportation program. (As of February 1, 2002, the citation will be: 10 C.C.R. 2505-10, Sec. 8.682 BENEFITS/EXCLUSIONS.)
C409	Meals and lodging expenses when travel to and from a non-emergent medically necessary covered service can reasonably be completed in one calendar day is excluded from the Colorado Medicaid medical transportation program. (As of February 1, 2002, the citation will be: 10 C.C.R. 2505-10, Sec. 8.682 BENEFITS/EXCLUSIONS.)

Denial Code	Long Description
C410	Reimbursement for travel expenses of an escort when the travel is not expected to extend beyond one calendar day is excluded from the Colorado Medicaid medical transportation program. (As of February 1, 2002, the citation will be: 10 C.C.R. 2505-10, Sec. 8.682 BENEFITS/EXCLUSIONS.)
C411	The required documentation was not submitted for authorization of out-of-state medical transportation. (As of February 1, 2002, the citation will be: 10 C.C.R. 2505-10, Sec. 8.686 OUT-OF-STATE TRANSPORTATION AUTHORIZATIONS.)
C412	The required documentation was not submitted for authorization of commercial airline or train transportation. (As of February 1, 2002, the citation will be: 10 C.C.R. 2505-10, Sec. 8.685.07 PRIOR AUTHORIZATION REQUIREMENTS/PROCEDURES, COMMERCIAL AIRLINE OR TRAIN.)
C413	The required documentation was not submitted for authorization of ambulance and air ambulance transportation. (As of February 1, 2002, the citation will be: 10 C.C.R. 2505-10, Sec. 8.685.08 PRIOR AUTHORIZATION REQUIREMENTS/PROCEDURES, AMBULANCE AND AIR AMBULANCE.)
C414	The required documentation was not submitted for authorization of ancillary services related to medical transportation. (As of February 1, 2002, the citation will be: 10 C.C.R. 2505-10, Sec. 8.685.09 PRIOR AUTHORIZATION REQUIREMENTS/PROCEDURES, ANCILLARY SERVICES.)
C415	Services authorized to another provider.
C420	Request for non-medical transportation is not required by care plan to prevent institutionalization.
C421	Item or service requested is not a benefit of the Home and Community Based Services for Persons Living with AIDS Waiver.
C430	Modification is not to prevent institutionalization of the client.
C431	Alternative funding for modification has not been considered.
C432	Modification did not include two bids.
C433	Amount of Modification exceeds cost containment.
C434	Cost of modification exceeds lifetime cap.
C435	Request for non-medical transportation is not required by care plan to prevent institutionalization.
C436	Item or service requested is not a benefit of the Home and Community Based Services for Persons with Mental Illness Waiver.
C437	Modification does not give client greater independence.
C438	Modification does not ensure the health safety and welfare of the client.
C439	Modification is not a direct medical or remedial benefit to the client.
C440	Modification duplicates an existing adaptation.
C441	Modification is part of new construction.
C442	Documentation was not provided from an Occupational Therapist or Physical Therapist.
C443	Modification includes purchase cost of durable medical equipment.
C444	Modification requested is not the most cost effective solution.
C445	The dates entered either on the Header or Detail lines are invalid. Please review the dates and submit a new Prior Authorization Request with valid dates.
C451	Provider is not active for all or part of the dates on this Prior Authorization Request. Please verify provider number.
C452	The information submitted does not support the need for the services requested, you may re-submit the PAR describing in more detail current medical conditions supporting the need for services.
C453	The requested information has not been submitted. You may submit a new PAR with the requested information-nursing assessment, plan of care and/or therapy assessments, current clinical summary.
C454	The revenue code is already authorized for this client, this provider, this date span. Please bill using the information on the original PAR, or submit a new PAR for revision to increase or decrease services.
C455	The clinical information does not substantiate medical necessity.
C456	The requested additional information is insufficient. Completion of the requested information is required to review this Prior Authorization.
C457	The agency is not a Medicaid Provider.
C458	PDN PARs shall include only Private Duty Nursing RN or LPN services. Other services are included on this PAR.
C459	Based on the needs of the client, authorization is being given for a lesser amount of services than requested.
C460	Revisions for increases in services shall be submitted and processed according to the same requirements as for new PARs, with a current written assessment/physician orders pertaining to the increase.

Denial Code	Long Description
C461	Services total more than twenty-four (24) hours per day.
C462	No services shall be approved for dates of service before the date that the completed PAR is received.
C463	Services requested are duplicative of care that is being reimbursed under another benefit or funding source, including but not limited to home health, other insurance, or medical foster care.
C464	*INACTIVE* Services requested are beyond the 20 hour per day benefit limitation as a result of an EPSDT medical screening however the correct documentation has not been received. (the EPSDT claim form does not meet this requirement.)
C465	*INACTIVE* A PAR shall cover a period of no longer than six (6) months.
C466	The plan of care you submitted with your PDN PAR does not indicate the frequency and the times of day that all technology-related care will be administered.
C467	The application you submitted for PDN is incomplete, please send the required information.
C468	This client is ineligible for Medicaid in the non-institutional setting.
C469	This client is ineligible for PDN.
C470	The hours requested on the PAR are greater than the plan of care orders.
C471	Nursing visits are unreasonable in amount, frequency, or duration.
C472	Information submitted does not support the need for the services requested, you may re-submit the PAR describing in more detail current medical conditions supporting the need for services.
C473	*INACTIVE* Client PAR is sent to the wrong authorizing agent, EPSDT HH, or Outpatient Therapy should be submitted to CFMC.
C474	Nursing visits solely for psychiatric counseling are not reimbursable.
C475	The requested additional information is insufficient. Completion of the requested information is required to review this Prior Authorization.
C476	Service previously authorized to this provider. The procedure code is already authorized for this client, this provider, this date span. Please bill using the information on the original PAR.
C477	Services authorized to another provider.
C478	Services requested are beyond the 16 hour per day benefit limitation as a result of an EPSDT medical screening however the correct documentation has not been received. (the EPSDT claim form does not meet this requirement.)
C479	The PAR shall cover a period of no longer than six (6) months.
C50A	*INACTIVE* The PAR that you sent directly to ACS is being denied. Please send this PAR to the authorizing agent: CFMC, Attention Medicaid/DME PARs, to the fax server number at 303-790-4643.
C518	*INACTIVE* Instructions from the therapist or other medical professional are required to support the need for ROM when it is the only skilled service performed by a Home Health Aide.
C51A	*INACTIVE* This is not a final denial. Please do not submit an appeal request. The required Client State Id number is missing or invalid. Please resubmit the 5615 and ULTC 100.2 Certification page with the correct information to DDM Ascend via FAX at: 877-431-9568.
C52A	*INACTIVE* This is not a final denial. Please do not submit an appeal request. The Client State Id number does not match the Client name. Please resubmit the 5615 and ULTC 100.2 Certification page with the correct information to DDM Ascend via FAX at: 877-431-9568.
C53A	*INACTIVE* This is not a final denial. Please do not submit an appeal request. The required Client date of birth is missing or invalid. Please resubmit the 5615 and ULTC 100.2 Certification page with the correct information to DDM Ascend via FAX at: 877-431-9568.
C55A	*INACTIVE* This is not a final denial. Please do not submit an appeal request. The required Billing Provider number is missing or invalid. Please resubmit the 5615 and ULTC 100.2 Certification page with the correct information to DDM Ascend via FAX at: 877-431-9568.
C600	Service does not require prior authorization. Submit charges on the appropriate claim form.
C643	Cost containment information is missing. Please resubmit with required information.
C700	This vision service was not provided by an ophthalmologist, optometrist or optician.
C800	*INACTIVE* Service previously authorized to this provider. The procedure code is already authorized for this client, this provider, this date span. Please bill using the information on the original PAR.
C850	*INACTIVE* Services authorized to another provider.
C851	Services authorized to another provider.

Denial Code	Long Description
C852	Duplicate requests cannot be processed. This prior authorization request (PAR) is a duplicate of another PAR that is currently in the system.
C899	The Prior Authorization did not include the appropriate procedure coding and/or modifier(s) for the effective dates submitted. Both the service and the administration fee must be included with the same effective dates. Please resubmit with corrected coding.
C900	Modification is not to prevent institutionalization of the client.
C901	Modification does not give client greater independence.
C902	Modification does not ensure the health safety and welfare of the client.
C903	Modification is not a direct medical or remedial benefit to the client.
C904	Modification duplicates an existing adaptation.
C905	Duplicates an existing adaptation.
C906	Documentation was not provided from an Occupational Therapist or Physical Therapist.
C907	Modification includes purchase cost of durable medical equipment.
C908	Modification requested is not the most cost effective solution.
C909	Alternative funding has not been considered.
C910	Modification did not include two bids.
C911	*INACTIVE* Amount of Modification exceeds cost containment.
C912	*INACTIVE* The item or service requested is not a Medicaid Home Health benefit.
C913	The item or service requested is not a Medicaid Private Duty Nursing (PDN) benefit.
C914	The procedure is not a benefit of the Colorado Medicaid program.
C915	The procedure is not a benefit for a child Medicaid client, age birth through age 20.
C916	The procedure is not a benefit for an adult Medicaid client, age 21 and older.
C917	A report of the dental condition that supports the need for service was not submitted for this child client.
C918	A report of dental condition and concurrent medical condition that supports the need for service not submitted for this adult client.
C919	The procedure code is not valid for the described procedure.
C920	The procedure code is not a benefit for this tooth number.
C921	The tooth surface designation submitted is not valid for this tooth number.
C922	The procedure is a duplicate service.
C923	Information required for prior authorization review was not submitted.
C924	Periodontal diagnosis and classification were not submitted.
C925	The information submitted does not support the need for the procedure.
C926	Submitted information does not support a favorable prognosis.
C927	*INACTIVE* TMJ PAR information from the primary surgeon was incomplete or not D14 X COCT669 2004-01-1320.36.06
C928	PAR is not required for the assistant surgeon.
C929	Prior Authorization Request cannot be approved after the service has been started.
C930	*INACTIVE* Condition does not qualify as a Handicapping Malocclusion.
C931	*INACTIVE* No certification that orthodontics is not in preparation for corrective jaw surgery.
C933	Orthodontic treatment is not a benefit to treat dental conditions which are primarily cosmetic in nature.
C934	Orthodontic treatment is not a benefit when there is no severe Handicapping malocclusion, and self-esteem is the primary reason for treatment.
C935	Phase One orthodontic treatment is not a benefit for the reported condition/s.
C936	Orthodontic prior authorization cannot be approved when the requesting provider is not enrolled as a Medicaid orthodontic provider.
CA01	*INACTIVE* This is not a final denial. Please do not submit an appeal request. The required Client State Id number is missing or invalid. Please resubmit PAR request with the corrected information to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CA02	*INACTIVE* This is not a final denial. Please do not submit an appeal request. The required Client State Id number does not match the Client Name. Please resubmit PAR request with the corrected information to: ACS, P.O. Box 30, Denver, CO 80201-0030.

Denial Code	Long Description
CA03	*INACTIVE* This is not a final denial. Please do not submit an appeal request. The required Client date of birth is missing or invalid. Please resubmit PAR request with the corrected information to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CA04	*INACTIVE* This is not a final denial. Please do not submit an appeal request. The required Requesting Provider Number is missing or invalid. Please resubmit PAR request with the corrected information to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CA05	*INACTIVE* This is not a final denial. Please do not submit an appeal request. The required Billing Provider Number is missing or invalid. Please resubmit PAR request with the corrected information to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CA06	This is not a final denial. Please do not submit an appeal request. The required Client State ID number is missing or invalid. Please resubmit PAR request with the corrected information to the authorizing agency listed in Appendix D.
CA07	This is not a final denial. Please do not submit an appeal request. The required Client State ID number does not match the Client Name. Please resubmit PAR request with the corrected information to the authorizing agency listed in Appendix D.
CA08	This is not a final denial. Please do not submit an appeal request. The required Client date of birth is missing or invalid. Please resubmit PAR request with the corrected information to the authorizing agency listed in Appendix D.
CA09	This is not a final denial. Please do not submit an appeal request. The required Requesting Provider Number is missing or invalid. Please resubmit PAR request with the corrected information to the authorizing agency listed in Appendix D.
CA10	This is not a final denial. Please do not submit an appeal request. The required Billing Provider Number is missing or invalid. Please resubmit PAR request with the corrected information to the authorizing agency listed in Appendix D.
CA11	The PAR that you sent directly to ACS is being denied. Please send this PAR to the authorizing agency listed in Appendix D.
CA12	*INACTIVE* This is not a final denial. Please do not submit an appeal request. The required Client State ID number is missing or invalid. Please resubmit PAR request with the corrected information to the authorizing agency listed in Appendix D.
CA13	*INACTIVE* This is not a final denial. Please do not submit an appeal request. The required Client State ID number does not match the Client Name. Please resubmit PAR request with the corrected information to the authorizing agency listed in Appendix D.
CA14	*INACTIVE* This is not a final denial. Please do not submit an appeal request. The required Client date of birth is missing or invalid. Please resubmit PAR request with the corrected information to the authorizing agency listed in Appendix D.
CA15	*INACTIVE* This is not a final denial. Please do not submit an appeal request. The required Requesting Provider Number is missing or invalid. Please resubmit PAR request with the corrected information to the authorizing agency listed in Appendix D.
CA16	*INACTIVE* This is not a final denial. Please do not submit an appeal request. The required Billing Provider Number is missing or invalid. Please resubmit PAR request with the corrected information to the authorizing agency listed in Appendix D.
CA17	Provider must be an enrolled in the Colorado Medical Assistance Program.
CA18	This is not a final denial. Please do not submit an appeal request. The required Client State Id number is missing or invalid. Please resubmit the 5615 and ULTC 100.2 Certification page with the correct information to the authorizing agency listed in Appendix D.
CA19	This is not a final denial. Please do not submit an appeal request. The Client State Id number does not match the Client name. Please resubmit the 5615 and ULTC 100.2 Certification page with the correct information to the authorizing agency listed in Appendix D.
CA20	This is not a final denial. Please do not submit an appeal request. The required Client date of birth is missing or invalid. Please resubmit the 5615 and ULTC 100.2 Certification page with the correct information to the authorizing agency listed in Appendix D.
CA21	This is not a final denial. Please do not submit an appeal request. The required Billing Provider number is missing or invalid. Please resubmit the 5615 and ULTC 100.2 Certification page with the correct information to the authorizing agency listed in Appendix D.

Denial Code	Long Description
CC01	Consumer Directed Attendant Support (CDAS) services must be submitted on the same Prior Authorization Request (PAR) as the administration fee. Please resubmit the PAR with both the administration fee/modifier and the service procedure code.
CD01	*INACTIVE* Client has not utilized the equipment in the manner for which it was intended. Repairs and/or replacement of equipment will not be allowed in cases of repeated misuse.
CD02	*INACTIVE* This product cannot be approved as its primary purpose is to either enhance the personal comfort of the client or provide convenience for the client caregiver.
CD03	The information submitted does not meet the Colorado Medicaid Program guidelines for medical necessity.
CD04	Service previously authorized to this provider or another provider. The procedure code is already authorized for this client, this date span.
CD05	This request is for a WHEELCHAIR. The Colorado Medicaid Program has provided a similar product within the last few years. It is Medicaid policy that the original wheelchair should be utilized for a minimum of 5 years. Please submit additional information documenting the need for a new wheelchair at this point in time.
CD06	It is the responsibility of the provider to service, repair and supply necessary parts for any Durable Medical Equipment product covered by a warranty during the warranty period. No replacement parts or repairs will be reimbursed by Colorado Medicaid during the warranty period.
CD07	This product would more appropriately be provided on a rental basis.
CD08	This product intended usage is for exercise. Colorado Medicaid does not cover products that are prescribed primarily for exercise.
CD09	This product has been requested for a client who is currently residing in a nursing facility or hospital setting. Therefore, it will not be reimbursed through the Durable Medical Equipment program of Colorado Medicaid. It is the responsibility of the facility to provide this product.
CD10	*INACTIVE* Prior Authorization Requests must be faxed to CFMC for the following items: electric wheelchairs, scooters, orthotics and prosthetics, augmentative communication devices. Please send the Prior Authorization Request for these items directly to CFMC, Attention Medicaid/DME PARs, to the fax server line at 303-790-4643.
CD11	This product is not a benefit of the Durable Medical Equipment program.
CD14	The requested information has not been submitted.
CD16	This product does not require prior authorization. Submit charges on the appropriate claim form.
CD21	Prior authorizations requests must be submitted in a timely fashion. Retroactive requests beyond three months shall only be considered in cases of client retroactive program eligibility.
CD23	Effective August 1, 2007 Pulse Oximeters will have a maximum allowable rental cap of $750.00 per year. Once the total rental payment reaches $750.00 the equipment will convert to a purchase. This change is in accordance with the following Rule: 8.590.2.R. Rental Policy.
CD30	This product would be more appropriately provided as a purchase.
CD31	As per Medicaid Bulletin March 2003, 1 unit equals 100. Your requested quantity has been divided by 100.
CD32	The amount requested exceeds the allowed quantity and has been reduced accordingly. Please refer to the current Medicaid Supply Bulletin and 10 C.C.R. 2505-10, Sec. 8.590.2. NP.
CD33	The amount requested is excessive for the diagnosis and has been reduced accordingly. Please refer to the current Medicaid Supply Bulletin and 10 C.C.R. 2505-10, Sec. 8. 590.2.NP.
CD35	Per Medicaid supply bulletin, A9900 is limited to specialized, detailed or complex work in the initial preparation of a product.
CD59	Prior Authorization is not required for Medicare Crossover claims. (8.590.3.B) Providers are required to bill Medicare first before billing Medicaid for this service. (Sec. 8.590.7.K)
CD60	*INACTIVE* Service previously authorized to this provider. The procedure code is already authorized for this client, this provider, this date span. Please bill using the information on the original PAR.
CD61	*INACTIVE* Services authorized to another provider.
CD63	This item is included in the rental/purchase of the equipment or service that has been approved. Please refer to the current Medicaid Supply Bulletin.
CDA1	*INACTIVE* This is not a final denial. Please do not submit an appeal request. The date(s) entered either on the Header or Detail lines are invalid. Please review the dates and submit a new PAR with valid dates to: ACS, P.O. Box 30, Denver, CO 80201-0030.

Denial Code	Long Description
CDA2	*INACTIVE* This is not a final denial. Please do not submit an appeal request. The information submitted does not support the need for the medical supplies or equipment requested. Please resubmit the PAR describing in more detail the current medical conditions that support the need for the supplies to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDA3	*INACTIVE* This is not a final denial. Please do not submit an appeal request. The additional information submitted is insufficient. Completion of the requested information is required for review. Please resubmit PAR with the requested information to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDA4	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Serial number is required for all repairs. Please resubmit PAR with the serial number to: ACS, P.O. Box 30, Denver, CO 80201-0030. Current Medicaid Supply Bulletin and 10 C.C.R. 2505-10, Sec. 8.590.3 (A).
CDA5	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Please resubmit PAR with the invoiced acquisition cost for this item to: ACS, P.O. Box 30, Denver, CO 80201-0030. Current Medicaid Supply Bulletin and 10 C.C.R. 2505-10, Sec. 8.590.6 (A-IK).
CDA6	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Wheelchair purchases must have the manufacturer, brand name and model name. Please resubmit PAR with the information requested above to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDA7	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Requesting providers must have prescriptive authority for this item. Please resubmit PAR with the name of the prescribing physician to: ACS, P.O. Box 30, Denver, CO 80201-0030. Current Medicaid Supply Bulletin.
CDA8	*INACTIVE* This is not a final denial. Please do not submit an appeal request. The Prior Authorization Request requires a physician signature. Please resubmit PAR with a physician signature to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDA9	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Procedure Code requested is invalid/incorrect or incomplete. Please resubmit PAR with proper code(s) from the current Medicaid Supply Bulletin to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDB1	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Please resubmit PAR with the name of meds, frequency, route and length of need to: ACS, P.O. Box 30, Denver, CO 80201-0030. Current Medicaid Supply Bulletin and 10 C.C.R. 2505-10, Sec. 8. 590.3.d.
CDB2	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Please resubmit PAR with the number of units requested to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDB3	*INACTIVE* This is not a final denial. Please do not submit an appeal request. PAR dates must be for one year. Please resubmit PAR with corrected date span or provide an explanation as to why dates are less than one year to: ACS, P.O. Box 30, Denver, CO 80201-0030. Please refer to the current Medicaid Supply Bulletin.
CDB4	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Additional information is required for this item. Please resubmit PAR and include whether these items are intended for use with a client owned piece of equipment to: ACS, P.O. Box 30, Denver, CO 80201-0030. Current Medicaid Supply Bulletin.
CDB5	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Additional information is required for this item. Please resubmit PAR and describe 1) the client level of impairment, 2) what has been used in the past, 3) if the client has available assistance 4) why this client is in need of this equipment/supply to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDB6	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Additional information is required for this item. Please resubmit PAR and describe 1) exactly why this item is needed, 2) what it will be used for, 3) the intended use for this item to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDB7	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Product information is required on this item. Please resubmit PAR with product information to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDB8	*INACTIVE* This is not a final denial. Please do not submit an appeal request. A serial number is required for all repairs. Please resubmit PAR with the serial number for the repair to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDB9	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Hospital Bed Questionnaire #1 is needed to review this request. Please resubmit PAR with the information requested to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDC1	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Pressure Relief Mattress Questionnaire #2 is needed to review this request. Please resubmit Prior Authorization Request with the information requested to: ACS, P.O. Box 30, Denver, CO 80201-0030.

Denial Code	Long Description
CDC2	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Patient Lift Questionnaire #3 is needed to review this request. Please resubmit PAR with the information requested to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDC3	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Electric/Power Lift Questionnaire #3 is needed to review this request. Please resubmit PAR with the information requested to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDC4	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Seat Lift Questionnaire #4 is needed to review this request. Please resubmit PAR with the information requested to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDC5	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Blood Pressure Unit/Monitor Questionnaire #5 is needed to review this request. Please resubmit PAR with the information requested to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDC6	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Pulse Oximeter Questionnaire #6 (with SaO2 readings) is needed to review this request. Please resubmit PAR with the information requested to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDC7	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Apnea Monitor Questionnaire #7 is needed to review this request. Please resubmit PAR with the information requested to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDC8	*INACTIVE* This is not a final denial. Please do not submit an appeal request. CPAP/BiPAP Questionnaire #8 with copy of sleep study is needed to review this request. Please resubmit PAR with the information requested to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDC9	*INACTIVE* This is not a final denial. Please do not submit an appeal request. TENS or NMES Questionnaire #9 is needed to review this request. Please resubmit PAR with the information requested to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDD1	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Oral and Enteral Nutrition Formula Questionnaire #10 (with particular attention to the number of calories per day) is needed to review this request. Please resubmit PAR with the information requested to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDD2	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Adult Orthotics and Prosthetics Questionnaire #11 is needed to review this request. Please resubmit PAR with the information requested to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDD3	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Wound Closure Therapy Questionnaire #12 is needed to review this request. Please resubmit PAR with the information requested to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDD4	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Augmentative Communication Device Questionnaire #13 is needed to review this request. Please resubmit PAR with the information requested to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDD5	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Mechanical High Frequency Chest Wall Oscillation Questionnaire #14 is needed to review this request. Please resubmit PAR with information requested to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDD6	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Wheelchair Tilt/Recline Device Questionnaire #15 is needed to review this request. Please resubmit PAR with the information requested to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDD7	*INACTIVE* This is not a final denial. Please do not submit an appeal request. The Questionnaire form you submitted is no longer valid. Please resubmit PAR with the current Questionnaire form to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CE01	This vision service was not provided by an ophthalmologist, optometrist or optician.
CE02	The clinical information does not substantiate medical necessity.
CF01	Proof of prior Medicaid orthodontic approval from another state was not submitted.
CF02	TMJ PAR information from the primary surgeon was incomplete
CF03	Condition does not qualify as a Handicapping Malocclusion.
CF04	Crowns and fixed prostheses that fail in less than five years do not meet a reasonable standard of care and the billing provider is expected to replace them at their own expense.
CF05	The services/treatments are not a covered benefit for Evaluation Procedures.
CF06	The services/treatments are not a covered benefit for Diagnostic Imaging Procedures.

Denial Code	Long Description
CF07	The services/treatments are not a covered benefit for Preventive Services.
CF08	The services/treatments are not a covered benefit for Minor Restorative Services.
CF09	The services/treatments are not a covered benefit for Major Restorative Services.
CF10	The services/treatments are not a covered benefit for Endodontic Services.
CF11	The services/treatments are not a covered benefit for Periodontal Treatment.
CF12	The services/treatments are not a covered benefit for Removable Prosthetics.
CF13	The services/treatments are not a covered benefit for Oral Surgery, palliative treatment and anesthesia.
CF14	The services/treatments are not a covered benefit for Adult Clients under any circumstances.
CF15	Prior authorization request was not submitted.
CF16	Dental services shall only be provided by a licensed dentist or dental hygienist who is enrolled with Colorado Medicaid.
CF17	Dental services described in 8.201.2 shall be available to Adult Clients age 21 years and older.
CF18	Dental services for adults 21 years of age and older are limited to a total of $1,000 per adult Medicaid recipient per state fiscal year.
CH10	*INACTIVE* Nursing visits solely for the purpose of assess and teach are not billable in this case.
CH11	*INACTIVE* Nursing visits are unreasonable in amount, frequency, or duration.
CH12	*INACTIVE* Home Health Aide units are requested, no skilled tasks are identified.
CH13	*INACTIVE* Home Health Aide visits are not medically necessary.
CH14	*INACTIVE* Home Health services shall be provided at the client place of residence except for EPSDT extraordinary HH which is prior authorized using a different process and form.
CH15	*INACTIVE* The client is 18 years old or over and skilled therapies are not a benefit under Long Term Home Health.
CH16	*INACTIVE* Extended Home Health Aide visits requested without submitting sufficient information about services on each visit.
CH17	*INACTIVE* Documentation to support PRN visits has not been submitted.
CH18	*INACTIVE* Written instructions from the therapist or other medical professional are required to support the need for ROM when it is the only skilled service performed by a Home Health Aide.
CH19	*INACTIVE* Medication set-up by a nurse is the only reason for visits and documentation that the pharmacy was contacted is missing.
CH2	*INACTIVE* information submitted does not support the need for the services requested, you may re-submit the PAR describing in more detail current medical conditions supporting the need for services.
CH20	*INACTIVE* Documentation does not support the need for two Home Health Aides at the same time for a two-person transfer.
CH21	*INACTIVE* Client PAR is sent to the wrong authorizing agent, EPSDT HH, PDN and Outpatient Therapy should be submitted to CFMC at PO Box 17300, Denver, CO 80217.
CH22	*INACTIVE* Based on the needs of the client, authorization is being given for a lesser amount of services than requested.
CH23	*INACTIVE* PAR form has been submitted later than 10 days from the HCFA-485 "from" date. PAR dates have been adjusted.
CH24	*INACTIVE* Revisions for increases in services shall be submitted and processed according to the same requirements as for new PARs, with a current written assessment/physician orders pertaining to the increase.
CH25	*INACTIVE* Nursing visits solely for psychiatric counseling are not reimbursable.
CH26	*INACTIVE* Any visit made solely for supervision of the Home Health aide shall not be reimbursed.
CH27	*INACTIVE* Nursing visits solely for foot care shall be reimbursed only if the client has a documented diagnosis that supports the need for a nurse, and the client or family caregiver is not able or willing to provide the foot care.
CH3	*INACTIVE* The requested information has not been submitted. You may submit a new PAR with the requested information-Home Health plan of care and/or therapy assessments, current clinical summary.
CH30	*INACTIVE* Client PAR is sent to the wrong authorizing agent, Private Duty Nursing PARs and application paperwork should be submitted do DDM Ascend via fax to 877-431-9568.
CH31	*INACTIVE* Improper billing may result from visits that are unreasonable in amount, frequency and duration or visits performed when skilled tasks performed are not medically necessary.

Denial Code	Long Description
CH4	*INACTIVE* This service does not require prior authorization. Submit charges on the appropriate claim form (Acute Home Health or Long Term Home Health with Acute Episode)
CH5	*INACTIVE* The revenue code is already authorized for this client, this provider, this date span. Please bill using the information on the original PAR, or submit a new PAR for revision to increase services.
CH6	*INACTIVE* The PAR that you sent directly to ACS is being denied. Please send this PAR to the authorizing agent: Single Entry Point Agency in county of client residence.
CH7	*INACTIVE* The clinical information does not substantiate medical necessity.
CH8	*INACTIVE* The requested additional information is insufficient. Completion of the requested information is required to review this Prior Authorization.
CH9	*INACTIVE* The agency is not a Medicaid Provider.
CJ01	The service is not a benefit of the Colorado Medicaid medical transportation program.
CN01	This is not a final denial. Please do not submit an appeal request. The Required 5615 noted in the Nursing Facility Billing Manual; General Prior Authorization Requirements is missing or incomplete. Please resubmit the 5615 and ULTC 100.2 certification page to the authorizing agent.
CN02	This is not a final denial. Please do not submit an appeal request. The Required ULTC 100.2 certification page noted in the Nursing Facility Billing Manual; General Prior Authorization Requirements is missing or incomplete. Please resubmit the 5615 and ULTC 100.2 certification page to the authorizing agent.
CN03	This is a not final denial. Please do not submit an appeal request. The required client's social security number is invalid or does not match the social security number of file with the Colorado Medical Assistance Program. Please correct and resubmit both the 5615 and the UTLC 100.2 certification page to the authorizing agent.
CN04	This is not a final denial. Please do not submit an appeal request. The required Client State Id number is missing or invalid. Please resubmit the 5615 and ULTC 100.2 Certification page with the correct information to the authorizing agency listed in Appendix D.
CN05	This is not a final denial. Please do not submit an appeal request. The Client State Id number does not match the Client name. Please resubmit the 5615 and ULTC 100.2 Certification page with the correct information to the authorizing agency listed in Appendix D.
CN06	This is not a final denial. Please do not submit an appeal request. The required Client date of birth is missing or invalid. Please resubmit the 5615 and ULTC 100.2 Certification page with the correct information to the authorizing agency listed in Appendix D.
CN07	This is not a final denial. Please do not submit an appeal request. The required Billing Provider number is missing or invalid. Please resubmit the 5615 and ULTC 100.2 Certification page with the correct information to the authorizing agency listed in Appendix D.
CQ01	This is not a final denial. Please do not submit an appeal request. The date(s) entered either on the Header or Detail lines are invalid. Please review the dates and submit a new PAR with valid dates to the appropriate authorizing agency listed in Appendix D.
CQ02	This is not a final denial. Please do not submit an appeal request. The information submitted does not support the need for the medical supplies or equipment requested. Please resubmit the PAR describing in more detail the current medical conditions that support the need for the supplies to the appropriate authorizing agency listed in Appendix D.
CQ03	This is not a final denial. Please do not submit an appeal request. The additional information submitted is insufficient. Completion of the requested information is required for review. Please resubmit PAR with the requested information to the appropriate authorizing agency listed in Appendix D.
CQ04	This is not a final denial. Please do not submit an appeal request. Serial number is required for all repairs. Please resubmit PAR with the serial number to the appropriate authorizing agency listed in Appendix D. Current Medicaid Supply Bulletin and 10 C.C.R. 2505-10, Sec. 8.590.3.D.8.
CQ05	This is not a final denial. Please do not submit an appeal request. Please resubmit PAR with the invoiced acquisition cost for this item to the appropriate authorizing agency listed in Appendix D. Current Medicaid Supply Bulletin and 10 C.C.R. 2505-10, Sec. 8.590.4.D.5.c.
CQ06	This is not a final denial. Please do not submit an appeal request. Wheelchair purchases must have the manufacturer, brand name and model name. Please resubmit PAR with the information requested above to the appropriate authorizing agency listed in Appendix D.
CQ07	This is not a final denial. Please do not submit an appeal request. Requesting providers must have prescriptive authority for this item. Please resubmit PAR with the name of the prescribing physician to the appropriate authorizing agency listed in Appendix D. Current Medicaid Supply Bulletin.

Denial Code	Long Description
CQ08	This is not a final denial. Please do not submit an appeal request. The Prior Authorization Request requires a physician's signature. Please resubmit PAR with a physician's signature to the appropriate authorizing agency listed in Appendix D.
CQ09	This is not a final denial. Please do not submit an appeal request. Procedure Code requested is invalid/incorrect or incomplete. Please resubmit PAR with proper code(s) from the current Medicaid Supply Bulletin to the appropriate authorizing agency listed in Appendix D.
CQ10	This is not a final denial. Please do not submit an appeal request. Please resubmit PAR with the name of meds, frequency, route and length of need to the appropriate authorizing agency listed in Appendix D. Current Medicaid Supply Bulletin and 10 C.C.R. 2505-10, Sec. 8. 590.3.d.
CQ11	This is not a final denial. Please do not submit an appeal request. Please resubmit PAR with the number of units requested to the appropriate authorizing agency listed in Appendix D.
CQ12	This is not a final denial. Please do not submit an appeal request. PAR dates must be for one year. Please resubmit PAR with corrected date span or provide an explanation as to why dates are less than one year to the appropriate authorizing agency listed in Appendix D. Please refer to the current Medicaid Supply Bulletin.
CQ13	This is not a final denial. Please do not submit an appeal request. Additional information is required for this item. Please resubmit PAR and include whether these items are intended for use with a client owned piece of equipment to the appropriate authorizing agency listed in Appendix D. Current Medicaid Supply Bulletin.
CQ14	This is not a final denial. Please do not submit an appeal request. Additional information is required for this item. Please resubmit PAR and describe 1) the client's level of impairment, 2) what has been used in the past, 3) if the client has available assistance 4) why this client is in need of this equipment/supply to the appropriate authorizing agency listed in Appendix D.
CQ15	This is not a final denial. Please do not submit an appeal request. Additional information is required for this item. Please resubmit PAR and describe 1) exactly why this item is needed, 2) what it will be used for, 3) the intended use for this item to the appropriate authorizing agency listed in Appendix D.
CQ16	This is not a final denial. Please do not submit an appeal request. Product information is required on this item. Please resubmit PAR with product information to the appropriate authorizing agency listed in Appendix D.
CQ17	This is not a final denial. Please do not submit an appeal request. A serial number is required for all repairs. Please resubmit PAR with the serial number for the repair to the appropriate authorizing agency listed in Appendix D.
CQ18	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Hospital Bed Questionnaire #1 is needed to review this request. Please resubmit PAR with the information requested to the appropriate authorizing agency listed in Appendix D.
CQ19	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Pressure Relief Mattress Questionnaire #2 is needed to review this request. Please resubmit Prior Authorization Request with the information requested to the appropriate authorizing agency listed in Appendix D.
CQ20	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Patient Lift Questionnaire #3 is needed to review this request. Please resubmit PAR with the information requested to the appropriate authorizing agency listed in Appendix D.
CQ21	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Electric/Power Lift Questionnaire #3 is needed to review this request. Please resubmit PAR with the information requested to the appropriate authorizing agency listed in Appendix D.
CQ22	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Seat Lift Questionnaire #4 is needed to review this request. Please resubmit PAR with the information requested to the appropriate authorizing agency listed in Appendix D.
CQ23	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Blood Pressure Unit/Monitor Questionnaire #5 is needed to review this request. Please resubmit PAR with the information requested to the appropriate authorizing agency listed in Appendix D.
CQ24	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Pulse Oximeter Questionnaire #6 (with SaO2 readings) is needed to review this request. Please resubmit PAR with the information requested to the appropriate authorizing agency listed in Appendix D.
CQ25	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Apnea Monitor Questionnaire #7 is needed to review this request. Please resubmit PAR with the information requested to the appropriate authorizing agency listed in Appendix D.

Denial Code	Long Description
CQ26	*INACTIVE* This is not a final denial. Please do not submit an appeal request. CPAP/BiPAP Questionnaire #8 with copy of sleep study is needed to review this request. Please resubmit PAR with the information requested to the appropriate authorizing agency listed in Appendix D.
CQ27	*INACTIVE* This is not a final denial. Please do not submit an appeal request. TENS or NMES Questionnaire #9 is needed to review this request. Please resubmit PAR with the information requested to the appropriate authorizing agency listed in Appendix D.
CQ28	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Oral and Enteral Nutrition Formula Questionnaire #10 (with particular attention to the number of calories per day) is needed to review this request. Please resubmit PAR with the information requested to the appropriate authorizing agency listed in Appendix D.
CQ29	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Adult Orthotics and Prosthetics Questionnaire #11 is needed to review this request. Please resubmit PAR with the information requested to the appropriate authorizing agency listed in Appendix D.
CQ30	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Wound Closure Therapy Questionnaire #12 is needed to review this request. Please resubmit PAR with the information requested to the appropriate authorizing agency listed in Appendix D.
CQ31	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Augmentative Communication Device Questionnaire #13 is needed to review this request. Please resubmit PAR with the information requested to the appropriate authorizing agency listed in Appendix D.
CQ32	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Mechanical High Frequency Chest Wall Oscillation Questionnaire #14 is needed to review this request. Please resubmit PAR with the information requested to the appropriate authorizing agency listed in Appendix D.
CQ33	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Wheelchair Tilt/Recline Device Questionnaire #15 is needed to review this request. Please resubmit PAR with the information requested to the appropriate authorizing agency listed in Appendix D.
CQ34	This is not a final denial. Please do not submit an appeal request. The Questionnaire form you submitted is no longer valid. Please resubmit PAR with the current Questionnaire form to the appropriate authorizing agency listed in Appendix D.
CQ35	Prior Authorization Requests must be submitted on paper for the following items: electric wheelchairs, scooters, orthotics and prosthetics, augmentative communication devices. Please send the Prior Authorization Request for these items directly to the appropriate authorizing agency listed in Appendix D.
CQ36	Client has not utilized the equipment in the manner for which it was intended. Repairs and/or replacement of equipment will not be allowed in cases of repeated misuse.
CQ37	This product cannot be approved as its primary purpose is to either enhance the personal comfort of the client or provide convenience for the client caregiver.
CQ38	This is a rejection, not a final denial. Please do not submit an appeal request. Completion of PAR requirements have not been met.
CQ39	Same or similar services have already been previously approved for this client.
CY01	*INACTIVE* Client PAR is sent to the wrong authorizing agent. Please refer to Appendix D for the appropriate authorizing agency when submitting EPSDT HH, or Outpatient Therapy PARs.
CY03	*INACTIVE* PAR form has been submitted later than 10 business days from the PAR start date. PAR units have been adjusted.
CY04	*INACTIVE* PAR form has been submitted later than 10 business days from the PAR start date. PAR units have been adjusted.
CZ01	*INACTIVE* Client PAR is sent to the wrong authorizing agent. Please refer to Appendix D for the appropriate authorizing agency when submitting EPSDT HH, or Outpatient Therapy PARs.
CZ02	*INACTIVE* Based on the needs of the client, authorization is being given for a lesser amount of services than requested.
CZ03	PAR form has been submitted later than 10 business days from the PAR start date. PAR units have been adjusted.
CZ04	The requested information has not been submitted. You may submit a new PAR with the requested information- Home Health plan of care and/or therapy assessments, current clinical summary.
CZ05	*INACTIVE* Home Health services shall be provided at the client place of residence (excluding nursing facilities and hospitals) except for EPSDT extraordinary HH which is prior authorized using a different process and form.

Denial Code	Long Description
CZ06	*INACTIVE* Client PAR is sent to the wrong authorizing agent, Private Duty Nursing PARs and application paperwork should be submitted to the authorizing agency listed in Appendix D.
CZ07	*INACTIVE* The revenue code is already authorized for this client, this provider, this date span. Please bill using the information on the original PAR, or submit a new PAR for revision to increase services.
CZ08	*INACTIVE* The clinical information does not substantiate medical necessity.
CZ09	*INACTIVE* The requested additional information is insufficient. Completion of the requested information is required to review this Prior Authorization.
CZ10	The agency is not a Medicaid Provider.
CZ11	*INACTIVE* Client PAR is sent to the wrong authorizing agent. Please refer to Appendix D for the appropriate authorizing agency.
CZ12	The item or service requested is not a Medicaid Home Health benefit.
CZ13	Skilled therapies are not a benefit under Adult Long Term Home Health.
CZ14	Revisions for increases to Home Health services shall be submitted and processed according to the same requirements defined for new PARs, and shall be submitted timely and include a current plan of care, physician's orders and any other required documentation to support the revision as listed in the Home Health Benefit Coverage Standard.
CZ15	Based on the needs of the client, authorization is being given for a lesser amount of services than requested.
CZ16	This client is 21 years or older and Home Health services shall be provided at the client place of residence (excluding nursing facilities and hospitals).
CZ17	The client is 18 years or older and the PAR was sent to the wrong authorizing agent; Adult Long Term Home Health PARs and applicable paperwork should be submitted to the authorizing agency listed in Appendix D.
CZ18	The revenue code is already authorized for this client, this provider and/or this date span. Please bill using the information on the original PAR, or submit a new PAR revision to increase or change services.
CZ19	The clinical information does not substantiate medical necessity.
CZ20	The information submitted is insufficient to make a medical necessity determination. Additional information is required to review this Prior Authorization.
CZ21	The Colorado Medical Assistance Program previously sent a letter notifying you of a decrease in your home health services and wants to make sure you have received all of the information you need. You may be eligible for a plan to decrease the amount of services over a three month period of time to help adjust to the change. You may talk with your case manager or home health provider to make a step-down plan if you need one. If you have not heard from your case manager or provider, or if you have any questions, please call 303-866-3447.
P001	THE BILLING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THE SERVICES.
P002	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P003	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P005	THE PRIOR AUTHORIZATION CAN NOT BE END DATED. THE PRIOR AUTHORIZATION STATUS IS NOT APPROVED OR APPROVED WITH REVISIONS.
P006	PLEASE FURNISH THE PROCEDURE CODE AND CORRESPONDING DESCRIPTION.
P008	THE BILLING PROVIDER NUMBER IS INVALID.
P009	THE BILLING PROVIDER NUMBER IS INVALID.
P010	THE REQUESTED END DATE IS INVALID.
P011	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P012	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P013	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P014	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P015	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P016	THE REQUESTED START DATE IS MISSING OR INVALID.
P019	THE REQUESTED START DATE IS MISSING OR INVALID.
P020	THE RENDERING PROVIDER NUMBER IS INVALID.

Denial Code	Long Description
P021	THE RENDERING PROVIDER NUMBER IS INVALID.
P022	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P023	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P024	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P026	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P027	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P030	FIRST MODIFIER IS INVALID.
P031	FIRST MODIFIER IS INVALID.
P032	SECOND MODIFIER IS INVALID.
P033	SECOND MODIFIER IS INVALID.
P034	THIRD MODIFIER IS INVALID.
P035	THIRD MODIFIER IS INVALID.
P036	FOURTH MODIFIER IS INVALID.
P037	FOURTH MODIFIER IS INVALID.
P038	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P039	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P040	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P041	CLIENTS FIRST NAME IS MISSING.
P042	CLIENTS LAST NAME IS MISSING.
P043	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P044	BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES REQUESTED.
P045	FIRST MODIFIER IS INVALID.
P046	SECOND MODIFIER IS INVALID.
P047	THIRD MODIFIER IS INVALID.
P048	FOURTH MODIFIER IS INVALID.
P052	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P053	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P054	RENDERING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES FOR THE BENEFIT PLAN.
P055	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P061	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P062	THE CLIENT ID AND/OR NAME INDICATED ON THE PA REQUEST IS INCORRECT. THE CLIENT ID AND/OR NAME HAS BEEN UPDATED. PLEASE VERIFY THE ID AND/OR NAME IS CORRECT.
P064	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
P067	THE FREQUENCY OF HOURS REQUESTED ARE NOT APPROPRIATE FOR THIS CLIENT AND HAVE BEEN MODIFIED ACCORDINGLY.
P079	BILLING PROVIDER IS ON PAYMENT SUSPENSION DUE TO CREDIBLE ALLEGATION OF FRAUD.
P120	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAS BEEN REDUCED.
P121	THE SERVICE/ PROCEDURE REQUESTED IS NOT SUPPORTED BY SUBMITTED DOCUMENTATION.
P126	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
P128	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.
P138	SERVICE(S) DO NOT MEET COLORADO MEDICAID GUIDELINES.
P167	REQUESTED DOCUMENTATION HAS NOT BEEN SUBMITTED.
P178	THE SERVICE REQUESTED IS NOT MEDICALLY NECESSARY.
P179	THE MEDICAL NECESSITY FOR THIS SERVICE IS NOT SUPPORTED BY THE SUBMITTED DOCUMENTATION.
P233	THE DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE ADDITIONAL CARE.
P257	THIS CLIENTS FUNCTIONAL ASSESSMENT SCORES PLACE THIS CLIENT OUTSIDE ELIGIBILITY FOR DAY TREATMENT.

Denial Code	Long Description
P274	OUR RECORDS INDICATE THIS CLIENT IS INVOLVED IN EFFECTIVE AND APPROPRIATE SERVICE ELSEWHERE.
P292	INTENSIVE REHABILITATION HOURS ARE NO LONGER APPROPRIATE AS INDICATED BY HISTORY, DIAGNOSIS, AND/ OR FUNCTIONAL ASSESSMENT SCORES.
P328	THE SERVICES REQUESTED INCLUDE NON-COVERED SERVICES, AND HOURS ARE REDUCED ACCORDINGLY.
P339	THE CLIENTS PAST HISTORY INDICATES REDUCED TREATMENT HOURS ARE WARRANTED.
P342	THE REQUEST DOES NOT MEET GENERALLY ACCEPTED CONDITIONS REQUIRING FLUORIDE TREATMENTS.
P346	SERVICES EXCEED COLORADO MEDICAID LIMITATION AND DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE MEDICAL NECESSITY OF THE SERVICE.
P349	THE SERVICE REQUESTED WAS PERFORMED LESS THAN FIVE YEARS AGO.
P353	THE EXISTING APPLIANCE HAS NOT BEEN WORN FOR THREE YEARS.
P367	THE CLIENT HAS BEEN TOTALLY WITHOUT TEETH AND AN APPLIANCE FOR FIVE YEARS.
P392	THE CLIENT IS MISSING AN ANTERIOR TOOTH AND/OR HAS TWO OR MORE POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P405	THE SERVICE(S) REQUESTED COULD ADEQUATELY BE PERFORMED IN THE DENTAL OFFICE.
P406	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE OF GOOD PERIODONTAL HEALTH (AMERICAN ACADEMY OF PERIODONTOLOGY PERIODONTAL CLASSIFICATION OF TYPE I OR II).
P407	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE VISIBLE ON RADIOGRAPHS THAT AT LEAST 50 PERCENT OF THE CLINICAL CROWN IS INTACT.
P409	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING SIX OR MORE TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED, INCLUDING THIRD MOLARS.
P410	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING ONE OR MORE ANTERIOR TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED.
P411	DOCUMENTATION DOES NOT SUPPORT THE NEED FOR PERIODONTIC SERVICES. POCKETS ARE LESS THAN 4MM AND/OR GREATER THAN 6MM FOR CLIENT AND/OR THE CLIENT IS UNDER THE AGE OF 13.
P412	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA.
P413	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA. THIS PA HAS BEEN GRANTED AS APPROVED NOT APPROVED WITH REVISIONS. THE DURATION REQUESTED MAY HAVE BEEN REDUCED TO REFLECT COVERAGE LIMITATIONS, PRESCRIBER ORDERS, CONFLICTI
P417	THE SERVICE(S) REQUESTED COULD BE ADEQUATELY PERFORMED WITH LOCAL ANESTHESIA.
P437	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO POOR ORAL HYGIENE.
P444	THIS LINE ITEM IS A DUPLICATE OF ANOTHER LINE ITEM ON THIS PRIOR AUTHORIZATION (PA) REQUEST. PLEASE CORRECT.
P446	THIS IS A DUPLICATE OF AN EXISTING PRIOR AUTHORIZATION (PA) REQUEST. YOU MAY CONTACT PROVIDER SERVICES IF YOU REQUIRE ASSISTANCE. DUPLICATE PA REQUEST
P448	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO DECAY HISTORY.
P449	QUESTIONABLE LONG TERM PROGNOSIS DUE TO GUM AND BONE DISEASE.
P456	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO APPARENT ROOT INFECTION.
P457	OUR RECORDS INDICATE THIS CLIENT HAS EXCEEDED ESTABLISHED PROGRAM LIMITATIONS. COLORADO MEDICAID WILL NOT AUTHORIZE NEW DENTURES.
P458	DOCUMENTATION PROVIDED INDICATES A LESS ELABORATE PROCEDURE SHOULD BE CONSIDERED.
P502	RENTAL ONLY ALLOWED; MEDICAL NEED FOR PURCHASE HAS NOT BEEN DOCUMENTED.
P503	PURCHASE ONLY ALLOWED; MEDICAL NEED FOR RENTAL HAS NOT BEEN DOCUMENTED.
P504	OCCUPATIONAL THERAPY GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P505	THE SERVICE REQUESTED IS INCLUDED IN THE NURSING HOME RATE STRUCTURE.
P511	THIS NATIONAL DRUG CODE IS ONLY BILLABLE AS PART OF A COMPOUND DRUG.
P515	THE PRESENCE OF A HANDICAPPING MALOCCLUSION OR HANDICAPPING DENTOFACIAL DEFORMITY IS NOT SUPPORTED BY THE DOCUMENTATION SUBMITTED.
P521	THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVERED BY COLORADO MEDICAID.
P522	GASTRO-INTESTINAL SURGERY FOR THE PURPOSE OF WEIGHT CONTROL IS COVERED ONLY AS A LIFE THREATENING PROCEDURE.
P523	THE TREATMENT REQUEST IS NOT CONSISTENT WITH THE CLIENT'S DIAGNOSIS.

Denial Code	Long Description
P524	PSYCHOTHERAPY PROVIDED IN THE CLIENTS HOME IS NOT A COVERED BENEFIT OF COLORADO MEDICAID.
P525	THE INFORMATION PROVIDED IS NOT CONSISTENT WITH THE INTENSITY OF SERVICES REQUESTED.
P526	INTENSIVE MULTIPLE MODALITY TREATMENT IS NOT CONSISTENT WITH THE INFORMATION PROVIDED.
P527	MULTIPLE PROVIDERS OF TREATMENT ARE NOT INDICATED FOR THIS CLIENT.
P528	THE DURATION OF TREATMENT SESSIONS EXCEED CURRENT COLORADO MEDICAID GUIDELINES.
P534	DOCUMENTATION OF POOR PHYSICAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P535	OTHER PHYSICAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P536	THE PHYSICAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P537	USE OF PHYSICAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P538	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF A PHYSICAL THERAPIST.
P539	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS AND LIVING ARRANGEMENT.
P540	GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P541	THE PROCEDURE(S) REQUESTED ARE NOT MEDICAL IN NATURE.
P542	DOCUMENTATION OF POOR OCCUPATIONAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P543	DOCUMENTATION OF POOR SPEECH THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P544	OTHER OCCUPATIONAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P546	THE OCCUPATIONAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P547	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF PHYSICAL THERAPY.
P548	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P549	ACTIVITIES TO PROMOTE DIVERSION OR GENERAL MOTIVATION ARE NONCOVERED COLORADO MEDICAID SERVICES.
P550	REVISIONS OF THE REQUEST IS NECESSITATED BY THE CLIENTS MINIMAL PROGRESS.
P551	RESTORATIVE NURSING INVOLVEMENT COULD BE INCREASED.
P552	CLIENTS DEMONSTRATED RESPONSE TO CURRENT THERAPY DOES NOT WARRANT THE INTENSE FREQUENCY REQUESTED.
P553	MAINTENANCE IS TWO TIMES PER WEEK OR LESS.
P554	THE SPEECH THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P555	USE OF OCCUPATIONAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P556	USE OF SPEECH THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P557	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF AN OCCUPATIONAL THERAPIST.
P558	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
P559	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P560	THE MATERIALS/ SERVICES REQUESTED ARE PRINCIPALLY COSMETIC IN NATURE.
P561	THE LENS FORMULA DOES NOT JUSTIFY REPLACEMENT.
P562	THE CHANGE IN THE LENS FORMULA DOES NOT WARRANT MULTIPLE REPLACEMENTS.
P563	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P564	LENSES ONLY ARE APPROVED; PLEASE DISPENSE A CONTRACTED FRAME. THE NON-CONTRACTED FRAME IS NOT MEDICALLY JUSTIFIED.
P565	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P566	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P567	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF OCCUPATIONAL THERAPY.

Denial Code	Long Description
P568	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF SPEECH THERAPY.
P569	LEVEL, INTENSITY, OR EXTENT OF SERVICE(S) REQUESTED HAS BEEN MODIFIED CONSISTENT WITH MEDICAL NEED AS DEFINED IN THE PLAN OF CARE.
P570	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P571	THE SERVICE ASKED FOR IS NOT COVERED BY COLORADO MEDICAID AS THESE TASKS CAN BE DONE BY NURSES OR ACTIVITY STAFF.
P572	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P573	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.
P574	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P575	MEDICAL NEED FOR EQUIPMENT/ SUPPLY REQUESTED IS NOT SUPPORTED BY DOCUMENTATION SUBMITTED.
P576	OTHER SPEECH THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P577	DOCUMENTATION SUBMITTED IDENTIFIES THAT THE CLIENT HAS FEWER THAN TWO POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P582	LESS EXPENSIVE ALTERNATIVE SERVICES ARE AVAILABLE FOR THIS CLIENT.
P634	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P711	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING PERIODONTAL SCALING AND ROOT PLANNING.
P712	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING GINGIVECTOMY.
P754	AN APPROVED SUBSTANCE ABUSE DAY TREATMENT PROGRAM CANNOT EXCEED A SIX WEEK PERIOD.
P761	THE CLIENT DOES NOT APPEAR TO BE ABLE OR WILLING TO ABSTAIN FROM ALCOHOL/DRUG USAGE WHILE IN TREATMENT. THEREFORE, SUBSTANCE ABUSE DAY TREATMENT SERVICES ARE NOT APPROVED.
P764	THIS CLIENT HAS COMPLETED INTENSIVE SUBSTANCE ABUSE TREATMENT WITHIN THE PAST 12 MONTHS. THE DOCUMENTATION PROVIDED IS NOT ADEQUATE TO JUSTIFY ADDITIONAL INTENSIVE TREATMENT AT THIS TIME.
P785	A LESS THAN SIX-WEEK HEALING PERIOD HAS BEEN SPECIFIED FOR THIS PRIOR AUTHORIZATION. THEREFORE IT IS NOT NECESSARY TO WAIT THE FULL SIX WEEKS AFTER EXTRACTIONS BEFORE TAKING DENTURE IMPRESSIONS.
P818	SIX-WEEK HEALING TIME IS REQUIRED BETWEEN EDENTULATION AND FINAL IMPRESSIONS. PAYMENT FOR DENTURES WILL BE DENIED OR RECOUPED IF HEALING PERIOD IS NOT OBSERVED.
P849	COLORADO MEDICAID HAS DETERMINED THERE WERE (ARE) SEVERAL HOME HEALTH AGENCIES WILLING TO PROVIDE MEDICALLY NECESSARY SKILLED NURSING SERVICES TO THIS CLIENT.
P864	THE DOCUMENTATION YOU HAVE SUBMITTED DOES NOT MEET THE REQUIREMENTS OF COLORADO MEDICAID.
P873	THE MEDICAL NECESSITY FOR THE HOURS REQUESTED IS NOT SUPPORTED BY THE INFORMATION SUBMITTED.
P874	THE DOCUMENTATION SUBMITTED INDICATES THE TASKS SPECIFIED CAN BE COMPLETED DURING THE VISITS APPROVED.
P878	THE DOCUMENTATION SUBMITTED DOES NOT INDICATE THAT MEDICALLY ORIENTED TASKS ARE MEDICALLY NECESSARY; THEREFORE PERSONAL CARE SERVICES HAVE BEEN APPROVED.
P880	THE QUANTITY OF SERVICES AUTHORIZED FOR THIS CLIENTS PERSONAL CARE HAS BEEN AMENDED BASED ON INFORMATION RECEIVED FROM ONE OR MORE OF THESE SOURCES: THE CLIENT, THEIR PHYSICIAN, AND/OR THE IN-HOME VISIT BY STAFF OF THE OIG (OFFICE OF INSPECTOR GENERAL).
P885	THE USE OF THIS DRUG FOR THE INTENDED PURPOSE IS NOT COVERED BY COLORADO MEDICAID, CONSISTENT WITH COLORADO ADMINISTRATIVE CODE AND FEDERAL LAW.
P924	THE MEDICAL RECORDS SUBMITTED WITH THE CURRENT REQUEST CONFLICT OR DISAGREE WITH OUR MEDICAL RECORDS ON THIS CLIENT.
P950	INDEPENDENT NURSES, PLEASE NOTE PAYABLE SERVICES MAY NOT EXCEED 12 HOURS/DAY OR 60 HOURS/WEEK.

Denial Code	Long Description
P951	SERVICES CAN ONLY BE AUTHORIZED THROUGH ONE YEAR FROM THE PRESCRIPTION DATE.
P952	LEAD INSPECTION IS A COVERED COLORADO MEDICAID SERVICE WHEN THE CHILD HAS BEEN SHOWN TO HAVE LEAD POISONING (E.G., CHILD HAS A BLOOD LEAD LEVEL > 19 UG/DL OR TWO CONSECUTIVE BLOOD LEAD LEVELS OF 15-19 UG/DL DONE AT LEAST 90 DAYS APART). THE INSPECTION MUS
P953	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P954	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P956	THE REQUEST CAN ONLY BE BACKDATED A MAXIMUM OF 14 DAYS FROM FIRST DATE RECEIVED BY COLORADO MEDICAID.
P957	COMPLETE PERIODONTAL CHARTING AT TIME OF SERVICE, AND SUBMIT CHARTING, COPY OF OPERATIVE REPORT, TOGETHER WITH A COPY OF THE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF), F-11035, TO PA UNIT ATTENTION DENTAL CONTSULTANT.
P958	NOTE THAT CODE D4341 HAS BEEN CHANGED. REFER TO THE DECISION NOTICE FOR AUTHORIZED QUANTITY.
P960	YOUR PA HAS BEEN APPROVED FOR 90 DAYS. THE 90 DAY APPROVAL DOES NOT IMPLY THE PA REQUEST MEETS PRIOR AUTHORIZATION CRITERIA. AFTER ADDITIONAL INFORMATION IS AVAILABLE IN INTERCHANGE, COLORADO MEDICAID WILL CREATE AN AMENDMENT REQUEST TO EXTEND THE PA FOR
P961	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P962	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
PA10	THE REQUESTED END DATE IS INVALID.
PA12	PLEASE FURNISH A WRITTEN DESCRIPTION OF THE CLIENTS DIAGNOSIS.
PA13	PROVIDE DIAGNOSES WITH DATES OF ONSET.
PA14	IDENTIFY PROBLEMS TO BE TREATED.
PA15	THE AUDIOLOGISTS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1), F-11020, AND PRIOR AUTHORIZATION REQUEST/HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2), F-11021.
PA16	THE PHYSICIANS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION/PHYSICIAN OTOLOGICAL REPORT (PA/POR), F-11019.
PA17	SUBMIT BRIEF HISTORY WITH REFERRAL INFORMATION, LIVING SITUATION, FUNCTIONAL STATUS, AND OTHER PERTINENT INFORMATION. WHAT CHANGE OF STATUS RESULTED IN REFERRAL AT THIS TIME?
PA18	PLEASE FURNISH THE CLIENTS HEIGHT AND WEIGHT.
PA19	PLEASE SUBMIT CLINICAL INFORMATION SUFFICIENT TO VERIFY THE NEED FOR THE REQUESTED SERVICE(S).
PA20	PLEASE RESUBMIT WITH COMPLETE PERIODONTAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PA21	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL EDUCATIONAL PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA22	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL PROGRAM PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA23	REFER TO THE DURABLE MEDICAL EQUIPMENT INDEX FOR APPROPRIATE CODE AND DESCRIPTION. DO NOT USE AN "UNLISTED" CODE.
PA24	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUALIZED FAMILY SERVICE PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA25	INFORMATION ON THE REQUEST FORM IS ILLEGIBLE, AND THE REQUEST CANNOT BE PROCESSED.
PA26	RE-EVALUATE YOUR GOALS. EMPHASIS SHOULD BE ON FUNCTIONAL SELF-CARE. GOALS MUST BE RELATED TO FUNCTIONAL OUTCOME.
PA27	PLEASE CLARIFY THE NUMBER OF HOURS PER WEEK REQUESTED.
PA28	PLEASE CLARIFY THE NUMBER OF HOURS PER DAY REQUESTED.
PA29	PLEASE CLARIFY THE NUMBER OF VISITS PER DAY REQUESTED.

Denial Code	Long Description
PA30	ATTACH SUPPORTIVE DOCUMENTATION; HOME EXERCISE PROGRAM AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA31	THE DIAGNOSIS CODE INDICATED ON THE REQUEST DOES NOT CORRESPOND TO THE DIAGNOSIS CODE DESCRIPTION.
PA32	PLEASE SUBMIT ADDITIONAL INFORMATION SUFFICIENT TO VERIFY APPROPRIATENESS AND NEED FOR TRANSPLANT.
PA33	PLEASE SUBMIT THE INITIAL AND PROGRESSIVE OBJECTIVE FINDINGS.
PA34	ATTACH SUPPORTIVE DOCUMENTATION, FACILITY PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA35	PLEASE SUBMIT THE CLIENTS ORIGINAL COMPLAINTS AND EXAMINATION FINDINGS.
PA36	ATTACH SUPPORTIVE DOCUMENTATION, IN-HOME AUTISM PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA37	PLEASE SUBMIT YOUR TREATMENT PLAN FOR THIS CLIENT.
PA38	ATTACH SUPPORTIVE DOCUMENTATION AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA39	INITIAL EVALUATIONS MUST BE PERFORMED BY AN OCCUPATIONAL THERAPIST REGISTERED (OTR), PER AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA) STANDARDS.
PA41	IDENTIFY THE PLACE OF SERVICE AND ITS EFFECT ON SUPPORTING THE DESIRED TREATMENT OUTCOME.
PA42	PLEASE INDICATE THE HOURS OF USE OF OXYGEN PER 24-HOUR PERIOD.
PA43	PROVIDE BASELINE DOCUMENTATION FOR THIS CLIENTS LIMITATIONS USING UNITS OF MEASUREMENT THAT ARE APPLIED CONSISTENTLY WHEN REPORTING STATUS.
PA44	IDENTIFY FUNCTIONAL LIMITATIONS AS THEY ARE RELATED TO IDENTIFIED CONDITIONS.
PA46	CORRELATE PLAN OF CARE TO REQUESTED PROCEDURE CODES.
PA47	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE FREQUENCY/DURATION REQUESTED.
PA48	PLEASE PROVIDE THE NAME AND CREDENTIALS OF THE RENDERING PROVIDER.
PA50	COLORADO MEDICAID RECORDS INDICATE THE CLIENT OWNS A WHEELCHAIR. DOCUMENT THE REASON AND NEED FOR REPLACEMENT AND COST TO REPAIR CURRENT WHEELCHAIR.
PA51	PLEASE DISTINGUISH PRIMARY AND SUPPORTIVE MODALITIES.
PA52	PLEASE SUBMIT A PROGRESS REPORT.
PA53	MULTIPLE FAMILY CLIENTS TREATMENT BY THE SAME PROVIDER REQUIRES FURTHER INFORMATION DOCUMENTING COORDINATION OF TREATMENT PLAN.
PA54	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE MINUTES REQUESTED.
PA55	MEDICAL NECESSITY OF TREATMENT REQUIRES ADDITIONAL DOCUMENTATION.
PA56	GIVEN AGE, DIAGNOSES, CURRENT LEVEL OF FUNCTION, PAST RESPONSE TO TREATMENT, AND LIVING SITUATION, EXPAND ON POTENTIAL FOR SIGNIFICANT FUNCTIONAL PROGRESS WITHIN THE NEXT SIX MONTHS. EMPHASIZE WHY PROGRESS IS EXPECTED WITH SERVICES AT THIS TIME.
PA57	SUBMIT THE INITIAL FINDINGS. INCLUDE A COMPREHENSIVE EVALUATION.
PA58	SUBMIT PROGRESSIVE, OBJECTIVE FINDINGS. INCLUDE A PERTINENT RE-EVALUATION.
PA59	PLEASE SUPPLY INFORMATION REGARDING THE CLIENTS MEDICATION REQUIREMENTS, IF ANY.
PA60	PLEASE SPECIFY IF THE CLIENT IS IN AN EDUCATIONAL SETTING.
PA61	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA62	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
PA63	THE SKILLS OF A THERAPIST ARE PURPOSEFUL AND SKILLED INTERVENTIONS REQUIRED TO CONTINUALLY DESIGN, IMPLEMENT, REASSESS, MODIFY/GRADE, AND/OR DISCONTINUE A PLAN OF CARE IN A TIMELY MANNER, BASED ON THE COMPLEXITY OF THE CLIENTS MEDICAL CONDITION AND/OR CO
PA64	PLEASE SUBMIT A THERAPY PLAN OF CARE, INCLUDING A CURRENT, DATED EVALUATION.
PA65	A PLAN OF CARE SIGNED AND DATED BY THE PHYSICIAN IS REQUIRED.
PA66	THE SKILLS OF A THERAPIST ARE REQUIRED WHEN ONLY THE THERAPIST CAN SAFELY AND EFFECTIVELY DELIVER THE THERAPEUTIC PROCEDURES BECAUSE OF THEIR UNIQUE KNOWLEDGE, TRAINING, AND EXPERTISE. DESCRIBE THE REASON THAT SOMEONE OTHER THAN A THERAPIST CANNOT SAFELY

Denial Code	Long Description
PA67	PLEASE SPECIFY IF THE CLIENTS WORK SITE DEMANDS GOOD BINAURAL HEARING.
PA68	DESCRIBE THE REASON, BASED ON THE CLIENTS COGNITIVE, PHYSICAL, COMMUNICATION, OR RESOURCE STATUS, THAT A HOME PROGRAM, EQUIPMENT, OR ENVIRONMENTAL ADAPTATIONS ALONE CANNOT MEET CLIENTS NEEDS.
PA69	PLEASE SPECIFY IF THE CLIENT HAS AN ACCOMPANYING DISABILITY THAT ADDS TO THE HEARING PROBLEM.
PA70	DISTINGUISH REQUESTED PROCEDURES AND GOALS FROM OTHER SERVICES THIS CLIENT RECEIVES. THEY MAY NOT BE DUPLICATIVE.
PA71	PLEASE INDICATE THE NUMBER OF DAYS REQUESTED.
PA73	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA74	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA75	PLEASE DOCUMENT CARRYOVER OF THE THERAPY PROGRAM TO NURSING.
PA76	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA79	PROVIDE EVIDENCE OF SIGNIFICANT FUNCTIONAL PROGRESS IN LAST SIX MONTHS.
PA84	THE GRANT DATE OF THIS REQUEST CANNOT BE PRIOR TO THE SIGNATURE DATE OF THE PRESCRIBING PHYSICIAN.
PA86	PROVIDE EVIDENCE OF SKILLS GAINED IN THERAPY CARRYING OVER TO OTHER SETTINGS WITHIN SIX MONTHS.
PA87	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE NUMBER OF SESSIONS REQUESTED.
PA88	THE REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL SCOPE OF PRACTICE.
PA89	PRIOR AUTHORIZATION IS NOT REQUIRED UNTIL LIMITATION OF SERVICE HAS BEEN REACHED.
PA91	PLEASE SUBMIT REQUIRED X-RAYS.
PA92	PLEASE PROVIDE AN EXPLANATION FOR THE MATERIAL SUBMITTED WITH THE REQUEST.
PA95	PLEASE DESCRIBE HOW THE PROVISION OF THIS SERVICE WOULD PREVENT INSTITUTIONALIZATION OF THE CLIENT.
PA96	COULD THE EXISTING DENTURE(S) BE RELINED OR REBASED? IF NOT, PLEASE EXPLAIN WHY NOT.
PA97	REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL STANDARDS OF PRACTICE.
PA98	PLEASE INDICATE IF THE CLIENT IS CURRENTLY BEING TUBE FED.
PB02	PLEASE PROVIDE THE REQUIRED DATED SIGNATURES ON THE ATTACHMENTS.
PB03	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING THE LOSS/DESTRUCTION/THEFT OF THE HEARING AID.
PB04	DESCRIBE THE CLIENTS ABILITY TO STAND OR AMBULATE SUFFICIENTLY TO ACCOMPLISH SELF-CARE ACTIVITIES.
PB07	PLEASE SUBMIT AN ORTHODONTIC STUDY MODEL OR DIAGNOSTIC CASTS.
PB09	PLEASE PROVIDE A PHOTOGRAPH OF THE INVOLVED AREA(S).
PB10	PLEASE PROVIDE AN ESTIMATION (IN GRAMS) OF THE TOTAL AMOUNT OF TISSUE TO BE RESECTED.
PB11	PLEASE SUBMIT THE PLAN OF CARE FOR CO-TREATMENT.
PB12	FURNISH A DETAILED DESCRIPTION FOR THE PROCEDURE CODE REQUESTED.
PB13	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB15	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB18	PLEASE COMPLETE THE ATTACHED OUT-OF-STATE PROVIDER DATA SHEET, F-11001, AND RESUBMIT.
PB20	A SIGNED AND DATED PRESCRIPTION IS REQUIRED WITHIN THREE MONTHS OF RECEIPT BY COLORADO MEDICAID FOR INITIAL REQUESTS AND WITHIN 12 MONTHS OF RECEIPT BY COLORADO MEDICAID FOR SUBSEQUENT REQUESTS.
PB21	PLEASE COMPLETE THE APPROPRIATE PRIOR AUTHORIZATION ATTACHMENT. CONTACT PROVIDER SERVICES OR THE PRIOR AUTHORIZATION UNIT FOR ASSISTANCE.
PB23	PHYSICAL THERAPY ASSISTANT NOTES AND ALL FORMS SUBMITTED MUST BE COSIGNED BY A REGISTERED PHYSICAL THERAPIST.
PB31	ARE YOU REQUESTING A COMPLETE APPLIANCE, OR REPLACEMENT PARTS?
PB32	THE PROCEDURE CODE INDICATED ON THE REQUEST DOES NOT MATCH THE DESCRIPTION OF SERVICE; PLEASE CORRECT AND RESUBMIT.

Denial Code	Long Description
PB35	THE SERVICE REQUESTED DOES NOT REQUIRE PRIOR AUTHORIZATION.
PB41	PLEASE FURNISH A CURRENT MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT, F-11090 (DATED WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID).
PB45	THE CERTIFICATION PERIOD ON THE PLAN OF CARE (POC) DOES NOT COVER THE REQUESTED GRANT/START DATE. PLEASE RESUBMIT YOUR REQUEST WITH A NEW POC.
PB49	A CERTIFIED OCCUPATIONAL THERAPY ASSISTANTS NOTES MUST BE COSIGNED BY AN OCCUPATIONAL THERAPIST REGISTERED.
PB51	ADDITIONAL INFORMATION IS REQUIRED ON PRIOR AUTHORIZATION TO ENABLE PRICING.
PB54	REQUESTED SERVICES DO NOT MATCH SERVICES ON THE PHYSICIANS ORDERS.
PB59	PLEASE PROVIDE AN INDIVIDUAL EDUCATIONAL PLAN (IEP), WHICH HAS BEEN SIGNED BY THE PROVIDER NO EARLIER THAN NINE MONTHS PRIOR TO RECEIPT AT COLORADO MEDICAID; OTHERWISE, DOCUMENT WHY NO IEP EXISTS.
PB65	PLEASE FURNISH THE ANTICIPATED TOTAL CHARGES FOR THIS REQUEST.
PB66	A PHOTOCOPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED; THE DATE MUST BE WITHIN SIX MONTHS OF RECEIPT BY COLORADO MEDICAID.
PB67	THE PRESCRIPTION DATE MUST INCLUDE MONTH, DAY, AND YEAR.
PB68	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID.
PB73	THE SERVICES IDENTIFIED ON THE PLAN OF CARE DO NOT APPEAR APPROPRIATE FOR THE PROCEDURE CODE(S) REQUESTED ON THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018.
PB74	THE CLIENT/PROVIDER DOES NOT HAVE RETROACTIVE ENROLLMENT.
PB75	THE REQUESTED START DATE IS MORE THAN 14 DAYS BEFORE OR 62 DAYS AFTER RECEIPT.
PB82	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
PB83	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A HOME HEALTH AIDE. PLEASE RESUBMIT AS A PERSONAL CARE WORKER OR PROVIDE ADDITIONAL DOCUMENTATION.
PB86	THE SERVICES REQUESTED ARE NOT BEING PROVIDED IN THE CLIENTS RESIDENCE. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL.
PB87	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A NURSE. PLEASE RESUBMIT AS A HOME HEALTH AIDE OR PROVIDE ADDITIONAL DOCUMENTATION.
PB92	PLEASE FURNISH THE CLIENTS COMPLETE ADDRESS.
PB94	IF THE CLIENT IS A RESIDENT OF A NURSING HOME, SUPPLY THE COMPLETE NAME AND ADDRESS OF THE NURSING HOME.
PB99	THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018, MUST BE SIGNED AND DATED.
PC01	PLEASE SUPPLY THE RENDERING PROVIDERS PROVIDER NUMBER.
PC03	THE DRUG ENFORCEMENT ADMINISTRATION NUMBER IS MISSING OR INVALID.
PC06	PLEASE DESCRIBE YOUR PROGRAM; INCLUDE ENTRY DATE, TERMINATION DATE, HOURS PER WEEK, AND NUMBER OF WEEKS OF PRIMARY INTENSIVE SERVICE REQUESTED.
PC07	PLEASE DESCRIBE YOUR "AFTERCARE/FOLLOW-UP" PLANS FOR THIS CLIENT.
PC08	PLEASE SUPPLY DOCUMENTATION OF PREVIOUS SUBSTANCE ABUSE SERVICES WITH DATE(S) AND OUTCOME.
PC09	PLEASE DESCRIBE IN DETAIL THE TREATMENT OBJECTIVES/GOALS FOR THIS CLIENT.
PC10	PLEASE DESCRIBE THE FAMILY SITUATION/DYNAMICS. EXPLAIN HOW THE FAMILY WILL BE INCORPORATED INTO THE CLIENTS PLAN OF CARE.
PC12	PLEASE EXPLAIN IF YOUR SERVICE ENCOURAGES THE CLIENT TO ATTEND SELF-HELP GROUPS.
PC13	PLEASE SUPPLY A SPECIFIC SCHEDULE OF ACTIVITIES, INCLUDING DAY, TIME OF DAY, LENGTH OF SESSION, AND SERVICE TO BE RENDERED DURING THAT TIME.
PC15	PLEASE FURNISH DIAGNOSTIC RATIONALE.
PC17	PLEASE DOCUMENT IF THE CLIENT EVER RECEIVED SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT.
PC19	PLEASE FURNISH MORE EXTENSIVE AND IN-DEPTH HISTORICAL AND PSYCHOSOCIAL DATA.
PC20	PLEASE SUPPLY THE DATE THE CLIENT BECAME TOTALLY ENDENTULOUS.
PC23	PLEASE SUBMIT A PHYSICIANS STATEMENT REGARDING THE MEDICAL NECESSITY OF DENTURES FOR THIS CLIENT. THE PHYSICIANS STATEMENT MUST DOCUMENT THE MEDICAL NEED FOR DENTURES.
PC24	THE SERVICE REQUESTED WAS PREVIOUSLY AUTHORIZED. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT INDICATING THIS FACT IS REQUIRED.

Denial Code	Long Description
PC25	PLEASE SUPPLY SUFFICIENT MITIGATING CIRCUMSTANCES TO WARRANT THE CONSTRUCTION OF NEW DENTURES(S).
PC26	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
PC28	PLEASE SUBMIT A PHYSICIANS STATEMENT INDICATING DENTURES ARE NECESSARY FOR THIS NURSING HOME CLIENT.
PC29	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING LOSS OR DESTRUCTION OF DENTURE(S). INCLUDE SIGNED STATEMENT FROM CLIENT OR FACILITY DIRECTOR REGARDING HOW, WHEN AND WHERE LOST.
PC30	PLEASE PROVIDE COMPLETE INTRAORAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PC31	PLEASE DESCRIBE ANY RELATED DEFORMITIES OF THE FEET.
PC34	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD WITH REQUESTED DME ITEM(S) AND DOCUMENT IF THE CLIENT CAN USE SAFELY AND INDEPENDENTLY.
PC35	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD AND DESCRIBE THE RESULTS AND EFFECTIVENESS OF THE SERVICE REQUESTED.
PC39	PLEASE INDICATE LITER FLOW PER MINUTE, HOURS OF USE PER 24 HOUR PERIOD, AND THE EXPECTED DURATION OF NEED.
PC40	THE ITEM DOES NOT REQUIRE PRIOR AUTHORIZATION UNTIL THE LIFE EXPECTANCY HAS BEEN REACHED.
PC41	PLEASE SUPPLY INFORMATION INDICATING THE NECESSITY OF POSITIONING THE CLIENT'S BODY IN MULTIPLE POSITIONS.
PC42	PLEASE INDICATE IF THE BED HEIGHT MUST BE CHANGED TO ALLOW FOR SAFE TRANSFER OR ADEQUATE BED CARE.
PC43	SUPPLY A PHYSICIANS STATEMENT INDICATING TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR UNIT HAS REDUCED PAIN, IMPROVED/INCREASED THE CLIENTS ACTIVITY LEVEL, AND/OR REDUCED CLIENTS USE OF PAIN MEDICATION.
PC44	A CURRENT AUTHORIZATION FOR THIS SERVICE IS ON FILE FOR ANOTHER PROVIDER. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT OF THAT FACT IS REQUIRED BY THE CLIENT OF FIRST PROVIDER.
PC59	DOCUMENT DECLINE OR PROGRESS IN SPECIFIC, MEASURABLE, OBJECTIVE TERMS.
PC60	DOCUMENT IF CLIENT HAS DEMONSTRATED A GOOD APPOINTMENT COMPLIANCE RECORD.
PC61	THE PHYSICIANS SIGNATURE DATE MUST NOT EXCEED 90 DAYS FROM THE DATE OF RECEIPT BY COLORADO MEDICAID.
PC62	REQUESTS FOR A CONTINUATION OF THERAPY SHOULD NOT BE SUBMITTED MORE THAN FOUR WEEKS PRIOR TO THE EXPIRATION DATE OF THE CURRENT AUTHORIZATION.
PC63	PLEASE FURNISH THE STYLE AND MANUFACTURER OF THE FRAME.
PC64	PLEASE FURNISH THE CLIENTS LENS FORMULA.
PC66	ALL REQUESTS FOR TINTS REQUIRE DOCUMENTATION OF THE VISUAL OR MEDICAL CONDITION RELATED TO PHOTOPHOBIA.
PC67	PLEASE DOCUMENT THE REASON AND JUSTIFICATION FOR REPLACEMENT BEYOND THE FIRST LENS/FRAME.
PC68	DOCUMENT IF ALL REMAINING MAXILLARY AND/OR MANDIBULAR TEETH ARE DECAY-FREE, PROPERLY RESTORED, AND PERIODONTICALLY SOUND.
PC72	SUPPLY MORE DETAIL REGARDING PROGRESS (ATTACHMENT OF GOALS, ETC.). CORRELATE PROGRESS TO PREVIOUS GOALS AND IDENTIFIED LIMITATIONS.
PC77	PLEASE SUBMIT A PLAN OF CARE DESCRIBING THE SERVICES THAT WOULD BE PROVIDED.
PC78	PLEASE DOCUMENT SPECIFIC, MEASURABLE GOALS.
PC82	THE PRIOR AUTHORIZATION (PA) SYSTEM CAN PROCESS ONLY 26 DETAILS PER PA REQUEST. PLEASE RESUBMIT YOUR REQUEST WITH NO MORE THAN 26 DETAILS.
PC83	PLEASE SUPPLY A PHYSICIANS PRESCRIPTION DATED WITHIN ONE MONTH OF REQUESTED SUBSTANCE ABUSE DAY TREATMENT.
PC84	PLEASE PROVIDE INFORMATION INDICATING THIS CLIENT IS APPROPRIATELY DETOXIFIED FROM ALCOHOL AND/OR OTHER DRUGS.
PC85	PLEASE PROVIDE INFORMATION TO INDICATE THE CLIENTS ABILITY TO ABSTAIN FROM ALCOHOL OR DRUGS WHILE IN THE SUBSTANCE ABUSE DAY TREATMENT PROGRAM.

Denial Code	Long Description
PC86	PLEASE INDICATE IF THIS CLIENT IS WILLING TO PARTICIPATE IN AFTERCARE OR CONTINUING CARE SERVICES.
PC87	PROVIDE MORE INFORMATION ON TREATMENT HISTORY; INCLUDE SERVICE PROVIDED, DATES, AND OUTCOME. PROVIDE DETAIL OF PREVIOUS TREATMENT.
PC88	PLEASE PROVIDE MORE RATIONALE FOR THE APPROPRIATENESS AND MEDICAL NECESSITY OF SUBSTANCE ABUSE DAY TREATMENT.
PC89	PROVIDE A TREATMENT PLAN THAT CONTAINS MEASURABLE GOALS AND OBJECTIVES CORRESPONDING TO THE IDENTIFIED DEFICIT.
PC91	PLEASE PROVIDE MORE INFORMATION ON FAMILY INVOLVEMENT TREATMENT.
PC92	PLEASE PROVIDE MORE HISTORY AND EXPLANATION ABOUT THE ISSUE OF ABSTINENCE FOR THIS CLIENT.
PC94	PLEASE PROVIDE THE ANTICIPATED BEGINNING DATE AND/OR THE ESTIMATED SUBSTANCE ABUSE DAY TREATMENT DISCHARGE DATE.
PC95	PLEASE SUPPLY JUSTIFICATION FOR BEGINNING CLIENT IN SERVICE PRIOR TO AUTHORIZATION BEING OBTAINED.
PC96	THE INITIAL THREE HOURS OF SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IN A CALENDAR YEAR DO NOT REQUIRE PRIOR AUTHORIZATION.
PC97	REIMBURSEMENT FOR INITIAL SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IS LIMITED TO THREE HOURS IN A CALENDAR YEAR AND DOES NOT REQUIRE PRIOR AUTHORIZATION.
PC98	THIS DRUG IS CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE BILL USING THE APPROPRIATE NATIONAL DRUG CODE (NDC) OR SUBMIT A COMPLETED DRUG ADDITION REQUEST FORM IF THE NDC IS NOT LISTED IN THE DRUG INDEX.
PC99	THIS DRUG IS NOT CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL, CURRENT ADMINISTRATIVE RULE, OR COLORADO DRUG INDEX FOR COVERAGE LIMITATIONS.
PD01	DOCUMENT THAT CLIENT HAS ACHIEVED GOOD ORAL HYGIENE, PERIODONTAL CASE TYPE 1 OR 2, AND IS MOTIVATED TO MAINTAIN SAME.
PD03	PLEASE PROVIDE AN ARTERIAL BLOOD GAS READING OR PULSE OXIMETRY RESULTS DONE ON ROOM AIR SIGNED AND DATED BY A MEDICAL DOCTOR. THIS SHOULD BE DONE WITHIN 60 DAYS OF REQUESTED SERVICE.
PD04	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 30 DAYS OF RECEIPT BY COLORADO MEDICAID.
PD07	SUBMIT A PHOTOCOPY OF A VALID PRESCRIPTION, ISSUED WITHIN THE PAST YEAR, OR COMPLETE SECTION B OF THE PRIOR AUTHORIZATION/DRUG ATTACHMENT (PA/DGA), F-11049.
PD10	BRAND MEDICALLY NECESSARY MUST BE IN THE PRESCRIBERS OWN HANDWRITING AND WRITTEN DIRECTLY ON THE PRESCRIPTION OR A SEPARATE ORDER ATTACHED TO THE ORIGINAL PRESCRIPTION.
PD12	COMPLETE DENTURES, PARTIAL DENTURES, DENTURE RELINES, AND FIXED PROSTHODONTIC SERVICES ARE NOT COVERED SERVICES FOR ADULTS FOR DATES OF SERVICE ON AND AFTER OCTOBER 1, 1995.
PD22	PLEASE COMPLETE ALL REQUIRED ELEMENTS ON THE PERSONAL CARE SCREENING TOOL (PCST), F-11133.
PD24	THIS PRIOR AUTHORIZATION REQUEST IS UNABLE TO BE PROCESSED. PLEASE RESUBMIT WITH ADDITIONAL REQUIRED FORMS, INCLUDING THE ENTIRE PERSONAL CARE SCREENING TOOL (PCST), F-11133; PERSONAL CARE ADDENDUM, F-11136; AND SUPPORTING DOCUMENTATION, AS DIRECTED.
PD25	THERE IS A PERSONAL CARE SCREENING TOOL (PCST), F-11133, COMPLETED BY ANOTHER AGENCY. CONTACT THE AGENCY TO TRANSFER SCREEN.
PD26	THERE IS A LIMITED TERM CARE FUNCTIONAL SCREEN (LTC-FS) COMPLETED BY ANOTHER AGENCY. THE PERSONAL CARE SCREENING TOOL (PCST), F-11133, INFORMATION IS IN CONFLICT WITH LTC-FS.
PD27	ONLY ONE LEVEL OF FUNCTION MAY BE SELECTED FOR ALL ELEMENTS EXCEPT TOILETING. COLORADO MEDICAID IS UNABLE TO PROCESS THE PRIOR AUTHORIZATION REQUEST.
PD28	NO UNITS MAY BE REQUESTED USING THIS PRIOR AUTHORIZATION PROCESS. PLEASE SUBMIT WITH THE APPROPRIATE ATTACHMENTS FOR REQUESTING SPECIFIC PERSONAL CARE WORKER UNITS.
PD29	CLIENT IS NOT ELIGIBLE FOR THE REQUESTED SERVICE(S) AS OF THE REQUESTED START DATE.
PD30	NO TRAVEL TIME MAY BE AUTHORIZED WHEN NO PERSONAL CARE WORKER SERVICE IS AUTHORIZED.
PD32	PROVIDER NOT CERTIFIED TO RENDER THE SERVICE(S) REQUESTED.

Denial Code	Long Description
PD34	BASED ON THE DOCUMENTATION SUBMITTED, THIS REQUEST CAN NOT BE PRIOR AUTHORIZED. REFER TO THE PA MESSAGES FROM THE CONSULTANT FOR COMPLETE EXPLANATION.
PD98	PLEASE DOCUMENT HOW AND WHEN EACH PREVIOUSLY AUTHORIZED PRO RE NATA VISIT WAS USED.

Physician

Denial Code	Long Description
0201	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
0233	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0235	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0237	CLIENT IDENTIFICATION NUMBER DOES NOT MATCH CLIENTS FIRST NAME.
0238	THE CLIENT IDENTIFICATION NUMBER DOES NOT MATCH THE CLIENTS LAST NAME.
0242	SECONDARY DIAGNOSIS CODE IS INVALID.
0248	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0249	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0251	PROCEDURE CODE MODIFIER IN FIRST POSITION IS INVALID.
0252	THE PROCEDURE CODE MODIFIER IN SECOND POSITION IS INVALID FOR REQUESTED START DATE OR DATE OF RECEIPT.
0253	THE PROCEDURE CODE MODIFIER IN THIRD POSITION IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
0258	THE PRIMARY DIAGNOSIS CODE IS REQUIRED.
0272	THE PRIMARY DIAGNSOSIS CODE IS INVALID.
0400	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0853	HCPCS - ANNUAL UPDATE
0885	NEVER EVENTS MODIFIERS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
0886	NEVER EVENTS DIAGNOSIS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
1000	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
1002	RENDERING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1003	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1007	RENDERING PROVIDER ID IS NOT ON FILE.
1047	THE RENDERING PROVIDERS CERTIFICATION HAS BEEN CANCELLED.
1048	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1801	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
1804	A CERTIFIED SUBSTANCE ABUSE DAY TREATMENT PROVIDER MUST SUBMIT A SUBSTANCE ABUSE DAY TREATMENT PROCEDURE CODE.
1806	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
1808	THE BILLING PROVIDER DOES NOT HAVE THE REQUIRED CERTIFICATION ADDENDUM ON FILE.
1900	THE BILLING PROVIDERS TAXONOMY CODE IS INVALID.
1901	THE RENDERING PROVIDERS TAXONOMY CODE IS INVALID.
1927	A NATIONAL PROVIDER IDENTIFIER IS REQUIRED FOR THE BILLING PROVIDER.
1934	A NATIONAL PROVIDER INDENTIFIER IS REQUIRED FOR THE RENDERING PROVIDER.
1936	THE BILLING PROVIDER NUMBER IS INVALID.
1937	THE RENDERING PROVIDER NUMBER IS INVALID.
1960	INTERNAL PROCESSING IS REQUIRED.
1963	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.
1964	THE BILLING PROVIDER INDICATED IS NOT ALLOWABLE AS A BILLING PROVIDER.

Denial Code	Long Description
1965	RENDERING PROVIDER NUMBER IS MISSING/INVALID FOR THIS PROCEDURE PROVIDER.
1974	PRESCRIBING/REFERRING/ORDERING PROVIDER INDICATED IS NOT CERTIFIED AS A PRESCRIBING/REFERRING/ORDERING PROVIDER.
1975	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
1976	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
2001	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2003	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2017	THE CLIENT IS ENROLLED IN A MEDICAID OR OTHER MANAGED CARE PROGRAM.
2037	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2603	CLIENT LOCKED-IN TO A PROVIDER OR ENROLLED IN A HOSPICE. CONTACT CLIENTS HOSPICE FOR PAYMENT OF SERVICES OR RESUBMIT WITH DOCUMENTATION OF UNRELATED NATURE OF CARE.
3324	THE MODIFIER HAS BEEN DISCONTINUED BY THE CENTERS OF MEDICARE AND MEDICAID SERVICES OR THE AMERICAN MEDICAL ASSOCIATION FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
3337	THE PROCEDURE CODE HAS BEEN TERMINATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AMERICAN MEDICAL ASSOCIATION, OR AMERICAN DENTAL ASSOCIATION FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT. RESUBMIT WITH VALID A PROCEDURE CODE.
3339	THE PROCEDURE BILLED IS NOT PAYABLE ACCORDING TO DEFICIT REDUCTION ACT (DEFRA) GUIDELINES.
3351	THE PROCEDURE IS NOT COVERED FOR CLIENTS WITH A NURSING HOME AUTHORIZATION ON THE REQUESTED START DATE OR DATE OF RECEIPT.
3353	THE PROCEDURE IS NOT A COVERED SERVICE FOR HOME AND COMMUNITY-BASED WAIVER CLIENTS.
4021	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4027	THE DIAGNOSIS CODE IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
4031	THE PROCEDURE SUBMITTED IS NOT APPROPRIATE FOR CLIENTS GENDER.
4032	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4034	THE PROCEDURE CODE HAS AN AGE RESTRICTION.
4036	THE PLACE OF SERVICE CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4040	THE PRIMARY DIAGNOSIS CODE IS NOT ON FILE.
4041	THE SECONDARY DIAGNOSIS IS NOT ON FILE.
4046	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4127	INTERNAL PROCESSING IS REQUIRED.
4131	INTERNAL PROCESSING IS REQUIRED.
4141	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4149	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4150	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4236	ETIOLOGY DIAGNOSIS CODE(S) (E-CODES) ARE INVALID AS THE PRIMARY DIAGNOSIS.
4244	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4245	THE FOURTH POSITION MODIFIER IS INVALID FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT.
4256	THE PROCEDURE CODE AND MODIFIER COMBINATION IS NOT PAYABLE FOR THE CLIENTS BENEFIT PLAN.
4257	THE MODIFIERS SUBMITTED ARE EITHER INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT OR THE MODIFIERS ARE MISSING.
4311	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4315	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4316	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4371	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4372	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4711	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR CLIENTS AGE.
4714	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS AGE.
4731	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS DIAGNOSIS.
4742	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4743	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4744	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.

Denial Code	Long Description
4745	DIAGNOSIS AND/OR PROCEDURE AND/OR PLACE OF SERVICE (POS) CODE IS NOT COVERED FOR EXPRESS ENROLLMENT CLIENTS.
4746	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4801	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4802	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
4821	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
4871	PLEASE REFER TO PA MESSAGES FOR RETURN INFORMATION.
4963	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS GENDER.
4990	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
7500	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
7509	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
P001	THE BILLING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THE SERVICES.
P002	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P003	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P005	THE PRIOR AUTHORIZATION CAN NOT BE END DATED. THE PRIOR AUTHORIZATION STATUS IS NOT APPROVED OR APPROVED WITH REVISIONS.
P006	PLEASE FURNISH THE PROCEDURE CODE AND CORRESPONDING DESCRIPTION.
P008	THE BILLING PROVIDER NUMBER IS INVALID.
P009	THE BILLING PROVIDER NUMBER IS INVALID.
P010	THE REQUESTED END DATE IS INVALID.
P011	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P012	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P013	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P014	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P015	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P016	THE REQUESTED START DATE IS MISSING OR INVALID.
P019	THE REQUESTED START DATE IS MISSING OR INVALID.
P020	THE RENDERING PROVIDER NUMBER IS INVALID.
P021	THE RENDERING PROVIDER NUMBER IS INVALID.
P022	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P023	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P024	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P026	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P027	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P030	FIRST MODIFIER IS INVALID.
P031	FIRST MODIFIER IS INVALID.
P032	SECOND MODIFIER IS INVALID.
P033	SECOND MODIFIER IS INVALID.
P034	THIRD MODIFIER IS INVALID.
P035	THIRD MODIFIER IS INVALID.
P036	FOURTH MODIFIER IS INVALID.
P037	FOURTH MODIFIER IS INVALID.
P038	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P039	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.

Denial Code	Long Description
P040	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P041	CLIENTS FIRST NAME IS MISSING.
P042	CLIENTS LAST NAME IS MISSING.
P043	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P044	BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES REQUESTED.
P045	FIRST MODIFIER IS INVALID.
P046	SECOND MODIFIER IS INVALID.
P047	THIRD MODIFIER IS INVALID.
P048	FOURTH MODIFIER IS INVALID.
P052	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P053	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P054	RENDERING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES FOR THE BENEFIT PLAN.
P055	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P061	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P062	THE CLIENT ID AND/OR NAME INDICATED ON THE PA REQUEST IS INCORRECT. THE CLIENT ID AND/OR NAME HAS BEEN UPDATED. PLEASE VERIFY THE ID AND/OR NAME IS CORRECT.
P064	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
P067	THE FREQUENCY OF HOURS REQUESTED ARE NOT APPROPRIATE FOR THIS CLIENT AND HAVE BEEN MODIFIED ACCORDINGLY.
P079	BILLING PROVIDER IS ON PAYMENT SUSPENSION DUE TO CREDIBLE ALLEGATION OF FRAUD.
P120	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAS BEEN REDUCED.
P121	THE SERVICE/ PROCEDURE REQUESTED IS NOT SUPPORTED BY SUBMITTED DOCUMENTATION.
P126	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
P128	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.
P138	SERVICE(S) DO NOT MEET COLORADO MEDICAID GUIDELINES.
P167	REQUESTED DOCUMENTATION HAS NOT BEEN SUBMITTED.
P178	THE SERVICE REQUESTED IS NOT MEDICALLY NECESSARY.
P179	THE MEDICAL NECESSITY FOR THIS SERVICE IS NOT SUPPORTED BY THE SUBMITTED DOCUMENTATION.
P233	THE DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE ADDITIONAL CARE.
P257	THIS CLIENTS FUNCTIONAL ASSESSMENT SCORES PLACE THIS CLIENT OUTSIDE ELIGIBILITY FOR DAY TREATMENT.
P274	OUR RECORDS INDICATE THIS CLIENT IS INVOLVED IN EFFECTIVE AND APPROPRIATE SERVICE ELSEWHERE.
P292	INTENSIVE REHABILITATION HOURS ARE NO LONGER APPROPRIATE AS INDICATED BY HISTORY, DIAGNOSIS, AND/ OR FUNCTIONAL ASSESSMENT SCORES.
P328	THE SERVICES REQUESTED INCLUDE NON-COVERED SERVICES, AND HOURS ARE REDUCED ACCORDINGLY.
P339	THE CLIENTS PAST HISTORY INDICATES REDUCED TREATMENT HOURS ARE WARRANTED.
P342	THE REQUEST DOES NOT MEET GENERALLY ACCEPTED CONDITIONS REQUIRING FLUORIDE TREATMENTS.
P346	SERVICES EXCEED COLORADO MEDICAID LIMITATION AND DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE MEDICAL NECESSITY OF THE SERVICE.
P349	THE SERVICE REQUESTED WAS PERFORMED LESS THAN FIVE YEARS AGO.
P353	THE EXISTING APPLIANCE HAS NOT BEEN WORN FOR THREE YEARS.
P367	THE CLIENT HAS BEEN TOTALLY WITHOUT TEETH AND AN APPLIANCE FOR FIVE YEARS.
P392	THE CLIENT IS MISSING AN ANTERIOR TOOTH AND/OR HAS TWO OR MORE POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P405	THE SERVICE(S) REQUESTED COULD ADEQUATELY BE PERFORMED IN THE DENTAL OFFICE.
P406	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE OF GOOD PERIODONTAL HEALTH (AMERICAN ACADEMY OF PERIODONTOLOGY PERIODONTAL CLASSIFICATION OF TYPE I OR II).
P407	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE VISIBLE ON RADIOGRAPHS THAT AT LEAST 50 PERCENT OF THE CLINICAL CROWN IS INTACT.

Denial Code	Long Description
P409	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING SIX OR MORE TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED, INCLUDING THIRD MOLARS.
P410	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING ONE OR MORE ANTERIOR TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED.
P411	DOCUMENTATION DOES NOT SUPPORT THE NEED FOR PERIODONTIC SERVICES. POCKETS ARE LESS THAN 4MM AND/OR GREATER THAN 6MM FOR CLIENT AND/OR THE CLIENT IS UNDER THE AGE OF 13.
P412	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA.
P413	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA. THIS PA HAS BEEN GRANTED AS APPROVED NOT APPROVED WITH REVISIONS. THE DURATION REQUESTED MAY HAVE BEEN REDUCED TO REFLECT COVERAGE LIMITATIONS, PRESCRIBER ORDERS, CONFLICTI
P417	THE SERVICE(S) REQUESTED COULD BE ADEQUATELY PERFORMED WITH LOCAL ANESTHESIA.
P437	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO POOR ORAL HYGIENE.
P444	THIS LINE ITEM IS A DUPLICATE OF ANOTHER LINE ITEM ON THIS PRIOR AUTHORIZATION (PA) REQUEST. PLEASE CORRECT.
P446	THIS IS A DUPLICATE OF AN EXISTING PRIOR AUTHORIZATION (PA) REQUEST. YOU MAY CONTACT PROVIDER SERVICES IF YOU REQUIRE ASSISTANCE. DUPLICATE PA REQUEST
P448	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO DECAY HISTORY.
P449	QUESTIONABLE LONG TERM PROGNOSIS DUE TO GUM AND BONE DISEASE.
P456	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO APPARENT ROOT INFECTION.
P457	OUR RECORDS INDICATE THIS CLIENT HAS EXCEEDED ESTABLISHED PROGRAM LIMITATIONS. COLORADO MEDICAID WILL NOT AUTHORIZE NEW DENTURES.
P458	DOCUMENTATION PROVIDED INDICATES A LESS ELABORATE PROCEDURE SHOULD BE CONSIDERED.
P502	RENTAL ONLY ALLOWED; MEDICAL NEED FOR PURCHASE HAS NOT BEEN DOCUMENTED.
P503	PURCHASE ONLY ALLOWED; MEDICAL NEED FOR RENTAL HAS NOT BEEN DOCUMENTED.
P504	OCCUPATIONAL THERAPY GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P505	THE SERVICE REQUESTED IS INCLUDED IN THE NURSING HOME RATE STRUCTURE.
P511	THIS NATIONAL DRUG CODE IS ONLY BILLABLE AS PART OF A COMPOUND DRUG.
P515	THE PRESENCE OF A HANDICAPPING MALOCCLUSION OR HANDICAPPING DENTOFACIAL DEFORMITY IS NOT SUPPORTED BY THE DOCUMENTATION SUBMITTED.
P521	THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVERED BY COLORADO MEDICAID.
P522	GASTRO-INTESTINAL SURGERY FOR THE PURPOSE OF WEIGHT CONTROL IS COVERED ONLY AS A LIFE THREATENING PROCEDURE.
P523	THE TREATMENT REQUEST IS NOT CONSISTENT WITH THE CLIENT'S DIAGNOSIS.
P524	PSYCHOTHERAPY PROVIDED IN THE CLIENTS HOME IS NOT A COVERED BENEFIT OF COLORADO MEDICAID.
P525	THE INFORMATION PROVIDED IS NOT CONSISTENT WITH THE INTENSITY OF SERVICES REQUESTED.
P526	INTENSIVE MULTIPLE MODALITY TREATMENT IS NOT CONSISTENT WITH THE INFORMATION PROVIDED.
P527	MULTIPLE PROVIDERS OF TREATMENT ARE NOT INDICATED FOR THIS CLIENT.
P528	THE DURATION OF TREATMENT SESSIONS EXCEED CURRENT COLORADO MEDICAID GUIDELINES.
P534	DOCUMENTATION OF POOR PHYSICAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P535	OTHER PHYSICAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P536	THE PHYSICAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P537	USE OF PHYSICAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P538	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF A PHYSICAL THERAPIST.
P539	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS AND LIVING ARRANGEMENT.
P540	GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P541	THE PROCEDURE(S) REQUESTED ARE NOT MEDICAL IN NATURE.

Denial Code	Long Description
P542	DOCUMENTATION OF POOR OCCUPATIONAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P543	DOCUMENTATION OF POOR SPEECH THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P544	OTHER OCCUPATIONAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P546	THE OCCUPATIONAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P547	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF PHYSICAL THERAPY.
P548	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P549	ACTIVITIES TO PROMOTE DIVERSION OR GENERAL MOTIVATION ARE NONCOVERED COLORADO MEDICAID SERVICES.
P550	REVISIONS OF THE REQUEST IS NECESSITATED BY THE CLIENTS MINIMAL PROGRESS.
P551	RESTORATIVE NURSING INVOLVEMENT COULD BE INCREASED.
P552	CLIENTS DEMONSTRATED RESPONSE TO CURRENT THERAPY DOES NOT WARRANT THE INTENSE FREQUENCY REQUESTED.
P553	MAINTENANCE IS TWO TIMES PER WEEK OR LESS.
P554	THE SPEECH THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P555	USE OF OCCUPATIONAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P556	USE OF SPEECH THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P557	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF AN OCCUPATIONAL THERAPIST.
P558	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
P559	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P560	THE MATERIALS/ SERVICES REQUESTED ARE PRINCIPALLY COSMETIC IN NATURE.
P561	THE LENS FORMULA DOES NOT JUSTIFY REPLACEMENT.
P562	THE CHANGE IN THE LENS FORMULA DOES NOT WARRANT MULTIPLE REPLACEMENTS.
P563	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P564	LENSES ONLY ARE APPROVED; PLEASE DISPENSE A CONTRACTED FRAME. THE NON-CONTRACTED FRAME IS NOT MEDICALLY JUSTIFIED.
P565	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P566	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P567	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF OCCUPATIONAL THERAPY.
P568	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF SPEECH THERAPY.
P569	LEVEL, INTENSITY, OR EXTENT OF SERVICE(S) REQUESTED HAS BEEN MODIFIED CONSISTENT WITH MEDICAL NEED AS DEFINED IN THE PLAN OF CARE.
P570	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P571	THE SERVICE ASKED FOR IS NOT COVERED BY COLORADO MEDICAID AS THESE TASKS CAN BE DONE BY NURSES OR ACTIVITY STAFF.
P572	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P573	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.
P574	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P575	MEDICAL NEED FOR EQUIPMENT/ SUPPLY REQUESTED IS NOT SUPPORTED BY DOCUMENTATION SUBMITTED.
P576	OTHER SPEECH THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.

Denial Code	Long Description
P577	DOCUMENTATION SUBMITTED IDENTIFIES THAT THE CLIENT HAS FEWER THAN TWO POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P582	LESS EXPENSIVE ALTERNATIVE SERVICES ARE AVAILABLE FOR THIS CLIENT.
P634	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P711	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING PERIODONTAL SCALING AND ROOT PLANNING.
P712	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING GINGIVECTOMY.
P754	AN APPROVED SUBSTANCE ABUSE DAY TREATMENT PROGRAM CANNOT EXCEED A SIX WEEK PERIOD.
P761	THE CLIENT DOES NOT APPEAR TO BE ABLE OR WILLING TO ABSTAIN FROM ALCOHOL/DRUG USAGE WHILE IN TREATMENT. THEREFORE, SUBSTANCE ABUSE DAY TREATMENT SERVICES ARE NOT APPROVED.
P764	THIS CLIENT HAS COMPLETED INTENSIVE SUBSTANCE ABUSE TREATMENT WITHIN THE PAST 12 MONTHS. THE DOCUMENTATION PROVIDED IS NOT ADEQUATE TO JUSTIFY ADDITIONAL INTENSIVE TREATMENT AT THIS TIME.
P785	A LESS THAN SIX-WEEK HEALING PERIOD HAS BEEN SPECIFIED FOR THIS PRIOR AUTHORIZATION. THEREFORE IT IS NOT NECESSARY TO WAIT THE FULL SIX WEEKS AFTER EXTRACTIONS BEFORE TAKING DENTURE IMPRESSIONS.
P818	SIX-WEEK HEALING TIME IS REQUIRED BETWEEN EDENTULATION AND FINAL IMPRESSIONS. PAYMENT FOR DENTURES WILL BE DENIED OR RECOUPED IF HEALING PERIOD IS NOT OBSERVED.
P849	COLORADO MEDICAID HAS DETERMINED THERE WERE (ARE) SEVERAL HOME HEALTH AGENCIES WILLING TO PROVIDE MEDICALLY NECESSARY SKILLED NURSING SERVICES TO THIS CLIENT.
P864	THE DOCUMENTATION YOU HAVE SUBMITTED DOES NOT MEET THE REQUIREMENTS OF COLORADO MEDICAID.
P873	THE MEDICAL NECESSITY FOR THE HOURS REQUESTED IS NOT SUPPORTED BY THE INFORMATION SUBMITTED.
P874	THE DOCUMENTATION SUBMITTED INDICATES THE TASKS SPECIFIED CAN BE COMPLETED DURING THE VISITS APPROVED.
P878	THE DOCUMENTATION SUBMITTED DOES NOT INDICATE THAT MEDICALLY ORIENTED TASKS ARE MEDICALLY NECESSARY; THEREFORE PERSONAL CARE SERVICES HAVE BEEN APPROVED.
P880	THE QUANTITY OF SERVICES AUTHORIZED FOR THIS CLIENTS PERSONAL CARE HAS BEEN AMENDED BASED ON INFORMATION RECEIVED FROM ONE OR MORE OF THESE SOURCES: THE CLIENT, THEIR PHYSICIAN, AND/OR THE IN-HOME VISIT BY STAFF OF THE OIG (OFFICE OF INSPECTOR GENERAL).
P885	THE USE OF THIS DRUG FOR THE INTENDED PURPOSE IS NOT COVERED BY COLORADO MEDICAID, CONSISTENT WITH COLORADO ADMINISTRATIVE CODE AND FEDERAL LAW.
P924	THE MEDICAL RECORDS SUBMITTED WITH THE CURRENT REQUEST CONFLICT OR DISAGREE WITH OUR MEDICAL RECORDS ON THIS CLIENT.
P950	INDEPENDENT NURSES, PLEASE NOTE PAYABLE SERVICES MAY NOT EXCEED 12 HOURS/DAY OR 60 HOURS/WEEK.
P951	SERVICES CAN ONLY BE AUTHORIZED THROUGH ONE YEAR FROM THE PRESCRIPTION DATE.
P952	LEAD INSPECTION IS A COVERED COLORADO MEDICAID SERVICE WHEN THE CHILD HAS BEEN SHOWN TO HAVE LEAD POISONING (E.G., CHILD HAS A BLOOD LEAD LEVEL > 19 UG/DL OR TWO CONSECUTIVE BLOOD LEAD LEVELS OF 15-19 UG/DL DONE AT LEAST 90 DAYS APART). THE INSPECTION MUS
P953	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P954	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P956	THE REQUEST CAN ONLY BE BACKDATED A MAXIMUM OF 14 DAYS FROM FIRST DATE RECEIVED BY COLORADO MEDICAID.
P957	COMPLETE PERIODONTAL CHARTING AT TIME OF SERVICE, AND SUBMIT CHARTING, COPY OF OPERATIVE REPORT, TOGETHER WITH A COPY OF THE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF), F-11035, TO PA UNIT ATTENTION DENTAL CONTSULTANT.
P958	NOTE THAT CODE D4341 HAS BEEN CHANGED. REFER TO THE DECISION NOTICE FOR AUTHORIZED QUANTITY.

Denial Code	Long Description
P960	YOUR PA HAS BEEN APPROVED FOR 90 DAYS. THE 90 DAY APPROVAL DOES NOT IMPLY THE PA REQUEST MEETS PRIOR AUTHORIZATION CRITERIA. AFTER ADDITIONAL INFORMATION IS AVAILABLE IN INTERCHANGE, COLORADO MEDICAID WILL CREATE AN AMENDMENT REQUEST TO EXTEND THE PA FOR
P961	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P962	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
PA10	THE REQUESTED END DATE IS INVALID.
PA12	PLEASE FURNISH A WRITTEN DESCRIPTION OF THE CLIENTS DIAGNOSIS.
PA13	PROVIDE DIAGNOSES WITH DATES OF ONSET.
PA14	IDENTIFY PROBLEMS TO BE TREATED.
PA15	THE AUDIOLOGISTS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1), F-11020, AND PRIOR AUTHORIZATION REQUEST/HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2), F-11021.
PA16	THE PHYSICIANS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION/PHYSICIAN OTOLOGICAL REPORT (PA/POR), F-11019.
PA17	SUBMIT BRIEF HISTORY WITH REFERRAL INFORMATION, LIVING SITUATION, FUNCTIONAL STATUS, AND OTHER PERTINENT INFORMATION. WHAT CHANGE OF STATUS RESULTED IN REFERRAL AT THIS TIME?
PA18	PLEASE FURNISH THE CLIENTS HEIGHT AND WEIGHT.
PA19	PLEASE SUBMIT CLINICAL INFORMATION SUFFICIENT TO VERIFY THE NEED FOR THE REQUESTED SERVICE(S).
PA20	PLEASE RESUBMIT WITH COMPLETE PERIODONTAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PA21	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL EDUCATIONAL PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA22	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL PROGRAM PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA23	REFER TO THE DURABLE MEDICAL EQUIPMENT INDEX FOR APPROPRIATE CODE AND DESCRIPTION. DO NOT USE AN "UNLISTED" CODE.
PA24	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUALIZED FAMILY SERVICE PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA25	INFORMATION ON THE REQUEST FORM IS ILLEGIBLE, AND THE REQUEST CANNOT BE PROCESSED.
PA26	RE-EVALUATE YOUR GOALS. EMPHASIS SHOULD BE ON FUNCTIONAL SELF-CARE. GOALS MUST BE RELATED TO FUNCTIONAL OUTCOME.
PA27	PLEASE CLARIFY THE NUMBER OF HOURS PER WEEK REQUESTED.
PA28	PLEASE CLARIFY THE NUMBER OF HOURS PER DAY REQUESTED.
PA29	PLEASE CLARIFY THE NUMBER OF VISITS PER DAY REQUESTED.
PA30	ATTACH SUPPORTIVE DOCUMENTATION; HOME EXERCISE PROGRAM AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA31	THE DIAGNOSIS CODE INDICATED ON THE REQUEST DOES NOT CORRESPOND TO THE DIAGNOSIS CODE DESCRIPTION.
PA32	PLEASE SUBMIT ADDITIONAL INFORMATION SUFFICIENT TO VERIFY APPROPRIATENESS AND NEED FOR TRANSPLANT.
PA33	PLEASE SUBMIT THE INITIAL AND PROGRESSIVE OBJECTIVE FINDINGS.
PA34	ATTACH SUPPORTIVE DOCUMENTATION, FACILITY PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA35	PLEASE SUBMIT THE CLIENTS ORIGINAL COMPLAINTS AND EXAMINATION FINDINGS.
PA36	ATTACH SUPPORTIVE DOCUMENTATION, IN-HOME AUTISM PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA37	PLEASE SUBMIT YOUR TREATMENT PLAN FOR THIS CLIENT.
PA38	ATTACH SUPPORTIVE DOCUMENTATION AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.

Denial Code	Long Description
PA39	INITIAL EVALUATIONS MUST BE PERFORMED BY AN OCCUPATIONAL THERAPIST REGISTERED (OTR), PER AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA) STANDARDS.
PA41	IDENTIFY THE PLACE OF SERVICE AND ITS EFFECT ON SUPPORTING THE DESIRED TREATMENT OUTCOME.
PA42	PLEASE INDICATE THE HOURS OF USE OF OXYGEN PER 24-HOUR PERIOD.
PA43	PROVIDE BASELINE DOCUMENTATION FOR THIS CLIENTS LIMITATIONS USING UNITS OF MEASUREMENT THAT ARE APPLIED CONSISTENTLY WHEN REPORTING STATUS.
PA44	IDENTIFY FUNCTIONAL LIMITATIONS AS THEY ARE RELATED TO IDENTIFIED CONDITIONS.
PA46	CORRELATE PLAN OF CARE TO REQUESTED PROCEDURE CODES.
PA47	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE FREQUENCY/DURATION REQUESTED.
PA48	PLEASE PROVIDE THE NAME AND CREDENTIALS OF THE RENDERING PROVIDER.
PA50	COLORADO MEDICAID RECORDS INDICATE THE CLIENT OWNS A WHEELCHAIR. DOCUMENT THE REASON AND NEED FOR REPLACEMENT AND COST TO REPAIR CURRENT WHEELCHAIR.
PA51	PLEASE DISTINGUISH PRIMARY AND SUPPORTIVE MODALITIES.
PA52	PLEASE SUBMIT A PROGRESS REPORT.
PA53	MULTIPLE FAMILY CLIENTS TREATMENT BY THE SAME PROVIDER REQUIRES FURTHER INFORMATION DOCUMENTING COORDINATION OF TREATMENT PLAN.
PA54	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE MINUTES REQUESTED.
PA55	MEDICAL NECESSITY OF TREATMENT REQUIRES ADDITIONAL DOCUMENTATION.
PA56	GIVEN AGE, DIAGNOSES, CURRENT LEVEL OF FUNCTION, PAST RESPONSE TO TREATMENT, AND LIVING SITUATION, EXPAND ON POTENTIAL FOR SIGNIFICANT FUNCTIONAL PROGRESS WITHIN THE NEXT SIX MONTHS. EMPHASIZE WHY PROGRESS IS EXPECTED WITH SERVICES AT THIS TIME.
PA57	SUBMIT THE INITIAL FINDINGS. INCLUDE A COMPREHENSIVE EVALUATION.
PA58	SUBMIT PROGRESSIVE, OBJECTIVE FINDINGS. INCLUDE A PERTINENT RE-EVALUATION.
PA59	PLEASE SUPPLY INFORMATION REGARDING THE CLIENTS MEDICATION REQUIREMENTS, IF ANY.
PA60	PLEASE SPECIFY IF THE CLIENT IS IN AN EDUCATIONAL SETTING.
PA61	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA62	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
PA63	THE SKILLS OF A THERAPIST ARE PURPOSEFUL AND SKILLED INTERVENTIONS REQUIRED TO CONTINUALLY DESIGN, IMPLEMENT, REASSESS, MODIFY/GRADE, AND/OR DISCONTINUE A PLAN OF CARE IN A TIMELY MANNER, BASED ON THE COMPLEXITY OF THE CLIENTS MEDICAL CONDITION AND/OR CO
PA64	PLEASE SUBMIT A THERAPY PLAN OF CARE, INCLUDING A CURRENT, DATED EVALUATION.
PA65	A PLAN OF CARE SIGNED AND DATED BY THE PHYSICIAN IS REQUIRED.
PA66	THE SKILLS OF A THERAPIST ARE REQUIRED WHEN ONLY THE THERAPIST CAN SAFELY AND EFFECTIVELY DELIVER THE THERAPEUTIC PROCEDURES BECAUSE OF THEIR UNIQUE KNOWLEDGE, TRAINING, AND EXPERTISE. DESCRIBE THE REASON THAT SOMEONE OTHER THAN A THERAPIST CANNOT SAFELY
PA67	PLEASE SPECIFY IF THE CLIENTS WORK SITE DEMANDS GOOD BINAURAL HEARING.
PA68	DESCRIBE THE REASON, BASED ON THE CLIENTS COGNITIVE, PHYSICAL, COMMUNICATION, OR RESOURCE STATUS, THAT A HOME PROGRAM, EQUIPMENT, OR ENVIRONMENTAL ADAPTATIONS ALONE CANNOT MEET CLIENTS NEEDS.
PA69	PLEASE SPECIFY IF THE CLIENT HAS AN ACCOMPANYING DISABILITY THAT ADDS TO THE HEARING PROBLEM.
PA70	DISTINGUISH REQUESTED PROCEDURES AND GOALS FROM OTHER SERVICES THIS CLIENT RECEIVES. THEY MAY NOT BE DUPLICATIVE.
PA71	PLEASE INDICATE THE NUMBER OF DAYS REQUESTED.
PA73	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA74	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA75	PLEASE DOCUMENT CARRYOVER OF THE THERAPY PROGRAM TO NURSING.
PA76	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).

Denial Code	Long Description
PA79	PROVIDE EVIDENCE OF SIGNIFICANT FUNCTIONAL PROGRESS IN LAST SIX MONTHS.
PA84	THE GRANT DATE OF THIS REQUEST CANNOT BE PRIOR TO THE SIGNATURE DATE OF THE PRESCRIBING PHYSICIAN.
PA86	PROVIDE EVIDENCE OF SKILLS GAINED IN THERAPY CARRYING OVER TO OTHER SETTINGS WITHIN SIX MONTHS.
PA87	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE NUMBER OF SESSIONS REQUESTED.
PA88	THE REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL SCOPE OF PRACTICE.
PA89	PRIOR AUTHORIZATION IS NOT REQUIRED UNTIL LIMITATION OF SERVICE HAS BEEN REACHED.
PA91	PLEASE SUBMIT REQUIRED X-RAYS.
PA92	PLEASE PROVIDE AN EXPLANATION FOR THE MATERIAL SUBMITTED WITH THE REQUEST.
PA95	PLEASE DESCRIBE HOW THE PROVISION OF THIS SERVICE WOULD PREVENT INSTITUTIONALIZATION OF THE CLIENT.
PA96	COULD THE EXISTING DENTURE(S) BE RELINED OR REBASED? IF NOT, PLEASE EXPLAIN WHY NOT.
PA97	REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL STANDARDS OF PRACTICE.
PA98	PLEASE INDICATE IF THE CLIENT IS CURRENTLY BEING TUBE FED.
PB02	PLEASE PROVIDE THE REQUIRED DATED SIGNATURES ON THE ATTACHMENTS.
PB03	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING THE LOSS/DESTRUCTION/THEFT OF THE HEARING AID.
PB04	DESCRIBE THE CLIENTS ABILITY TO STAND OR AMBULATE SUFFICIENTLY TO ACCOMPLISH SELF-CARE ACTIVITIES.
PB07	PLEASE SUBMIT AN ORTHODONTIC STUDY MODEL OR DIAGNOSTIC CASTS.
PB09	PLEASE PROVIDE A PHOTOGRAPH OF THE INVOLVED AREA(S).
PB10	PLEASE PROVIDE AN ESTIMATION (IN GRAMS) OF THE TOTAL AMOUNT OF TISSUE TO BE RESECTED.
PB11	PLEASE SUBMIT THE PLAN OF CARE FOR CO-TREATMENT.
PB12	FURNISH A DETAILED DESCRIPTION FOR THE PROCEDURE CODE REQUESTED.
PB13	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB15	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB18	PLEASE COMPLETE THE ATTACHED OUT-OF-STATE PROVIDER DATA SHEET, F-11001, AND RESUBMIT.
PB20	A SIGNED AND DATED PRESCRIPTION IS REQUIRED WITHIN THREE MONTHS OF RECEIPT BY COLORADO MEDICAID FOR INITIAL REQUESTS AND WITHIN 12 MONTHS OF RECEIPT BY COLORADO MEDICAID FOR SUBSEQUENT REQUESTS.
PB21	PLEASE COMPLETE THE APPROPRIATE PRIOR AUTHORIZATION ATTACHMENT. CONTACT PROVIDER SERVICES OR THE PRIOR AUTHORIZATION UNIT FOR ASSISTANCE.
PB23	PHYSICAL THERAPY ASSISTANT NOTES AND ALL FORMS SUBMITTED MUST BE COSIGNED BY A REGISTERED PHYSICAL THERAPIST.
PB31	ARE YOU REQUESTING A COMPLETE APPLIANCE, OR REPLACEMENT PARTS?
PB32	THE PROCEDURE CODE INDICATED ON THE REQUEST DOES NOT MATCH THE DESCRIPTION OF SERVICE; PLEASE CORRECT AND RESUBMIT.
PB35	THE SERVICE REQUESTED DOES NOT REQUIRE PRIOR AUTHORIZATION.
PB41	PLEASE FURNISH A CURRENT MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT, F-11090 (DATED WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID).
PB45	THE CERTIFICATION PERIOD ON THE PLAN OF CARE (POC) DOES NOT COVER THE REQUESTED GRANT/START DATE. PLEASE RESUBMIT YOUR REQUEST WITH A NEW POC.
PB49	A CERTIFIED OCCUPATIONAL THERAPY ASSISTANTS NOTES MUST BE COSIGNED BY AN OCCUPATIONAL THERAPIST REGISTERED.
PB51	ADDITIONAL INFORMATION IS REQUIRED ON PRIOR AUTHORIZATION TO ENABLE PRICING.
PB54	REQUESTED SERVICES DO NOT MATCH SERVICES ON THE PHYSICIANS ORDERS.
PB59	PLEASE PROVIDE AN INDIVIDUAL EDUCATIONAL PLAN (IEP), WHICH HAS BEEN SIGNED BY THE PROVIDER NO EARLIER THAN NINE MONTHS PRIOR TO RECEIPT AT COLORADO MEDICAID; OTHERWISE, DOCUMENT WHY NO IEP EXISTS.
PB65	PLEASE FURNISH THE ANTICIPATED TOTAL CHARGES FOR THIS REQUEST.
PB66	A PHOTOCOPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED; THE DATE MUST BE WITHIN SIX MONTHS OF RECEIPT BY COLORADO MEDICAID.

Denial Code	Long Description
PB67	THE PRESCRIPTION DATE MUST INCLUDE MONTH, DAY, AND YEAR.
PB68	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID.
PB73	THE SERVICES IDENTIFIED ON THE PLAN OF CARE DO NOT APPEAR APPROPRIATE FOR THE PROCEDURE CODE(S) REQUESTED ON THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018.
PB74	THE CLIENT/PROVIDER DOES NOT HAVE RETROACTIVE ENROLLMENT.
PB75	THE REQUESTED START DATE IS MORE THAN 14 DAYS BEFORE OR 62 DAYS AFTER RECEIPT.
PB82	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
PB83	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A HOME HEALTH AIDE. PLEASE RESUBMIT AS A PERSONAL CARE WORKER OR PROVIDE ADDITIONAL DOCUMENTATION.
PB86	THE SERVICES REQUESTED ARE NOT BEING PROVIDED IN THE CLIENTS RESIDENCE. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL.
PB87	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A NURSE. PLEASE RESUBMIT AS A HOME HEALTH AIDE OR PROVIDE ADDITIONAL DOCUMENTATION.
PB92	PLEASE FURNISH THE CLIENTS COMPLETE ADDRESS.
PB94	IF THE CLIENT IS A RESIDENT OF A NURSING HOME, SUPPLY THE COMPLETE NAME AND ADDRESS OF THE NURSING HOME.
PB99	THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018, MUST BE SIGNED AND DATED.
PC01	PLEASE SUPPLY THE RENDERING PROVIDERS PROVIDER NUMBER.
PC03	THE DRUG ENFORCEMENT ADMINISTRATION NUMBER IS MISSING OR INVALID.
PC06	PLEASE DESCRIBE YOUR PROGRAM; INCLUDE ENTRY DATE, TERMINATION DATE, HOURS PER WEEK, AND NUMBER OF WEEKS OF PRIMARY INTENSIVE SERVICE REQUESTED.
PC07	PLEASE DESCRIBE YOUR "AFTERCARE/FOLLOW-UP" PLANS FOR THIS CLIENT.
PC08	PLEASE SUPPLY DOCUMENTATION OF PREVIOUS SUBSTANCE ABUSE SERVICES WITH DATE(S) AND OUTCOME.
PC09	PLEASE DESCRIBE IN DETAIL THE TREATMENT OBJECTIVES/GOALS FOR THIS CLIENT.
PC10	PLEASE DESCRIBE THE FAMILY SITUATION/DYNAMICS. EXPLAIN HOW THE FAMILY WILL BE INCORPORATED INTO THE CLIENTS PLAN OF CARE.
PC12	PLEASE EXPLAIN IF YOUR SERVICE ENCOURAGES THE CLIENT TO ATTEND SELF-HELP GROUPS.
PC13	PLEASE SUPPLY A SPECIFIC SCHEDULE OF ACTIVITIES, INCLUDING DAY, TIME OF DAY, LENGTH OF SESSION, AND SERVICE TO BE RENDERED DURING THAT TIME.
PC15	PLEASE FURNISH DIAGNOSTIC RATIONALE.
PC17	PLEASE DOCUMENT IF THE CLIENT EVER RECEIVED SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT.
PC19	PLEASE FURNISH MORE EXTENSIVE AND IN-DEPTH HISTORICAL AND PSYCHOSOCIAL DATA.
PC20	PLEASE SUPPLY THE DATE THE CLIENT BECAME TOTALLY ENDENTULOUS.
PC23	PLEASE SUBMIT A PHYSICIANS STATEMENT REGARDING THE MEDICAL NECESSITY OF DENTURES FOR THIS CLIENT. THE PHYSICIANS STATEMENT MUST DOCUMENT THE MEDICAL NEED FOR DENTURES.
PC24	THE SERVICE REQUESTED WAS PREVIOUSLY AUTHORIZED. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT INDICATING THIS FACT IS REQUIRED.
PC25	PLEASE SUPPLY SUFFICIENT MITIGATING CIRCUMSTANCES TO WARRANT THE CONSTRUCTION OF NEW DENTURES(S).
PC26	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
PC28	PLEASE SUBMIT A PHYSICIANS STATEMENT INDICATING DENTURES ARE NECESSARY FOR THIS NURSING HOME CLIENT.
PC29	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING LOSS OR DESTRUCTION OF DENTURE(S). INCLUDE SIGNED STATEMENT FROM CLIENT OR FACILITY DIRECTOR REGARDING HOW, WHEN AND WHERE LOST.
PC30	PLEASE PROVIDE COMPLETE INTRAORAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PC31	PLEASE DESCRIBE ANY RELATED DEFORMITIES OF THE FEET.
PC34	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD WITH REQUESTED DME ITEM(S) AND DOCUMENT IF THE CLIENT CAN USE SAFELY AND INDEPENDENTLY.
PC35	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD AND DESCRIBE THE RESULTS AND EFFECTIVENESS OF THE SERVICE REQUESTED.

Denial Code	Long Description
PC39	PLEASE INDICATE LITER FLOW PER MINUTE, HOURS OF USE PER 24 HOUR PERIOD, AND THE EXPECTED DURATION OF NEED.
PC40	THE ITEM DOES NOT REQUIRE PRIOR AUTHORIZATION UNTIL THE LIFE EXPECTANCY HAS BEEN REACHED.
PC41	PLEASE SUPPLY INFORMATION INDICATING THE NECESSITY OF POSITIONING THE CLIENT'S BODY IN MULTIPLE POSITIONS.
PC42	PLEASE INDICATE IF THE BED HEIGHT MUST BE CHANGED TO ALLOW FOR SAFE TRANSFER OR ADEQUATE BED CARE.
PC43	SUPPLY A PHYSICIANS STATEMENT INDICATING TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR UNIT HAS REDUCED PAIN, IMPROVED/INCREASED THE CLIENTS ACTIVITY LEVEL, AND/OR REDUCED CLIENTS USE OF PAIN MEDICATION.
PC44	A CURRENT AUTHORIZATION FOR THIS SERVICE IS ON FILE FOR ANOTHER PROVIDER. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT OF THAT FACT IS REQUIRED BY THE CLIENT OF FIRST PROVIDER.
PC59	DOCUMENT DECLINE OR PROGRESS IN SPECIFIC, MEASURABLE, OBJECTIVE TERMS.
PC60	DOCUMENT IF CLIENT HAS DEMONSTRATED A GOOD APPOINTMENT COMPLIANCE RECORD.
PC61	THE PHYSICIANS SIGNATURE DATE MUST NOT EXCEED 90 DAYS FROM THE DATE OF RECEIPT BY COLORADO MEDICAID.
PC62	REQUESTS FOR A CONTINUATION OF THERAPY SHOULD NOT BE SUBMITTED MORE THAN FOUR WEEKS PRIOR TO THE EXPIRATION DATE OF THE CURRENT AUTHORIZATION.
PC63	PLEASE FURNISH THE STYLE AND MANUFACTURER OF THE FRAME.
PC64	PLEASE FURNISH THE CLIENTS LENS FORMULA.
PC66	ALL REQUESTS FOR TINTS REQUIRE DOCUMENTATION OF THE VISUAL OR MEDICAL CONDITION RELATED TO PHOTOPHOBIA.
PC67	PLEASE DOCUMENT THE REASON AND JUSTIFICATION FOR REPLACEMENT BEYOND THE FIRST LENS/FRAME.
PC68	DOCUMENT IF ALL REMAINING MAXILLARY AND/OR MANDIBULAR TEETH ARE DECAY-FREE, PROPERLY RESTORED, AND PERIODONTICALLY SOUND.
PC72	SUPPLY MORE DETAIL REGARDING PROGRESS (ATTACHMENT OF GOALS, ETC.). CORRELATE PROGRESS TO PREVIOUS GOALS AND IDENTIFIED LIMITATIONS.
PC77	PLEASE SUBMIT A PLAN OF CARE DESCRIBING THE SERVICES THAT WOULD BE PROVIDED.
PC78	PLEASE DOCUMENT SPECIFIC, MEASURABLE GOALS.
PC82	THE PRIOR AUTHORIZATION (PA) SYSTEM CAN PROCESS ONLY 26 DETAILS PER PA REQUEST. PLEASE RESUBMIT YOUR REQUEST WITH NO MORE THAN 26 DETAILS.
PC83	PLEASE SUPPLY A PHYSICIANS PRESCRIPTION DATED WITHIN ONE MONTH OF REQUESTED SUBSTANCE ABUSE DAY TREATMENT.
PC84	PLEASE PROVIDE INFORMATION INDICATING THIS CLIENT IS APPROPRIATELY DETOXIFIED FROM ALCOHOL AND/OR OTHER DRUGS.
PC85	PLEASE PROVIDE INFORMATION TO INDICATE THE CLIENTS ABILITY TO ABSTAIN FROM ALCOHOL OR DRUGS WHILE IN THE SUBSTANCE ABUSE DAY TREATMENT PROGRAM.
PC86	PLEASE INDICATE IF THIS CLIENT IS WILLING TO PARTICIPATE IN AFTERCARE OR CONTINUING CARE SERVICES.
PC87	PROVIDE MORE INFORMATION ON TREATMENT HISTORY; INCLUDE SERVICE PROVIDED, DATES, AND OUTCOME. PROVIDE DETAIL OF PREVIOUS TREATMENT.
PC88	PLEASE PROVIDE MORE RATIONALE FOR THE APPROPRIATENESS AND MEDICAL NECESSITY OF SUBSTANCE ABUSE DAY TREATMENT.
PC89	PROVIDE A TREATMENT PLAN THAT CONTAINS MEASURABLE GOALS AND OBJECTIVES CORRESPONDING TO THE IDENTIFIED DEFICIT.
PC91	PLEASE PROVIDE MORE INFORMATION ON FAMILY INVOLVEMENT TREATMENT.
PC92	PLEASE PROVIDE MORE HISTORY AND EXPLANATION ABOUT THE ISSUE OF ABSTINENCE FOR THIS CLIENT.
PC94	PLEASE PROVIDE THE ANTICIPATED BEGINNING DATE AND/OR THE ESTIMATED SUBSTANCE ABUSE DAY TREATMENT DISCHARGE DATE.
PC95	PLEASE SUPPLY JUSTIFICATION FOR BEGINNING CLIENT IN SERVICE PRIOR TO AUTHORIZATION BEING OBTAINED.
PC96	THE INITIAL THREE HOURS OF SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IN A CALENDAR YEAR DO NOT REQUIRE PRIOR AUTHORIZATION.

Denial Code	Long Description
PC97	REIMBURSEMENT FOR INITIAL SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IS LIMITED TO THREE HOURS IN A CALENDAR YEAR AND DOES NOT REQUIRE PRIOR AUTHORIZATION.
PC98	THIS DRUG IS CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE BILL USING THE APPROPRIATE NATIONAL DRUG CODE (NDC) OR SUBMIT A COMPLETED DRUG ADDITION REQUEST FORM IF THE NDC IS NOT LISTED IN THE DRUG INDEX.
PC99	THIS DRUG IS NOT CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL, CURRENT ADMINISTRATIVE RULE, OR COLORADO DRUG INDEX FOR COVERAGE LIMITATIONS.
PD01	DOCUMENT THAT CLIENT HAS ACHIEVED GOOD ORAL HYGIENE, PERIODONTAL CASE TYPE 1 OR 2, AND IS MOTIVATED TO MAINTAIN SAME.
PD03	PLEASE PROVIDE AN ARTERIAL BLOOD GAS READING OR PULSE OXIMETRY RESULTS DONE ON ROOM AIR SIGNED AND DATED BY A MEDICAL DOCTOR. THIS SHOULD BE DONE WITHIN 60 DAYS OF REQUESTED SERVICE.
PD04	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 30 DAYS OF RECEIPT BY COLORADO MEDICAID.
PD07	SUBMIT A PHOTOCOPY OF A VALID PRESCRIPTION, ISSUED WITHIN THE PAST YEAR, OR COMPLETE SECTION B OF THE PRIOR AUTHORIZATION/DRUG ATTACHMENT (PA/DGA), F-11049.
PD10	BRAND MEDICALLY NECESSARY MUST BE IN THE PRESCRIBERS OWN HANDWRITING AND WRITTEN DIRECTLY ON THE PRESCRIPTION OR A SEPARATE ORDER ATTACHED TO THE ORIGINAL PRESCRIPTION.
PD12	COMPLETE DENTURES, PARTIAL DENTURES, DENTURE RELINES, AND FIXED PROSTHODONTIC SERVICES ARE NOT COVERED SERVICES FOR ADULTS FOR DATES OF SERVICE ON AND AFTER OCTOBER 1, 1995.
PD22	PLEASE COMPLETE ALL REQUIRED ELEMENTS ON THE PERSONAL CARE SCREENING TOOL (PCST), F-11133.
PD24	THIS PRIOR AUTHORIZATION REQUEST IS UNABLE TO BE PROCESSED. PLEASE RESUBMIT WITH ADDITIONAL REQUIRED FORMS, INCLUDING THE ENTIRE PERSONAL CARE SCREENING TOOL (PCST), F-11133; PERSONAL CARE ADDENDUM, F-11136; AND SUPPORTING DOCUMENTATION, AS DIRECTED.
PD25	THERE IS A PERSONAL CARE SCREENING TOOL (PCST), F-11133, COMPLETED BY ANOTHER AGENCY. CONTACT THE AGENCY TO TRANSFER SCREEN.
PD26	THERE IS A LIMITED TERM CARE FUNCTIONAL SCREEN (LTC-FS) COMPLETED BY ANOTHER AGENCY. THE PERSONAL CARE SCREENING TOOL (PCST), F-11133, INFORMATION IS IN CONFLICT WITH LTC-FS.
PD27	ONLY ONE LEVEL OF FUNCTION MAY BE SELECTED FOR ALL ELEMENTS EXCEPT TOILETING. COLORADO MEDICAID IS UNABLE TO PROCESS THE PRIOR AUTHORIZATION REQUEST.
PD28	NO UNITS MAY BE REQUESTED USING THIS PRIOR AUTHORIZATION PROCESS. PLEASE SUBMIT WITH THE APPROPRIATE ATTACHMENTS FOR REQUESTING SPECIFIC PERSONAL CARE WORKER UNITS.
PD29	CLIENT IS NOT ELIGIBLE FOR THE REQUESTED SERVICE(S) AS OF THE REQUESTED START DATE.
PD30	NO TRAVEL TIME MAY BE AUTHORIZED WHEN NO PERSONAL CARE WORKER SERVICE IS AUTHORIZED.
PD32	PROVIDER NOT CERTIFIED TO RENDER THE SERVICE(S) REQUESTED.
PD34	BASED ON THE DOCUMENTATION SUBMITTED, THIS REQUEST CAN NOT BE PRIOR AUTHORIZED. REFER TO THE PA MESSAGES FROM THE CONSULTANT FOR COMPLETE EXPLANATION.
PD98	PLEASE DOCUMENT HOW AND WHEN EACH PREVIOUSLY AUTHORIZED PRO RE NATA VISIT WAS USED.

Private Duty Nursing PDN

Denial Code	Long Description
0201	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
0233	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0235	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0237	CLIENT IDENTIFICATION NUMBER DOES NOT MATCH CLIENTS FIRST NAME.
0238	THE CLIENT IDENTIFICATION NUMBER DOES NOT MATCH THE CLIENTS LAST NAME.
0242	SECONDARY DIAGNOSIS CODE IS INVALID.

Denial Code	Long Description
0248	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0249	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0251	PROCEDURE CODE MODIFIER IN FIRST POSITION IS INVALID.
0252	THE PROCEDURE CODE MODIFIER IN SECOND POSITION IS INVALID FOR REQUESTED START DATE OR DATE OF RECEIPT.
0253	THE PROCEDURE CODE MODIFIER IN THIRD POSITION IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
0258	THE PRIMARY DIAGNOSIS CODE IS REQUIRED.
0272	THE PRIMARY DIAGNSOSIS CODE IS INVALID.
0400	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0853	HCPCS - ANNUAL UPDATE
0885	NEVER EVENTS MODIFIERS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
0886	NEVER EVENTS DIAGNOSIS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
1000	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
1002	RENDERING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1003	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1007	RENDERING PROVIDER ID IS NOT ON FILE.
1047	THE RENDERING PROVIDERS CERTIFICATION HAS BEEN CANCELLED.
1048	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1801	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
1804	A CERTIFIED SUBSTANCE ABUSE DAY TREATMENT PROVIDER MUST SUBMIT A SUBSTANCE ABUSE DAY TREATMENT PROCEDURE CODE.
1806	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
1808	THE BILLING PROVIDER DOES NOT HAVE THE REQUIRED CERTIFICATION ADDENDUM ON FILE.
1900	THE BILLING PROVIDERS TAXONOMY CODE IS INVALID.
1901	THE RENDERING PROVIDERS TAXONOMY CODE IS INVALID.
1927	A NATIONAL PROVIDER IDENTIFIER IS REQUIRED FOR THE BILLING PROVIDER.
1934	A NATIONAL PROVIDER INDENTIFIER IS REQUIRED FOR THE RENDERING PROVIDER.
1936	THE BILLING PROVIDER NUMBER IS INVALID.
1937	THE RENDERING PROVIDER NUMBER IS INVALID.
1960	INTERNAL PROCESSING IS REQUIRED.
1963	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.
1964	THE BILLING PROVIDER INDICATED IS NOT ALLOWABLE AS A BILLING PROVIDER.
1965	RENDERING PROVIDER NUMBER IS MISSING/INVALID FOR THIS PROCEDURE PROVIDER.
1974	PRESCRIBING/REFERRING/ORDERING PROVIDER INDICATED IS NOT CERTIFIED AS A PRESCRIBING/REFERRING/ORDERING PROVIDER.
1975	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
1976	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
2001	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2003	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2017	THE CLIENT IS ENROLLED IN A MEDICAID OR OTHER MANAGED CARE PROGRAM.
2037	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2603	CLIENT LOCKED-IN TO A PROVIDER OR ENROLLED IN A HOSPICE. CONTACT CLIENTS HOSPICE FOR PAYMENT OF SERVICES OR RESUBMIT WITH DOCUMENTATION OF UNRELATED NATURE OF CARE.

Denial Code	Long Description
3324	THE MODIFIER HAS BEEN DISCONTINUED BY THE CENTERS OF MEDICARE AND MEDICAID SERVICES OR THE AMERICAN MEDICAL ASSOCIATION FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
3337	THE PROCEDURE CODE HAS BEEN TERMINATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AMERICAN MEDICAL ASSOCIATION, OR AMERICAN DENTAL ASSOCIATION FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT. RESUBMIT WITH VALID A PROCEDURE CODE.
3339	THE PROCEDURE BILLED IS NOT PAYABLE ACCORDING TO DEFICIT REDUCTION ACT (DEFRA) GUIDELINES.
3351	THE PROCEDURE IS NOT COVERED FOR CLIENTS WITH A NURSING HOME AUTHORIZATION ON THE REQUESTED START DATE OR DATE OF RECEIPT.
3353	THE PROCEDURE IS NOT A COVERED SERVICE FOR HOME AND COMMUNITY-BASED WAIVER CLIENTS.
4021	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4027	THE DIAGNOSIS CODE IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
4031	THE PROCEDURE SUBMITTED IS NOT APPROPRIATE FOR CLIENTS GENDER.
4032	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4034	THE PROCEDURE CODE HAS AN AGE RESTRICTION.
4036	THE PLACE OF SERVICE CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4040	THE PRIMARY DIAGNOSIS CODE IS NOT ON FILE.
4041	THE SECONDARY DIAGNOSIS IS NOT ON FILE.
4046	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4127	INTERNAL PROCESSING IS REQUIRED.
4131	INTERNAL PROCESSING IS REQUIRED.
4141	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4149	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4150	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4236	ETIOLOGY DIAGNOSIS CODE(S) (E-CODES) ARE INVALID AS THE PRIMARY DIAGNOSIS.
4244	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4245	THE FOURTH POSITION MODIFIER IS INVALID FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT.
4256	THE PROCEDURE CODE AND MODIFIER COMBINATION IS NOT PAYABLE FOR THE CLIENTS BENEFIT PLAN.
4257	THE MODIFIERS SUBMITTED ARE EITHER INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT OR THE MODIFIERS ARE MISSING.
4311	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4315	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4316	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4371	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4372	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4711	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR CLIENTS AGE.
4714	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS AGE.
4731	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS DIAGNOSIS.
4742	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4743	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4744	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4745	DIAGNOSIS AND/OR PROCEDURE AND/OR PLACE OF SERVICE (POS) CODE IS NOT COVERED FOR EXPRESS ENROLLMENT CLIENTS.
4746	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4801	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4802	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.

Denial Code	Long Description
4821	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
4871	PLEASE REFER TO PA MESSAGES FOR RETURN INFORMATION.
4963	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS GENDER.
4990	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
7500	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
7509	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
P001	THE BILLING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THE SERVICES.
P002	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P003	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P005	THE PRIOR AUTHORIZATION CAN NOT BE END DATED. THE PRIOR AUTHORIZATION STATUS IS NOT APPROVED OR APPROVED WITH REVISIONS.
P006	PLEASE FURNISH THE PROCEDURE CODE AND CORRESPONDING DESCRIPTION.
P008	THE BILLING PROVIDER NUMBER IS INVALID.
P009	THE BILLING PROVIDER NUMBER IS INVALID.
P010	THE REQUESTED END DATE IS INVALID.
P011	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P012	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P013	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P014	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P015	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P016	THE REQUESTED START DATE IS MISSING OR INVALID.
P019	THE REQUESTED START DATE IS MISSING OR INVALID.
P020	THE RENDERING PROVIDER NUMBER IS INVALID.
P021	THE RENDERING PROVIDER NUMBER IS INVALID.
P022	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P023	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P024	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P026	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P027	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P030	FIRST MODIFIER IS INVALID.
P031	FIRST MODIFIER IS INVALID.
P032	SECOND MODIFIER IS INVALID.
P033	SECOND MODIFIER IS INVALID.
P034	THIRD MODIFIER IS INVALID.
P035	THIRD MODIFIER IS INVALID.
P036	FOURTH MODIFIER IS INVALID.
P037	FOURTH MODIFIER IS INVALID.
P038	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P039	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P040	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.

Denial Code	Long Description
P041	CLIENTS FIRST NAME IS MISSING.
P042	CLIENTS LAST NAME IS MISSING.
P043	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P044	BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES REQUESTED.
P045	FIRST MODIFIER IS INVALID.
P046	SECOND MODIFIER IS INVALID.
P047	THIRD MODIFIER IS INVALID.
P048	FOURTH MODIFIER IS INVALID.
P052	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P053	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P054	RENDERING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES FOR THE BENEFIT PLAN.
P055	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P061	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P062	THE CLIENT ID AND/OR NAME INDICATED ON THE PA REQUEST IS INCORRECT. THE CLIENT ID AND/OR NAME HAS BEEN UPDATED. PLEASE VERIFY THE ID AND/OR NAME IS CORRECT.
P064	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
P067	THE FREQUENCY OF HOURS REQUESTED ARE NOT APPROPRIATE FOR THIS CLIENT AND HAVE BEEN MODIFIED ACCORDINGLY.
P079	BILLING PROVIDER IS ON PAYMENT SUSPENSION DUE TO CREDIBLE ALLEGATION OF FRAUD.
P120	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAS BEEN REDUCED.
P121	THE SERVICE/ PROCEDURE REQUESTED IS NOT SUPPORTED BY SUBMITTED DOCUMENTATION.
P126	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
P128	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.
P138	SERVICE(S) DO NOT MEET COLORADO MEDICAID GUIDELINES.
P167	REQUESTED DOCUMENTATION HAS NOT BEEN SUBMITTED.
P178	THE SERVICE REQUESTED IS NOT MEDICALLY NECESSARY.
P179	THE MEDICAL NECESSITY FOR THIS SERVICE IS NOT SUPPORTED BY THE SUBMITTED DOCUMENTATION.
P233	THE DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE ADDITIONAL CARE.
P257	THIS CLIENTS FUNCTIONAL ASSESSMENT SCORES PLACE THIS CLIENT OUTSIDE ELIGIBILITY FOR DAY TREATMENT.
P274	OUR RECORDS INDICATE THIS CLIENT IS INVOLVED IN EFFECTIVE AND APPROPRIATE SERVICE ELSEWHERE.
P292	INTENSIVE REHABILITATION HOURS ARE NO LONGER APPROPRIATE AS INDICATED BY HISTORY, DIAGNOSIS, AND/ OR FUNCTIONAL ASSESSMENT SCORES.
P328	THE SERVICES REQUESTED INCLUDE NON-COVERED SERVICES, AND HOURS ARE REDUCED ACCORDINGLY.
P339	THE CLIENTS PAST HISTORY INDICATES REDUCED TREATMENT HOURS ARE WARRANTED.
P342	THE REQUEST DOES NOT MEET GENERALLY ACCEPTED CONDITIONS REQUIRING FLUORIDE TREATMENTS.
P346	SERVICES EXCEED COLORADO MEDICAID LIMITATION AND DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE MEDICAL NECESSITY OF THE SERVICE.
P349	THE SERVICE REQUESTED WAS PERFORMED LESS THAN FIVE YEARS AGO.
P353	THE EXISTING APPLIANCE HAS NOT BEEN WORN FOR THREE YEARS.
P367	THE CLIENT HAS BEEN TOTALLY WITHOUT TEETH AND AN APPLIANCE FOR FIVE YEARS.
P392	THE CLIENT IS MISSING AN ANTERIOR TOOTH AND/OR HAS TWO OR MORE POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P405	THE SERVICE(S) REQUESTED COULD ADEQUATELY BE PERFORMED IN THE DENTAL OFFICE.
P406	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE OF GOOD PERIODONTAL HEALTH (AMERICAN ACADEMY OF PERIODONTOLOGY PERIODONTAL CLASSIFICATION OF TYPE I OR II).

Denial Code	Long Description
P407	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE VISIBLE ON RADIOGRAPHS THAT AT LEAST 50 PERCENT OF THE CLINICAL CROWN IS INTACT.
P409	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING SIX OR MORE TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED, INCLUDING THIRD MOLARS.
P410	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING ONE OR MORE ANTERIOR TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED.
P411	DOCUMENTATION DOES NOT SUPPORT THE NEED FOR PERIODONTIC SERVICES. POCKETS ARE LESS THAN 4MM AND/OR GREATER THAN 6MM FOR CLIENT AND/OR THE CLIENT IS UNDER THE AGE OF 13.
P412	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA.
P413	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA. THIS PA HAS BEEN GRANTED AS APPROVED NOT APPROVED WITH REVISIONS. THE DURATION REQUESTED MAY HAVE BEEN REDUCED TO REFLECT COVERAGE LIMITATIONS, PRESCRIBER ORDERS, CONFLICTI
P417	THE SERVICE(S) REQUESTED COULD BE ADEQUATELY PERFORMED WITH LOCAL ANESTHESIA.
P437	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO POOR ORAL HYGIENE.
P444	THIS LINE ITEM IS A DUPLICATE OF ANOTHER LINE ITEM ON THIS PRIOR AUTHORIZATION (PA) REQUEST. PLEASE CORRECT.
P446	THIS IS A DUPLICATE OF AN EXISTING PRIOR AUTHORIZATION (PA) REQUEST. YOU MAY CONTACT PROVIDER SERVICES IF YOU REQUIRE ASSISTANCE. DUPLICATE PA REQUEST
P448	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO DECAY HISTORY.
P449	QUESTIONABLE LONG TERM PROGNOSIS DUE TO GUM AND BONE DISEASE.
P456	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO APPARENT ROOT INFECTION.
P457	OUR RECORDS INDICATE THIS CLIENT HAS EXCEEDED ESTABLISHED PROGRAM LIMITATIONS. COLORADO MEDICAID WILL NOT AUTHORIZE NEW DENTURES.
P458	DOCUMENTATION PROVIDED INDICATES A LESS ELABORATE PROCEDURE SHOULD BE CONSIDERED.
P502	RENTAL ONLY ALLOWED; MEDICAL NEED FOR PURCHASE HAS NOT BEEN DOCUMENTED.
P503	PURCHASE ONLY ALLOWED; MEDICAL NEED FOR RENTAL HAS NOT BEEN DOCUMENTED.
P504	OCCUPATIONAL THERAPY GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P505	THE SERVICE REQUESTED IS INCLUDED IN THE NURSING HOME RATE STRUCTURE.
P511	THIS NATIONAL DRUG CODE IS ONLY BILLABLE AS PART OF A COMPOUND DRUG.
P515	THE PRESENCE OF A HANDICAPPING MALOCCLUSION OR HANDICAPPING DENTOFACIAL DEFORMITY IS NOT SUPPORTED BY THE DOCUMENTATION SUBMITTED.
P521	THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVERED BY COLORADO MEDICAID.
P522	GASTRO-INTESTINAL SURGERY FOR THE PURPOSE OF WEIGHT CONTROL IS COVERED ONLY AS A LIFE THREATENING PROCEDURE.
P523	THE TREATMENT REQUEST IS NOT CONSISTENT WITH THE CLIENT'S DIAGNOSIS.
P524	PSYCHOTHERAPY PROVIDED IN THE CLIENTS HOME IS NOT A COVERED BENEFIT OF COLORADO MEDICAID.
P525	THE INFORMATION PROVIDED IS NOT CONSISTENT WITH THE INTENSITY OF SERVICES REQUESTED.
P526	INTENSIVE MULTIPLE MODALITY TREATMENT IS NOT CONSISTENT WITH THE INFORMATION PROVIDED.
P527	MULTIPLE PROVIDERS OF TREATMENT ARE NOT INDICATED FOR THIS CLIENT.
P528	THE DURATION OF TREATMENT SESSIONS EXCEED CURRENT COLORADO MEDICAID GUIDELINES.
P534	DOCUMENTATION OF POOR PHYSICAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P535	OTHER PHYSICAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P536	THE PHYSICAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P537	USE OF PHYSICAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P538	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF A PHYSICAL THERAPIST.

Denial Code	Long Description
P539	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS AND LIVING ARRANGEMENT.
P540	GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P541	THE PROCEDURE(S) REQUESTED ARE NOT MEDICAL IN NATURE.
P542	DOCUMENTATION OF POOR OCCUPATIONAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P543	DOCUMENTATION OF POOR SPEECH THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P544	OTHER OCCUPATIONAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P546	THE OCCUPATIONAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P547	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF PHYSICAL THERAPY.
P548	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P549	ACTIVITIES TO PROMOTE DIVERSION OR GENERAL MOTIVATION ARE NONCOVERED COLORADO MEDICAID SERVICES.
P550	REVISIONS OF THE REQUEST IS NECESSITATED BY THE CLIENTS MINIMAL PROGRESS.
P551	RESTORATIVE NURSING INVOLVEMENT COULD BE INCREASED.
P552	CLIENTS DEMONSTRATED RESPONSE TO CURRENT THERAPY DOES NOT WARRANT THE INTENSE FREQUENCY REQUESTED.
P553	MAINTENANCE IS TWO TIMES PER WEEK OR LESS.
P554	THE SPEECH THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P555	USE OF OCCUPATIONAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P556	USE OF SPEECH THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P557	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF AN OCCUPATIONAL THERAPIST.
P558	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
P559	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P560	THE MATERIALS/ SERVICES REQUESTED ARE PRINCIPALLY COSMETIC IN NATURE.
P561	THE LENS FORMULA DOES NOT JUSTIFY REPLACEMENT.
P562	THE CHANGE IN THE LENS FORMULA DOES NOT WARRANT MULTIPLE REPLACEMENTS.
P563	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P564	LENSES ONLY ARE APPROVED; PLEASE DISPENSE A CONTRACTED FRAME. THE NON-CONTRACTED FRAME IS NOT MEDICALLY JUSTIFIED.
P565	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P566	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P567	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF OCCUPATIONAL THERAPY.
P568	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF SPEECH THERAPY.
P569	LEVEL, INTENSITY, OR EXTENT OF SERVICE(S) REQUESTED HAS BEEN MODIFIED CONSISTENT WITH MEDICAL NEED AS DEFINED IN THE PLAN OF CARE.
P570	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P571	THE SERVICE ASKED FOR IS NOT COVERED BY COLORADO MEDICAID AS THESE TASKS CAN BE DONE BY NURSES OR ACTIVITY STAFF.

Denial Code	Long Description
P572	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P573	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.
P574	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P575	MEDICAL NEED FOR EQUIPMENT/ SUPPLY REQUESTED IS NOT SUPPORTED BY DOCUMENTATION SUBMITTED.
P576	OTHER SPEECH THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P577	DOCUMENTATION SUBMITTED IDENTIFIES THAT THE CLIENT HAS FEWER THAN TWO POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P582	LESS EXPENSIVE ALTERNATIVE SERVICES ARE AVAILABLE FOR THIS CLIENT.
P634	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P711	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING PERIODONTAL SCALING AND ROOT PLANNING.
P712	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING GINGIVECTOMY.
P754	AN APPROVED SUBSTANCE ABUSE DAY TREATMENT PROGRAM CANNOT EXCEED A SIX WEEK PERIOD.
P761	THE CLIENT DOES NOT APPEAR TO BE ABLE OR WILLING TO ABSTAIN FROM ALCOHOL/DRUG USAGE WHILE IN TREATMENT. THEREFORE, SUBSTANCE ABUSE DAY TREATMENT SERVICES ARE NOT APPROVED.
P764	THIS CLIENT HAS COMPLETED INTENSIVE SUBSTANCE ABUSE TREATMENT WITHIN THE PAST 12 MONTHS. THE DOCUMENTATION PROVIDED IS NOT ADEQUATE TO JUSTIFY ADDITIONAL INTENSIVE TREATMENT AT THIS TIME.
P785	A LESS THAN SIX-WEEK HEALING PERIOD HAS BEEN SPECIFIED FOR THIS PRIOR AUTHORIZATION. THEREFORE IT IS NOT NECESSARY TO WAIT THE FULL SIX WEEKS AFTER EXTRACTIONS BEFORE TAKING DENTURE IMPRESSIONS.
P818	SIX-WEEK HEALING TIME IS REQUIRED BETWEEN EDENTULATION AND FINAL IMPRESSIONS. PAYMENT FOR DENTURES WILL BE DENIED OR RECOUPED IF HEALING PERIOD IS NOT OBSERVED.
P849	COLORADO MEDICAID HAS DETERMINED THERE WERE (ARE) SEVERAL HOME HEALTH AGENCIES WILLING TO PROVIDE MEDICALLY NECESSARY SKILLED NURSING SERVICES TO THIS CLIENT.
P864	THE DOCUMENTATION YOU HAVE SUBMITTED DOES NOT MEET THE REQUIREMENTS OF COLORADO MEDICAID.
P873	THE MEDICAL NECESSITY FOR THE HOURS REQUESTED IS NOT SUPPORTED BY THE INFORMATION SUBMITTED.
P874	THE DOCUMENTATION SUBMITTED INDICATES THE TASKS SPECIFIED CAN BE COMPLETED DURING THE VISITS APPROVED.
P878	THE DOCUMENTATION SUBMITTED DOES NOT INDICATE THAT MEDICALLY ORIENTED TASKS ARE MEDICALLY NECESSARY; THEREFORE PERSONAL CARE SERVICES HAVE BEEN APPROVED.
P880	THE QUANTITY OF SERVICES AUTHORIZED FOR THIS CLIENTS PERSONAL CARE HAS BEEN AMENDED BASED ON INFORMATION RECEIVED FROM ONE OR MORE OF THESE SOURCES: THE CLIENT, THEIR PHYSICIAN, AND/OR THE IN-HOME VISIT BY STAFF OF THE OIG (OFFICE OF INSPECTOR GENERAL).
P885	THE USE OF THIS DRUG FOR THE INTENDED PURPOSE IS NOT COVERED BY COLORADO MEDICAID, CONSISTENT WITH COLORADO ADMINISTRATIVE CODE AND FEDERAL LAW.
P924	THE MEDICAL RECORDS SUBMITTED WITH THE CURRENT REQUEST CONFLICT OR DISAGREE WITH OUR MEDICAL RECORDS ON THIS CLIENT.
P950	INDEPENDENT NURSES, PLEASE NOTE PAYABLE SERVICES MAY NOT EXCEED 12 HOURS/DAY OR 60 HOURS/WEEK.
P951	SERVICES CAN ONLY BE AUTHORIZED THROUGH ONE YEAR FROM THE PRESCRIPTION DATE.
P952	LEAD INSPECTION IS A COVERED COLORADO MEDICAID SERVICE WHEN THE CHILD HAS BEEN SHOWN TO HAVE LEAD POISONING (E.G., CHILD HAS A BLOOD LEAD LEVEL > 19 UG/DL OR TWO CONSECUTIVE BLOOD LEAD LEVELS OF 15-19 UG/DL DONE AT LEAST 90 DAYS APART). THE INSPECTION MUS
P953	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.

Denial Code	Long Description
P954	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P956	THE REQUEST CAN ONLY BE BACKDATED A MAXIMUM OF 14 DAYS FROM FIRST DATE RECEIVED BY COLORADO MEDICAID.
P957	COMPLETE PERIODONTAL CHARTING AT TIME OF SERVICE, AND SUBMIT CHARTING, COPY OF OPERATIVE REPORT, TOGETHER WITH A COPY OF THE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF), F-11035, TO PA UNIT ATTENTION DENTAL CONTSULTANT.
P958	NOTE THAT CODE D4341 HAS BEEN CHANGED. REFER TO THE DECISION NOTICE FOR AUTHORIZED QUANTITY.
P960	YOUR PA HAS BEEN APPROVED FOR 90 DAYS. THE 90 DAY APPROVAL DOES NOT IMPLY THE PA REQUEST MEETS PRIOR AUTHORIZATION CRITERIA. AFTER ADDITIONAL INFORMATION IS AVAILABLE IN INTERCHANGE, COLORADO MEDICAID WILL CREATE AN AMENDMENT REQUEST TO EXTEND THE PA FOR
P961	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P962	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
PA10	THE REQUESTED END DATE IS INVALID.
PA12	PLEASE FURNISH A WRITTEN DESCRIPTION OF THE CLIENTS DIAGNOSIS.
PA13	PROVIDE DIAGNOSES WITH DATES OF ONSET.
PA14	IDENTIFY PROBLEMS TO BE TREATED.
PA15	THE AUDIOLOGISTS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1), F-11020, AND PRIOR AUTHORIZATION REQUEST/HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2), F-11021.
PA16	THE PHYSICIANS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION/PHYSICIAN OTOLOGICAL REPORT (PA/POR), F-11019.
PA17	SUBMIT BRIEF HISTORY WITH REFERRAL INFORMATION, LIVING SITUATION, FUNCTIONAL STATUS, AND OTHER PERTINENT INFORMATION. WHAT CHANGE OF STATUS RESULTED IN REFERRAL AT THIS TIME?
PA18	PLEASE FURNISH THE CLIENTS HEIGHT AND WEIGHT.
PA19	PLEASE SUBMIT CLINICAL INFORMATION SUFFICIENT TO VERIFY THE NEED FOR THE REQUESTED SERVICE(S).
PA20	PLEASE RESUBMIT WITH COMPLETE PERIODONTAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PA21	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL EDUCATIONAL PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA22	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL PROGRAM PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA23	REFER TO THE DURABLE MEDICAL EQUIPMENT INDEX FOR APPROPRIATE CODE AND DESCRIPTION. DO NOT USE AN "UNLISTED" CODE.
PA24	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUALIZED FAMILY SERVICE PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA25	INFORMATION ON THE REQUEST FORM IS ILLEGIBLE, AND THE REQUEST CANNOT BE PROCESSED.
PA26	RE-EVALUATE YOUR GOALS. EMPHASIS SHOULD BE ON FUNCTIONAL SELF-CARE. GOALS MUST BE RELATED TO FUNCTIONAL OUTCOME.
PA27	PLEASE CLARIFY THE NUMBER OF HOURS PER WEEK REQUESTED.
PA28	PLEASE CLARIFY THE NUMBER OF HOURS PER DAY REQUESTED.
PA29	PLEASE CLARIFY THE NUMBER OF VISITS PER DAY REQUESTED.
PA30	ATTACH SUPPORTIVE DOCUMENTATION; HOME EXERCISE PROGRAM AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA31	THE DIAGNOSIS CODE INDICATED ON THE REQUEST DOES NOT CORRESPOND TO THE DIAGNOSIS CODE DESCRIPTION.

Denial Code	Long Description
PA32	PLEASE SUBMIT ADDITIONAL INFORMATION SUFFICIENT TO VERIFY APPROPRIATENESS AND NEED FOR TRANSPLANT.
PA33	PLEASE SUBMIT THE INITIAL AND PROGRESSIVE OBJECTIVE FINDINGS.
PA34	ATTACH SUPPORTIVE DOCUMENTATION, FACILITY PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA35	PLEASE SUBMIT THE CLIENTS ORIGINAL COMPLAINTS AND EXAMINATION FINDINGS.
PA36	ATTACH SUPPORTIVE DOCUMENTATION, IN-HOME AUTISM PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA37	PLEASE SUBMIT YOUR TREATMENT PLAN FOR THIS CLIENT.
PA38	ATTACH SUPPORTIVE DOCUMENTATION AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA39	INITIAL EVALUATIONS MUST BE PERFORMED BY AN OCCUPATIONAL THERAPIST REGISTERED (OTR), PER AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA) STANDARDS.
PA41	IDENTIFY THE PLACE OF SERVICE AND ITS EFFECT ON SUPPORTING THE DESIRED TREATMENT OUTCOME.
PA42	PLEASE INDICATE THE HOURS OF USE OF OXYGEN PER 24-HOUR PERIOD.
PA43	PROVIDE BASELINE DOCUMENTATION FOR THIS CLIENTS LIMITATIONS USING UNITS OF MEASUREMENT THAT ARE APPLIED CONSISTENTLY WHEN REPORTING STATUS.
PA44	IDENTIFY FUNCTIONAL LIMITATIONS AS THEY ARE RELATED TO IDENTIFIED CONDITIONS.
PA46	CORRELATE PLAN OF CARE TO REQUESTED PROCEDURE CODES.
PA47	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE FREQUENCY/DURATION REQUESTED.
PA48	PLEASE PROVIDE THE NAME AND CREDENTIALS OF THE RENDERING PROVIDER.
PA50	COLORADO MEDICAID RECORDS INDICATE THE CLIENT OWNS A WHEELCHAIR. DOCUMENT THE REASON AND NEED FOR REPLACEMENT AND COST TO REPAIR CURRENT WHEELCHAIR.
PA51	PLEASE DISTINGUISH PRIMARY AND SUPPORTIVE MODALITIES.
PA52	PLEASE SUBMIT A PROGRESS REPORT.
PA53	MULTIPLE FAMILY CLIENTS TREATMENT BY THE SAME PROVIDER REQUIRES FURTHER INFORMATION DOCUMENTING COORDINATION OF TREATMENT PLAN.
PA54	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE MINUTES REQUESTED.
PA55	MEDICAL NECESSITY OF TREATMENT REQUIRES ADDITIONAL DOCUMENTATION.
PA56	GIVEN AGE, DIAGNOSES, CURRENT LEVEL OF FUNCTION, PAST RESPONSE TO TREATMENT, AND LIVING SITUATION, EXPAND ON POTENTIAL FOR SIGNIFICANT FUNCTIONAL PROGRESS WITHIN THE NEXT SIX MONTHS. EMPHASIZE WHY PROGRESS IS EXPECTED WITH SERVICES AT THIS TIME.
PA57	SUBMIT THE INITIAL FINDINGS. INCLUDE A COMPREHENSIVE EVALUATION.
PA58	SUBMIT PROGRESSIVE, OBJECTIVE FINDINGS. INCLUDE A PERTINENT RE-EVALUATION.
PA59	PLEASE SUPPLY INFORMATION REGARDING THE CLIENTS MEDICATION REQUIREMENTS, IF ANY.
PA60	PLEASE SPECIFY IF THE CLIENT IS IN AN EDUCATIONAL SETTING.
PA61	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA62	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
PA63	THE SKILLS OF A THERAPIST ARE PURPOSEFUL AND SKILLED INTERVENTIONS REQUIRED TO CONTINUALLY DESIGN, IMPLEMENT, REASSESS, MODIFY/GRADE, AND/OR DISCONTINUE A PLAN OF CARE IN A TIMELY MANNER, BASED ON THE COMPLEXITY OF THE CLIENTS MEDICAL CONDITION AND/OR CO
PA64	PLEASE SUBMIT A THERAPY PLAN OF CARE, INCLUDING A CURRENT, DATED EVALUATION.
PA65	A PLAN OF CARE SIGNED AND DATED BY THE PHYSICIAN IS REQUIRED.

Denial Code	Long Description
PA66	THE SKILLS OF A THERAPIST ARE REQUIRED WHEN ONLY THE THERAPIST CAN SAFELY AND EFFECTIVELY DELIVER THE THERAPEUTIC PROCEDURES BECAUSE OF THEIR UNIQUE KNOWLEDGE, TRAINING, AND EXPERTISE. DESCRIBE THE REASON THAT SOMEONE OTHER THAN A THERAPIST CANNOT SAFELY
PA67	PLEASE SPECIFY IF THE CLIENTS WORK SITE DEMANDS GOOD BINAURAL HEARING.
PA68	DESCRIBE THE REASON, BASED ON THE CLIENTS COGNITIVE, PHYSICAL, COMMUNICATION, OR RESOURCE STATUS, THAT A HOME PROGRAM, EQUIPMENT, OR ENVIRONMENTAL ADAPTATIONS ALONE CANNOT MEET CLIENTS NEEDS.
PA69	PLEASE SPECIFY IF THE CLIENT HAS AN ACCOMPANYING DISABILITY THAT ADDS TO THE HEARING PROBLEM.
PA70	DISTINGUISH REQUESTED PROCEDURES AND GOALS FROM OTHER SERVICES THIS CLIENT RECEIVES. THEY MAY NOT BE DUPLICATIVE.
PA71	PLEASE INDICATE THE NUMBER OF DAYS REQUESTED.
PA73	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA74	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA75	PLEASE DOCUMENT CARRYOVER OF THE THERAPY PROGRAM TO NURSING.
PA76	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA79	PROVIDE EVIDENCE OF SIGNIFICANT FUNCTIONAL PROGRESS IN LAST SIX MONTHS.
PA84	THE GRANT DATE OF THIS REQUEST CANNOT BE PRIOR TO THE SIGNATURE DATE OF THE PRESCRIBING PHYSICIAN.
PA86	PROVIDE EVIDENCE OF SKILLS GAINED IN THERAPY CARRYING OVER TO OTHER SETTINGS WITHIN SIX MONTHS.
PA87	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE NUMBER OF SESSIONS REQUESTED.
PA88	THE REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL SCOPE OF PRACTICE.
PA89	PRIOR AUTHORIZATION IS NOT REQUIRED UNTIL LIMITATION OF SERVICE HAS BEEN REACHED.
PA91	PLEASE SUBMIT REQUIRED X-RAYS.
PA92	PLEASE PROVIDE AN EXPLANATION FOR THE MATERIAL SUBMITTED WITH THE REQUEST.
PA95	PLEASE DESCRIBE HOW THE PROVISION OF THIS SERVICE WOULD PREVENT INSTITUTIONALIZATION OF THE CLIENT.
PA96	COULD THE EXISTING DENTURE(S) BE RELINED OR REBASED? IF NOT, PLEASE EXPLAIN WHY NOT.
PA97	REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL STANDARDS OF PRACTICE.
PA98	PLEASE INDICATE IF THE CLIENT IS CURRENTLY BEING TUBE FED.
PB02	PLEASE PROVIDE THE REQUIRED DATED SIGNATURES ON THE ATTACHMENTS.
PB03	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING THE LOSS/DESTRUCTION/THEFT OF THE HEARING AID.
PB04	DESCRIBE THE CLIENTS ABILITY TO STAND OR AMBULATE SUFFICIENTLY TO ACCOMPLISH SELF-CARE ACTIVITIES.
PB07	PLEASE SUBMIT AN ORTHODONTIC STUDY MODEL OR DIAGNOSTIC CASTS.
PB09	PLEASE PROVIDE A PHOTOGRAPH OF THE INVOLVED AREA(S).
PB10	PLEASE PROVIDE AN ESTIMATION (IN GRAMS) OF THE TOTAL AMOUNT OF TISSUE TO BE RESECTED.
PB11	PLEASE SUBMIT THE PLAN OF CARE FOR CO-TREATMENT.
PB12	FURNISH A DETAILED DESCRIPTION FOR THE PROCEDURE CODE REQUESTED.
PB13	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB15	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB18	PLEASE COMPLETE THE ATTACHED OUT-OF-STATE PROVIDER DATA SHEET, F-11001, AND RESUBMIT.
PB20	A SIGNED AND DATED PRESCRIPTION IS REQUIRED WITHIN THREE MONTHS OF RECEIPT BY COLORADO MEDICAID FOR INITIAL REQUESTS AND WITHIN 12 MONTHS OF RECEIPT BY COLORADO MEDICAID FOR SUBSEQUENT REQUESTS.

Denial Code	Long Description
PB21	PLEASE COMPLETE THE APPROPRIATE PRIOR AUTHORIZATION ATTACHMENT. CONTACT PROVIDER SERVICES OR THE PRIOR AUTHORIZATION UNIT FOR ASSISTANCE.
PB23	PHYSICAL THERAPY ASSISTANT NOTES AND ALL FORMS SUBMITTED MUST BE COSIGNED BY A REGISTERED PHYSICAL THERAPIST.
PB31	ARE YOU REQUESTING A COMPLETE APPLIANCE, OR REPLACEMENT PARTS?
PB32	THE PROCEDURE CODE INDICATED ON THE REQUEST DOES NOT MATCH THE DESCRIPTION OF SERVICE; PLEASE CORRECT AND RESUBMIT.
PB35	THE SERVICE REQUESTED DOES NOT REQUIRE PRIOR AUTHORIZATION.
PB41	PLEASE FURNISH A CURRENT MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT, F-11090 (DATED WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID).
PB45	THE CERTIFICATION PERIOD ON THE PLAN OF CARE (POC) DOES NOT COVER THE REQUESTED GRANT/START DATE. PLEASE RESUBMIT YOUR REQUEST WITH A NEW POC.
PB49	A CERTIFIED OCCUPATIONAL THERAPY ASSISTANTS NOTES MUST BE COSIGNED BY AN OCCUPATIONAL THERAPIST REGISTERED.
PB51	ADDITIONAL INFORMATION IS REQUIRED ON PRIOR AUTHORIZATION TO ENABLE PRICING.
PB54	REQUESTED SERVICES DO NOT MATCH SERVICES ON THE PHYSICIANS ORDERS.
PB59	PLEASE PROVIDE AN INDIVIDUAL EDUCATIONAL PLAN (IEP), WHICH HAS BEEN SIGNED BY THE PROVIDER NO EARLIER THAN NINE MONTHS PRIOR TO RECEIPT AT COLORADO MEDICAID; OTHERWISE, DOCUMENT WHY NO IEP EXISTS.
PB65	PLEASE FURNISH THE ANTICIPATED TOTAL CHARGES FOR THIS REQUEST.
PB66	A PHOTOCOPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED; THE DATE MUST BE WITHIN SIX MONTHS OF RECEIPT BY COLORADO MEDICAID.
PB67	THE PRESCRIPTION DATE MUST INCLUDE MONTH, DAY, AND YEAR.
PB68	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID.
PB73	THE SERVICES IDENTIFIED ON THE PLAN OF CARE DO NOT APPEAR APPROPRIATE FOR THE PROCEDURE CODE(S) REQUESTED ON THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018.
PB74	THE CLIENT/PROVIDER DOES NOT HAVE RETROACTIVE ENROLLMENT.
PB75	THE REQUESTED START DATE IS MORE THAN 14 DAYS BEFORE OR 62 DAYS AFTER RECEIPT.
PB82	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
PB83	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A HOME HEALTH AIDE. PLEASE RESUBMIT AS A PERSONAL CARE WORKER OR PROVIDE ADDITIONAL DOCUMENTATION.
PB86	THE SERVICES REQUESTED ARE NOT BEING PROVIDED IN THE CLIENTS RESIDENCE. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL.
PB87	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A NURSE. PLEASE RESUBMIT AS A HOME HEALTH AIDE OR PROVIDE ADDITIONAL DOCUMENTATION.
PB92	PLEASE FURNISH THE CLIENTS COMPLETE ADDRESS.
PB94	IF THE CLIENT IS A RESIDENT OF A NURSING HOME, SUPPLY THE COMPLETE NAME AND ADDRESS OF THE NURSING HOME.
PB99	THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018, MUST BE SIGNED AND DATED.
PC01	PLEASE SUPPLY THE RENDERING PROVIDERS PROVIDER NUMBER.
PC03	THE DRUG ENFORCEMENT ADMINISTRATION NUMBER IS MISSING OR INVALID.
PC06	PLEASE DESCRIBE YOUR PROGRAM; INCLUDE ENTRY DATE, TERMINATION DATE, HOURS PER WEEK, AND NUMBER OF WEEKS OF PRIMARY INTENSIVE SERVICE REQUESTED.
PC07	PLEASE DESCRIBE YOUR "AFTERCARE/FOLLOW-UP" PLANS FOR THIS CLIENT.
PC08	PLEASE SUPPLY DOCUMENTATION OF PREVIOUS SUBSTANCE ABUSE SERVICES WITH DATE(S) AND OUTCOME.
PC09	PLEASE DESCRIBE IN DETAIL THE TREATMENT OBJECTIVES/GOALS FOR THIS CLIENT.

Denial Code	Long Description
PC10	PLEASE DESCRIBE THE FAMILY SITUATION/DYNAMICS. EXPLAIN HOW THE FAMILY WILL BE INCORPORATED INTO THE CLIENTS PLAN OF CARE.
PC12	PLEASE EXPLAIN IF YOUR SERVICE ENCOURAGES THE CLIENT TO ATTEND SELF-HELP GROUPS.
PC13	PLEASE SUPPLY A SPECIFIC SCHEDULE OF ACTIVITIES, INCLUDING DAY, TIME OF DAY, LENGTH OF SESSION, AND SERVICE TO BE RENDERED DURING THAT TIME.
PC15	PLEASE FURNISH DIAGNOSTIC RATIONALE.
PC17	PLEASE DOCUMENT IF THE CLIENT EVER RECEIVED SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT.
PC19	PLEASE FURNISH MORE EXTENSIVE AND IN-DEPTH HISTORICAL AND PSYCHOSOCIAL DATA.
PC20	PLEASE SUPPLY THE DATE THE CLIENT BECAME TOTALLY ENDENTULOUS.
PC23	PLEASE SUBMIT A PHYSICIANS STATEMENT REGARDING THE MEDICAL NECESSITY OF DENTURES FOR THIS CLIENT. THE PHYSICIANS STATEMENT MUST DOCUMENT THE MEDICAL NEED FOR DENTURES.
PC24	THE SERVICE REQUESTED WAS PREVIOUSLY AUTHORIZED. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT INDICATING THIS FACT IS REQUIRED.
PC25	PLEASE SUPPLY SUFFICIENT MITIGATING CIRCUMSTANCES TO WARRANT THE CONSTRUCTION OF NEW DENTURES(S).
PC26	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
PC28	PLEASE SUBMIT A PHYSICIANS STATEMENT INDICATING DENTURES ARE NECESSARY FOR THIS NURSING HOME CLIENT.
PC29	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING LOSS OR DESTRUCTION OF DENTURE(S). INCLUDE SIGNED STATEMENT FROM CLIENT OR FACILITY DIRECTOR REGARDING HOW, WHEN AND WHERE LOST.
PC30	PLEASE PROVIDE COMPLETE INTRAORAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PC31	PLEASE DESCRIBE ANY RELATED DEFORMITIES OF THE FEET.
PC34	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD WITH REQUESTED DME ITEM(S) AND DOCUMENT IF THE CLIENT CAN USE SAFELY AND INDEPENDENTLY.
PC35	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD AND DESCRIBE THE RESULTS AND EFFECTIVENESS OF THE SERVICE REQUESTED.
PC39	PLEASE INDICATE LITER FLOW PER MINUTE, HOURS OF USE PER 24 HOUR PERIOD, AND THE EXPECTED DURATION OF NEED.
PC40	THE ITEM DOES NOT REQUIRE PRIOR AUTHORIZATION UNTIL THE LIFE EXPECTANCY HAS BEEN REACHED.
PC41	PLEASE SUPPLY INFORMATION INDICATING THE NECESSITY OF POSITIONING THE CLIENT'S BODY IN MULTIPLE POSITIONS.
PC42	PLEASE INDICATE IF THE BED HEIGHT MUST BE CHANGED TO ALLOW FOR SAFE TRANSFER OR ADEQUATE BED CARE.
PC43	SUPPLY A PHYSICIANS STATEMENT INDICATING TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR UNIT HAS REDUCED PAIN, IMPROVED/INCREASED THE CLIENTS ACTIVITY LEVEL, AND/OR REDUCED CLIENTS USE OF PAIN MEDICATION.
PC44	A CURRENT AUTHORIZATION FOR THIS SERVICE IS ON FILE FOR ANOTHER PROVIDER. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT OF THAT FACT IS REQUIRED BY THE CLIENT OF FIRST PROVIDER.
PC59	DOCUMENT DECLINE OR PROGRESS IN SPECIFIC, MEASURABLE, OBJECTIVE TERMS.
PC60	DOCUMENT IF CLIENT HAS DEMONSTRATED A GOOD APPOINTMENT COMPLIANCE RECORD.
PC61	THE PHYSICIANS SIGNATURE DATE MUST NOT EXCEED 90 DAYS FROM THE DATE OF RECEIPT BY COLORADO MEDICAID.
PC62	REQUESTS FOR A CONTINUATION OF THERAPY SHOULD NOT BE SUBMITTED MORE THAN FOUR WEEKS PRIOR TO THE EXPIRATION DATE OF THE CURRENT AUTHORIZATION.
PC63	PLEASE FURNISH THE STYLE AND MANUFACTURER OF THE FRAME.
PC64	PLEASE FURNISH THE CLIENTS LENS FORMULA.

Denial Code	Long Description
PC66	ALL REQUESTS FOR TINTS REQUIRE DOCUMENTATION OF THE VISUAL OR MEDICAL CONDITION RELATED TO PHOTOPHOBIA.
PC67	PLEASE DOCUMENT THE REASON AND JUSTIFICATION FOR REPLACEMENT BEYOND THE FIRST LENS/FRAME.
PC68	DOCUMENT IF ALL REMAINING MAXILLARY AND/OR MANDIBULAR TEETH ARE DECAY-FREE, PROPERLY RESTORED, AND PERIODONTICALLY SOUND.
PC72	SUPPLY MORE DETAIL REGARDING PROGRESS (ATTACHMENT OF GOALS, ETC.). CORRELATE PROGRESS TO PREVIOUS GOALS AND IDENTIFIED LIMITATIONS.
PC77	PLEASE SUBMIT A PLAN OF CARE DESCRIBING THE SERVICES THAT WOULD BE PROVIDED.
PC78	PLEASE DOCUMENT SPECIFIC, MEASURABLE GOALS.
PC82	THE PRIOR AUTHORIZATION (PA) SYSTEM CAN PROCESS ONLY 26 DETAILS PER PA REQUEST. PLEASE RESUBMIT YOUR REQUEST WITH NO MORE THAN 26 DETAILS.
PC83	PLEASE SUPPLY A PHYSICIANS PRESCRIPTION DATED WITHIN ONE MONTH OF REQUESTED SUBSTANCE ABUSE DAY TREATMENT.
PC84	PLEASE PROVIDE INFORMATION INDICATING THIS CLIENT IS APPROPRIATELY DETOXIFIED FROM ALCOHOL AND/OR OTHER DRUGS.
PC85	PLEASE PROVIDE INFORMATION TO INDICATE THE CLIENTS ABILITY TO ABSTAIN FROM ALCOHOL OR DRUGS WHILE IN THE SUBSTANCE ABUSE DAY TREATMENT PROGRAM.
PC86	PLEASE INDICATE IF THIS CLIENT IS WILLING TO PARTICIPATE IN AFTERCARE OR CONTINUING CARE SERVICES.
PC87	PROVIDE MORE INFORMATION ON TREATMENT HISTORY; INCLUDE SERVICE PROVIDED, DATES, AND OUTCOME. PROVIDE DETAIL OF PREVIOUS TREATMENT.
PC88	PLEASE PROVIDE MORE RATIONALE FOR THE APPROPRIATENESS AND MEDICAL NECESSITY OF SUBSTANCE ABUSE DAY TREATMENT.
PC89	PROVIDE A TREATMENT PLAN THAT CONTAINS MEASURABLE GOALS AND OBJECTIVES CORRESPONDING TO THE IDENTIFIED DEFICIT.
PC91	PLEASE PROVIDE MORE INFORMATION ON FAMILY INVOLVEMENT TREATMENT.
PC92	PLEASE PROVIDE MORE HISTORY AND EXPLANATION ABOUT THE ISSUE OF ABSTINENCE FOR THIS CLIENT.
PC94	PLEASE PROVIDE THE ANTICIPATED BEGINNING DATE AND/OR THE ESTIMATED SUBSTANCE ABUSE DAY TREATMENT DISCHARGE DATE.
PC95	PLEASE SUPPLY JUSTIFICATION FOR BEGINNING CLIENT IN SERVICE PRIOR TO AUTHORIZATION BEING OBTAINED.
PC96	THE INITIAL THREE HOURS OF SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IN A CALENDAR YEAR DO NOT REQUIRE PRIOR AUTHORIZATION.
PC97	REIMBURSEMENT FOR INITIAL SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IS LIMITED TO THREE HOURS IN A CALENDAR YEAR AND DOES NOT REQUIRE PRIOR AUTHORIZATION.
PC98	THIS DRUG IS CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE BILL USING THE APPROPRIATE NATIONAL DRUG CODE (NDC) OR SUBMIT A COMPLETED DRUG ADDITION REQUEST FORM IF THE NDC IS NOT LISTED IN THE DRUG INDEX.
PC99	THIS DRUG IS NOT CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL, CURRENT ADMINISTRATIVE RULE, OR COLORADO DRUG INDEX FOR COVERAGE LIMITATIONS.
PD01	DOCUMENT THAT CLIENT HAS ACHIEVED GOOD ORAL HYGIENE, PERIODONTAL CASE TYPE 1 OR 2, AND IS MOTIVATED TO MAINTAIN SAME.
PD03	PLEASE PROVIDE AN ARTERIAL BLOOD GAS READING OR PULSE OXIMETRY RESULTS DONE ON ROOM AIR SIGNED AND DATED BY A MEDICAL DOCTOR. THIS SHOULD BE DONE WITHIN 60 DAYS OF REQUESTED SERVICE.
PD04	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 30 DAYS OF RECEIPT BY COLORADO MEDICAID.
PD07	SUBMIT A PHOTOCOPY OF A VALID PRESCRIPTION, ISSUED WITHIN THE PAST YEAR, OR COMPLETE SECTION B OF THE PRIOR AUTHORIZATION/DRUG ATTACHMENT (PA/DGA), F-11049.

Denial Code	Long Description
PD10	BRAND MEDICALLY NECESSARY MUST BE IN THE PRESCRIBERS OWN HANDWRITING AND WRITTEN DIRECTLY ON THE PRESCRIPTION OR A SEPARATE ORDER ATTACHED TO THE ORIGINAL PRESCRIPTION.
PD12	COMPLETE DENTURES, PARTIAL DENTURES, DENTURE RELINES, AND FIXED PROSTHODONTIC SERVICES ARE NOT COVERED SERVICES FOR ADULTS FOR DATES OF SERVICE ON AND AFTER OCTOBER 1, 1995.
PD22	PLEASE COMPLETE ALL REQUIRED ELEMENTS ON THE PERSONAL CARE SCREENING TOOL (PCST), F-11133.
PD24	THIS PRIOR AUTHORIZATION REQUEST IS UNABLE TO BE PROCESSED. PLEASE RESUBMIT WITH ADDITIONAL REQUIRED FORMS, INCLUDING THE ENTIRE PERSONAL CARE SCREENING TOOL (PCST), F-11133; PERSONAL CARE ADDENDUM, F-11136; AND SUPPORTING DOCUMENTATION, AS DIRECTED.
PD25	THERE IS A PERSONAL CARE SCREENING TOOL (PCST), F-11133, COMPLETED BY ANOTHER AGENCY. CONTACT THE AGENCY TO TRANSFER SCREEN.
PD26	THERE IS A LIMITED TERM CARE FUNCTIONAL SCREEN (LTC-FS) COMPLETED BY ANOTHER AGENCY. THE PERSONAL CARE SCREENING TOOL (PCST), F-11133, INFORMATION IS IN CONFLICT WITH LTC-FS.
PD27	ONLY ONE LEVEL OF FUNCTION MAY BE SELECTED FOR ALL ELEMENTS EXCEPT TOILETING. COLORADO MEDICAID IS UNABLE TO PROCESS THE PRIOR AUTHORIZATION REQUEST.
PD28	NO UNITS MAY BE REQUESTED USING THIS PRIOR AUTHORIZATION PROCESS. PLEASE SUBMIT WITH THE APPROPRIATE ATTACHMENTS FOR REQUESTING SPECIFIC PERSONAL CARE WORKER UNITS.
PD29	CLIENT IS NOT ELIGIBLE FOR THE REQUESTED SERVICE(S) AS OF THE REQUESTED START DATE.
PD30	NO TRAVEL TIME MAY BE AUTHORIZED WHEN NO PERSONAL CARE WORKER SERVICE IS AUTHORIZED.
PD32	PROVIDER NOT CERTIFIED TO RENDER THE SERVICE(S) REQUESTED.
PD34	BASED ON THE DOCUMENTATION SUBMITTED, THIS REQUEST CAN NOT BE PRIOR AUTHORIZED. REFER TO THE PA MESSAGES FROM THE CONSULTANT FOR COMPLETE EXPLANATION.
PD98	PLEASE DOCUMENT HOW AND WHEN EACH PREVIOUSLY AUTHORIZED PRO RE NATA VISIT WAS USED.

Prosthetics, Orthotics

Denial Code	Long Description
0201	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
0233	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0235	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0237	CLIENT IDENTIFICATION NUMBER DOES NOT MATCH CLIENTS FIRST NAME.
0238	THE CLIENT IDENTIFICATION NUMBER DOES NOT MATCH THE CLIENTS LAST NAME.
0242	SECONDARY DIAGNOSIS CODE IS INVALID.
0248	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0249	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0251	PROCEDURE CODE MODIFIER IN FIRST POSITION IS INVALID.
0252	THE PROCEDURE CODE MODIFIER IN SECOND POSITION IS INVALID FOR REQUESTED START DATE OR DATE OF RECEIPT.
0253	THE PROCEDURE CODE MODIFIER IN THIRD POSITION IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
0258	THE PRIMARY DIAGNOSIS CODE IS REQUIRED.
0272	THE PRIMARY DIAGNSOSIS CODE IS INVALID.
0400	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0853	HCPCS - ANNUAL UPDATE
0885	NEVER EVENTS MODIFIERS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
0886	NEVER EVENTS DIAGNOSIS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.

Denial Code	Long Description
1000	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
1002	RENDERING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1003	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1007	RENDERING PROVIDER ID IS NOT ON FILE.
1047	THE RENDERING PROVIDERS CERTIFICATION HAS BEEN CANCELLED.
1048	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1801	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
1804	A CERTIFIED SUBSTANCE ABUSE DAY TREATMENT PROVIDER MUST SUBMIT A SUBSTANCE ABUSE DAY TREATMENT PROCEDURE CODE.
1806	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
1808	THE BILLING PROVIDER DOES NOT HAVE THE REQUIRED CERTIFICATION ADDENDUM ON FILE.
1900	THE BILLING PROVIDERS TAXONOMY CODE IS INVALID.
1901	THE RENDERING PROVIDERS TAXONOMY CODE IS INVALID.
1927	A NATIONAL PROVIDER IDENTIFIER IS REQUIRED FOR THE BILLING PROVIDER.
1934	A NATIONAL PROVIDER INDENTIFIER IS REQUIRED FOR THE RENDERING PROVIDER.
1936	THE BILLING PROVIDER NUMBER IS INVALID.
1937	THE RENDERING PROVIDER NUMBER IS INVALID.
1960	INTERNAL PROCESSING IS REQUIRED.
1963	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.
1964	THE BILLING PROVIDER INDICATED IS NOT ALLOWABLE AS A BILLING PROVIDER.
1965	RENDERING PROVIDER NUMBER IS MISSING/INVALID FOR THIS PROCEDURE PROVIDER.
1974	PRESCRIBING/REFERRING/ORDERING PROVIDER INDICATED IS NOT CERTIFIED AS A PRESCRIBING/REFERRING/ORDERING PROVIDER.
1975	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
1976	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
2001	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2003	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2017	THE CLIENT IS ENROLLED IN A MEDICAID OR OTHER MANAGED CARE PROGRAM.
2037	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2603	CLIENT LOCKED-IN TO A PROVIDER OR ENROLLED IN A HOSPICE. CONTACT CLIENTS HOSPICE FOR PAYMENT OF SERVICES OR RESUBMIT WITH DOCUMENTATION OF UNRELATED NATURE OF CARE.
3324	THE MODIFIER HAS BEEN DISCONTINUED BY THE CENTERS OF MEDICARE AND MEDICAID SERVICES OR THE AMERICAN MEDICAL ASSOCIATION FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
3337	THE PROCEDURE CODE HAS BEEN TERMINATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AMERICAN MEDICAL ASSOCIATION, OR AMERICAN DENTAL ASSOCIATION FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT. RESUBMIT WITH VALID A PROCEDURE CODE.
3339	THE PROCEDURE BILLED IS NOT PAYABLE ACCORDING TO DEFICIT REDUCTION ACT (DEFRA) GUIDELINES.
3351	THE PROCEDURE IS NOT COVERED FOR CLIENTS WITH A NURSING HOME AUTHORIZATION ON THE REQUESTED START DATE OR DATE OF RECEIPT.
3353	THE PROCEDURE IS NOT A COVERED SERVICE FOR HOME AND COMMUNITY-BASED WAIVER CLIENTS.
4021	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4027	THE DIAGNOSIS CODE IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
4031	THE PROCEDURE SUBMITTED IS NOT APPROPRIATE FOR CLIENTS GENDER.
4032	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4034	THE PROCEDURE CODE HAS AN AGE RESTRICTION.
4036	THE PLACE OF SERVICE CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4040	THE PRIMARY DIAGNOSIS CODE IS NOT ON FILE.
4041	THE SECONDARY DIAGNOSIS IS NOT ON FILE.
4046	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4127	INTERNAL PROCESSING IS REQUIRED.
4131	INTERNAL PROCESSING IS REQUIRED.
4141	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.

Denial Code	Long Description
4149	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4150	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4236	ETIOLOGY DIAGNOSIS CODE(S) (E-CODES) ARE INVALID AS THE PRIMARY DIAGNOSIS.
4245	THE FOURTH POSITION MODIFIER IS INVALID FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT.
4256	THE PROCEDURE CODE AND MODIFIER COMBINATION IS NOT PAYABLE FOR THE CLIENTS BENEFIT PLAN.
4257	THE MODIFIERS SUBMITTED ARE EITHER INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT OR THE MODIFIERS ARE MISSING.
4311	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4315	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4316	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4372	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4714	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS AGE.
4731	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS DIAGNOSIS.
4742	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4743	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4744	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4745	DIAGNOSIS AND/OR PROCEDURE AND/OR PLACE OF SERVICE (POS) CODE IS NOT COVERED FOR EXPRESS ENROLLMENT CLIENTS.
4746	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4801	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4802	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
4821	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
4871	PLEASE REFER TO PA MESSAGES FOR RETURN INFORMATION.
4963	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS GENDER.
4990	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
7500	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
7509	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
P001	THE BILLING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THE SERVICES.
P002	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P003	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P005	THE PRIOR AUTHORIZATION CAN NOT BE END DATED. THE PRIOR AUTHORIZATION STATUS IS NOT APPROVED OR APPROVED WITH REVISIONS.
P006	PLEASE FURNISH THE PROCEDURE CODE AND CORRESPONDING DESCRIPTION.
P008	THE BILLING PROVIDER NUMBER IS INVALID.
P009	THE BILLING PROVIDER NUMBER IS INVALID.
P010	THE REQUESTED END DATE IS INVALID.
P011	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P012	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P013	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P014	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P015	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P016	THE REQUESTED START DATE IS MISSING OR INVALID.
P020	THE RENDERING PROVIDER NUMBER IS INVALID.
P021	THE RENDERING PROVIDER NUMBER IS INVALID.
P022	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.

Denial Code	Long Description
P023	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P024	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P026	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P027	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P030	FIRST MODIFIER IS INVALID.
P031	FIRST MODIFIER IS INVALID.
P032	SECOND MODIFIER IS INVALID.
P033	SECOND MODIFIER IS INVALID.
P034	THIRD MODIFIER IS INVALID.
P035	THIRD MODIFIER IS INVALID.
P036	FOURTH MODIFIER IS INVALID.
P037	FOURTH MODIFIER IS INVALID.
P038	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P039	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P040	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P041	CLIENTS FIRST NAME IS MISSING.
P042	CLIENTS LAST NAME IS MISSING.
P043	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P044	BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES REQUESTED.
P045	FIRST MODIFIER IS INVALID.
P046	SECOND MODIFIER IS INVALID.
P047	THIRD MODIFIER IS INVALID.
P048	FOURTH MODIFIER IS INVALID.
P052	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P053	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P054	RENDERING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES FOR THE BENEFIT PLAN.
P055	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P061	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P062	THE CLIENT ID AND/OR NAME INDICATED ON THE PA REQUEST IS INCORRECT. THE CLIENT ID AND/OR NAME HAS BEEN UPDATED. PLEASE VERIFY THE ID AND/OR NAME IS CORRECT.
P064	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
P067	THE FREQUENCY OF HOURS REQUESTED ARE NOT APPROPRIATE FOR THIS CLIENT AND HAVE BEEN MODIFIED ACCORDINGLY.
P079	BILLING PROVIDER IS ON PAYMENT SUSPENSION DUE TO CREDIBLE ALLEGATION OF FRAUD.
P120	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAS BEEN REDUCED.
P121	THE SERVICE/ PROCEDURE REQUESTED IS NOT SUPPORTED BY SUBMITTED DOCUMENTATION.
P126	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
P128	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.
P138	SERVICE(S) DO NOT MEET COLORADO MEDICAID GUIDELINES.
P167	REQUESTED DOCUMENTATION HAS NOT BEEN SUBMITTED.
P178	THE SERVICE REQUESTED IS NOT MEDICALLY NECESSARY.
P179	THE MEDICAL NECESSITY FOR THIS SERVICE IS NOT SUPPORTED BY THE SUBMITTED DOCUMENTATION.
P233	THE DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE ADDITIONAL CARE.
P257	THIS CLIENTS FUNCTIONAL ASSESSMENT SCORES PLACE THIS CLIENT OUTSIDE ELIGIBILITY FOR DAY TREATMENT.
P274	OUR RECORDS INDICATE THIS CLIENT IS INVOLVED IN EFFECTIVE AND APPROPRIATE SERVICE ELSEWHERE.

Denial Code	Long Description
P292	INTENSIVE REHABILITATION HOURS ARE NO LONGER APPROPRIATE AS INDICATED BY HISTORY, DIAGNOSIS, AND/ OR FUNCTIONAL ASSESSMENT SCORES.
P328	THE SERVICES REQUESTED INCLUDE NON-COVERED SERVICES, AND HOURS ARE REDUCED ACCORDINGLY.
P339	THE CLIENTS PAST HISTORY INDICATES REDUCED TREATMENT HOURS ARE WARRANTED.
P342	THE REQUEST DOES NOT MEET GENERALLY ACCEPTED CONDITIONS REQUIRING FLUORIDE TREATMENTS.
P346	SERVICES EXCEED COLORADO MEDICAID LIMITATION AND DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE MEDICAL NECESSITY OF THE SERVICE.
P349	THE SERVICE REQUESTED WAS PERFORMED LESS THAN FIVE YEARS AGO.
P353	THE EXISTING APPLIANCE HAS NOT BEEN WORN FOR THREE YEARS.
P367	THE CLIENT HAS BEEN TOTALLY WITHOUT TEETH AND AN APPLIANCE FOR FIVE YEARS.
P392	THE CLIENT IS MISSING AN ANTERIOR TOOTH AND/OR HAS TWO OR MORE POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P405	THE SERVICE(S) REQUESTED COULD ADEQUATELY BE PERFORMED IN THE DENTAL OFFICE.
P406	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE OF GOOD PERIODONTAL HEALTH (AMERICAN ACADEMY OF PERIODONTOLOGY PERIODONTAL CLASSIFICATION OF TYPE I OR II).
P407	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE VISIBLE ON RADIOGRAPHS THAT AT LEAST 50 PERCENT OF THE CLINICAL CROWN IS INTACT.
P409	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING SIX OR MORE TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED, INCLUDING THIRD MOLARS.
P410	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING ONE OR MORE ANTERIOR TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED.
P411	DOCUMENTATION DOES NOT SUPPORT THE NEED FOR PERIODONTIC SERVICES. POCKETS ARE LESS THAN 4MM AND/OR GREATER THAN 6MM FOR CLIENT AND/OR THE CLIENT IS UNDER THE AGE OF 13.
P412	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA.
P413	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA. THIS PA HAS BEEN GRANTED AS APPROVED NOT APPROVED WITH REVISIONS. THE DURATION REQUESTED MAY HAVE BEEN REDUCED TO REFLECT COVERAGE LIMITATIONS, PRESCRIBER ORDERS, CONFLICTI
P417	THE SERVICE(S) REQUESTED COULD BE ADEQUATELY PERFORMED WITH LOCAL ANESTHESIA.
P437	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO POOR ORAL HYGIENE.
P444	THIS LINE ITEM IS A DUPLICATE OF ANOTHER LINE ITEM ON THIS PRIOR AUTHORIZATION (PA) REQUEST. PLEASE CORRECT.
P446	THIS IS A DUPLICATE OF AN EXISTING PRIOR AUTHORIZATION (PA) REQUEST. YOU MAY CONTACT PROVIDER SERVICES IF YOU REQUIRE ASSISTANCE. DUPLICATE PA REQUEST
P448	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO DECAY HISTORY.
P449	QUESTIONABLE LONG TERM PROGNOSIS DUE TO GUM AND BONE DISEASE.
P456	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO APPARENT ROOT INFECTION.
P457	OUR RECORDS INDICATE THIS CLIENT HAS EXCEEDED ESTABLISHED PROGRAM LIMITATIONS. COLORADO MEDICAID WILL NOT AUTHORIZE NEW DENTURES.
P458	DOCUMENTATION PROVIDED INDICATES A LESS ELABORATE PROCEDURE SHOULD BE CONSIDERED.
P502	RENTAL ONLY ALLOWED; MEDICAL NEED FOR PURCHASE HAS NOT BEEN DOCUMENTED.
P503	PURCHASE ONLY ALLOWED; MEDICAL NEED FOR RENTAL HAS NOT BEEN DOCUMENTED.
P504	OCCUPATIONAL THERAPY GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P505	THE SERVICE REQUESTED IS INCLUDED IN THE NURSING HOME RATE STRUCTURE.
P511	THIS NATIONAL DRUG CODE IS ONLY BILLABLE AS PART OF A COMPOUND DRUG.
P515	THE PRESENCE OF A HANDICAPPING MALOCCLUSION OR HANDICAPPING DENTOFACIAL DEFORMITY IS NOT SUPPORTED BY THE DOCUMENTATION SUBMITTED.
P521	THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVERED BY COLORADO MEDICAID.
P522	GASTRO-INTESTINAL SURGERY FOR THE PURPOSE OF WEIGHT CONTROL IS COVERED ONLY AS A LIFE THREATENING PROCEDURE.
P523	THE TREATMENT REQUEST IS NOT CONSISTENT WITH THE CLIENT'S DIAGNOSIS.
P524	PSYCHOTHERAPY PROVIDED IN THE CLIENTS HOME IS NOT A COVERED BENEFIT OF COLORADO MEDICAID.

Denial Code	Long Description
P525	THE INFORMATION PROVIDED IS NOT CONSISTENT WITH THE INTENSITY OF SERVICES REQUESTED.
P526	INTENSIVE MULTIPLE MODALITY TREATMENT IS NOT CONSISTENT WITH THE INFORMATION PROVIDED.
P527	MULTIPLE PROVIDERS OF TREATMENT ARE NOT INDICATED FOR THIS CLIENT.
P528	THE DURATION OF TREATMENT SESSIONS EXCEED CURRENT COLORADO MEDICAID GUIDELINES.
P534	DOCUMENTATION OF POOR PHYSICAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P535	OTHER PHYSICAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P536	THE PHYSICAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P537	USE OF PHYSICAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P538	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF A PHYSICAL THERAPIST.
P539	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS AND LIVING ARRANGEMENT.
P540	GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P541	THE PROCEDURE(S) REQUESTED ARE NOT MEDICAL IN NATURE.
P542	DOCUMENTATION OF POOR OCCUPATIONAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P543	DOCUMENTATION OF POOR SPEECH THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P544	OTHER OCCUPATIONAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P546	THE OCCUPATIONAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P547	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF PHYSICAL THERAPY.
P548	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P549	ACTIVITIES TO PROMOTE DIVERSION OR GENERAL MOTIVATION ARE NONCOVERED COLORADO MEDICAID SERVICES.
P550	REVISIONS OF THE REQUEST IS NECESSITATED BY THE CLIENTS MINIMAL PROGRESS.
P551	RESTORATIVE NURSING INVOLVEMENT COULD BE INCREASED.
P552	CLIENTS DEMONSTRATED RESPONSE TO CURRENT THERAPY DOES NOT WARRANT THE INTENSE FREQUENCY REQUESTED.
P553	MAINTENANCE IS TWO TIMES PER WEEK OR LESS.
P554	THE SPEECH THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P555	USE OF OCCUPATIONAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P556	USE OF SPEECH THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P557	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF AN OCCUPATIONAL THERAPIST.
P558	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
P559	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P560	THE MATERIALS/ SERVICES REQUESTED ARE PRINCIPALLY COSMETIC IN NATURE.
P561	THE LENS FORMULA DOES NOT JUSTIFY REPLACEMENT.
P562	THE CHANGE IN THE LENS FORMULA DOES NOT WARRANT MULTIPLE REPLACEMENTS.
P563	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P564	LENSES ONLY ARE APPROVED; PLEASE DISPENSE A CONTRACTED FRAME. THE NON-CONTRACTED FRAME IS NOT MEDICALLY JUSTIFIED.
P565	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P566	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P567	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF OCCUPATIONAL THERAPY.

Denial Code	Long Description
P568	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF SPEECH THERAPY.
P569	LEVEL, INTENSITY, OR EXTENT OF SERVICE(S) REQUESTED HAS BEEN MODIFIED CONSISTENT WITH MEDICAL NEED AS DEFINED IN THE PLAN OF CARE.
P570	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P571	THE SERVICE ASKED FOR IS NOT COVERED BY COLORADO MEDICAID AS THESE TASKS CAN BE DONE BY NURSES OR ACTIVITY STAFF.
P572	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P573	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.
P574	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P575	MEDICAL NEED FOR EQUIPMENT/ SUPPLY REQUESTED IS NOT SUPPORTED BY DOCUMENTATION SUBMITTED.
P576	OTHER SPEECH THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P577	DOCUMENTATION SUBMITTED IDENTIFIES THAT THE CLIENT HAS FEWER THAN TWO POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P582	LESS EXPENSIVE ALTERNATIVE SERVICES ARE AVAILABLE FOR THIS CLIENT.
P634	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P711	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING PERIODONTAL SCALING AND ROOT PLANNING.
P712	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING GINGIVECTOMY.
P754	AN APPROVED SUBSTANCE ABUSE DAY TREATMENT PROGRAM CANNOT EXCEED A SIX WEEK PERIOD.
P761	THE CLIENT DOES NOT APPEAR TO BE ABLE OR WILLING TO ABSTAIN FROM ALCOHOL/DRUG USAGE WHILE IN TREATMENT. THEREFORE, SUBSTANCE ABUSE DAY TREATMENT SERVICES ARE NOT APPROVED.
P764	THIS CLIENT HAS COMPLETED INTENSIVE SUBSTANCE ABUSE TREATMENT WITHIN THE PAST 12 MONTHS. THE DOCUMENTATION PROVIDED IS NOT ADEQUATE TO JUSTIFY ADDITIONAL INTENSIVE TREATMENT AT THIS TIME.
P785	A LESS THAN SIX-WEEK HEALING PERIOD HAS BEEN SPECIFIED FOR THIS PRIOR AUTHORIZATION. THEREFORE IT IS NOT NECESSARY TO WAIT THE FULL SIX WEEKS AFTER EXTRACTIONS BEFORE TAKING DENTURE IMPRESSIONS.
P818	SIX-WEEK HEALING TIME IS REQUIRED BETWEEN EDENTULATION AND FINAL IMPRESSIONS. PAYMENT FOR DENTURES WILL BE DENIED OR RECOUPED IF HEALING PERIOD IS NOT OBSERVED.
P849	COLORADO MEDICAID HAS DETERMINED THERE WERE (ARE) SEVERAL HOME HEALTH AGENCIES WILLING TO PROVIDE MEDICALLY NECESSARY SKILLED NURSING SERVICES TO THIS CLIENT.
P864	THE DOCUMENTATION YOU HAVE SUBMITTED DOES NOT MEET THE REQUIREMENTS OF COLORADO MEDICAID.
P873	THE MEDICAL NECESSITY FOR THE HOURS REQUESTED IS NOT SUPPORTED BY THE INFORMATION SUBMITTED.
P874	THE DOCUMENTATION SUBMITTED INDICATES THE TASKS SPECIFIED CAN BE COMPLETED DURING THE VISITS APPROVED.
P878	THE DOCUMENTATION SUBMITTED DOES NOT INDICATE THAT MEDICALLY ORIENTED TASKS ARE MEDICALLY NECESSARY; THEREFORE PERSONAL CARE SERVICES HAVE BEEN APPROVED.
P880	THE QUANTITY OF SERVICES AUTHORIZED FOR THIS CLIENTS PERSONAL CARE HAS BEEN AMENDED BASED ON INFORMATION RECEIVED FROM ONE OR MORE OF THESE SOURCES: THE CLIENT, THEIR PHYSICIAN, AND/OR THE IN-HOME VISIT BY STAFF OF THE OIG (OFFICE OF INSPECTOR GENERAL).
P885	THE USE OF THIS DRUG FOR THE INTENDED PURPOSE IS NOT COVERED BY COLORADO MEDICAID, CONSISTENT WITH COLORADO ADMINISTRATIVE CODE AND FEDERAL LAW.
P924	THE MEDICAL RECORDS SUBMITTED WITH THE CURRENT REQUEST CONFLICT OR DISAGREE WITH OUR MEDICAL RECORDS ON THIS CLIENT.
P950	INDEPENDENT NURSES, PLEASE NOTE PAYABLE SERVICES MAY NOT EXCEED 12 HOURS/DAY OR 60 HOURS/WEEK.

Denial Code	Long Description
P951	SERVICES CAN ONLY BE AUTHORIZED THROUGH ONE YEAR FROM THE PRESCRIPTION DATE.
P952	LEAD INSPECTION IS A COVERED COLORADO MEDICAID SERVICE WHEN THE CHILD HAS BEEN SHOWN TO HAVE LEAD POISONING (E.G., CHILD HAS A BLOOD LEAD LEVEL > 19 UG/DL OR TWO CONSECUTIVE BLOOD LEAD LEVELS OF 15-19 UG/DL DONE AT LEAST 90 DAYS APART). THE INSPECTION MUS
P953	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P954	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P956	THE REQUEST CAN ONLY BE BACKDATED A MAXIMUM OF 14 DAYS FROM FIRST DATE RECEIVED BY COLORADO MEDICAID.
P957	COMPLETE PERIODONTAL CHARTING AT TIME OF SERVICE, AND SUBMIT CHARTING, COPY OF OPERATIVE REPORT, TOGETHER WITH A COPY OF THE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF), F-11035, TO PA UNIT ATTENTION DENTAL CONTSULTANT.
P958	NOTE THAT CODE D4341 HAS BEEN CHANGED. REFER TO THE DECISION NOTICE FOR AUTHORIZED QUANTITY.
P960	YOUR PA HAS BEEN APPROVED FOR 90 DAYS. THE 90 DAY APPROVAL DOES NOT IMPLY THE PA REQUEST MEETS PRIOR AUTHORIZATION CRITERIA. AFTER ADDITIONAL INFORMATION IS AVAILABLE IN INTERCHANGE, COLORADO MEDICAID WILL CREATE AN AMENDMENT REQUEST TO EXTEND THE PA FOR
P961	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P962	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
PA10	THE REQUESTED END DATE IS INVALID.
PA12	PLEASE FURNISH A WRITTEN DESCRIPTION OF THE CLIENTS DIAGNOSIS.
PA13	PROVIDE DIAGNOSES WITH DATES OF ONSET.
PA14	IDENTIFY PROBLEMS TO BE TREATED.
PA15	THE AUDIOLOGISTS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1), F-11020, AND PRIOR AUTHORIZATION REQUEST/HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2), F-11021.
PA16	THE PHYSICIANS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION/PHYSICIAN OTOLOGICAL REPORT (PA/POR), F-11019.
PA17	SUBMIT BRIEF HISTORY WITH REFERRAL INFORMATION, LIVING SITUATION, FUNCTIONAL STATUS, AND OTHER PERTINENT INFORMATION. WHAT CHANGE OF STATUS RESULTED IN REFERRAL AT THIS TIME?
PA18	PLEASE FURNISH THE CLIENTS HEIGHT AND WEIGHT.
PA19	PLEASE SUBMIT CLINICAL INFORMATION SUFFICIENT TO VERIFY THE NEED FOR THE REQUESTED SERVICE(S).
PA20	PLEASE RESUBMIT WITH COMPLETE PERIODONTAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PA21	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL EDUCATIONAL PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA22	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL PROGRAM PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA23	REFER TO THE DURABLE MEDICAL EQUIPMENT INDEX FOR APPROPRIATE CODE AND DESCRIPTION. DO NOT USE AN "UNLISTED" CODE.
PA24	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUALIZED FAMILY SERVICE PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA25	INFORMATION ON THE REQUEST FORM IS ILLEGIBLE, AND THE REQUEST CANNOT BE PROCESSED.
PA26	RE-EVALUATE YOUR GOALS. EMPHASIS SHOULD BE ON FUNCTIONAL SELF-CARE. GOALS MUST BE RELATED TO FUNCTIONAL OUTCOME.
PA27	PLEASE CLARIFY THE NUMBER OF HOURS PER WEEK REQUESTED.
PA28	PLEASE CLARIFY THE NUMBER OF HOURS PER DAY REQUESTED.
PA29	PLEASE CLARIFY THE NUMBER OF VISITS PER DAY REQUESTED.

Denial Code	Long Description
PA30	ATTACH SUPPORTIVE DOCUMENTATION; HOME EXERCISE PROGRAM AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA31	THE DIAGNOSIS CODE INDICATED ON THE REQUEST DOES NOT CORRESPOND TO THE DIAGNOSIS CODE DESCRIPTION.
PA32	PLEASE SUBMIT ADDITIONAL INFORMATION SUFFICIENT TO VERIFY APPROPRIATENESS AND NEED FOR TRANSPLANT.
PA33	PLEASE SUBMIT THE INITIAL AND PROGRESSIVE OBJECTIVE FINDINGS.
PA34	ATTACH SUPPORTIVE DOCUMENTATION, FACILITY PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA35	PLEASE SUBMIT THE CLIENTS ORIGINAL COMPLAINTS AND EXAMINATION FINDINGS.
PA36	ATTACH SUPPORTIVE DOCUMENTATION, IN-HOME AUTISM PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA37	PLEASE SUBMIT YOUR TREATMENT PLAN FOR THIS CLIENT.
PA38	ATTACH SUPPORTIVE DOCUMENTATION AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA39	INITIAL EVALUATIONS MUST BE PERFORMED BY AN OCCUPATIONAL THERAPIST REGISTERED (OTR), PER AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA) STANDARDS.
PA41	IDENTIFY THE PLACE OF SERVICE AND ITS EFFECT ON SUPPORTING THE DESIRED TREATMENT OUTCOME.
PA42	PLEASE INDICATE THE HOURS OF USE OF OXYGEN PER 24-HOUR PERIOD.
PA43	PROVIDE BASELINE DOCUMENTATION FOR THIS CLIENTS LIMITATIONS USING UNITS OF MEASUREMENT THAT ARE APPLIED CONSISTENTLY WHEN REPORTING STATUS.
PA44	IDENTIFY FUNCTIONAL LIMITATIONS AS THEY ARE RELATED TO IDENTIFIED CONDITIONS.
PA46	CORRELATE PLAN OF CARE TO REQUESTED PROCEDURE CODES.
PA47	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE FREQUENCY/DURATION REQUESTED.
PA48	PLEASE PROVIDE THE NAME AND CREDENTIALS OF THE RENDERING PROVIDER.
PA50	COLORADO MEDICAID RECORDS INDICATE THE CLIENT OWNS A WHEELCHAIR. DOCUMENT THE REASON AND NEED FOR REPLACEMENT AND COST TO REPAIR CURRENT WHEELCHAIR.
PA51	PLEASE DISTINGUISH PRIMARY AND SUPPORTIVE MODALITIES.
PA52	PLEASE SUBMIT A PROGRESS REPORT.
PA53	MULTIPLE FAMILY CLIENTS TREATMENT BY THE SAME PROVIDER REQUIRES FURTHER INFORMATION DOCUMENTING COORDINATION OF TREATMENT PLAN.
PA54	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE MINUTES REQUESTED.
PA55	MEDICAL NECESSITY OF TREATMENT REQUIRES ADDITIONAL DOCUMENTATION.
PA56	GIVEN AGE, DIAGNOSES, CURRENT LEVEL OF FUNCTION, PAST RESPONSE TO TREATMENT, AND LIVING SITUATION, EXPAND ON POTENTIAL FOR SIGNIFICANT FUNCTIONAL PROGRESS WITHIN THE NEXT SIX MONTHS. EMPHASIZE WHY PROGRESS IS EXPECTED WITH SERVICES AT THIS TIME.
PA57	SUBMIT THE INITIAL FINDINGS. INCLUDE A COMPREHENSIVE EVALUATION.
PA58	SUBMIT PROGRESSIVE, OBJECTIVE FINDINGS. INCLUDE A PERTINENT RE-EVALUATION.
PA59	PLEASE SUPPLY INFORMATION REGARDING THE CLIENTS MEDICATION REQUIREMENTS, IF ANY.
PA60	PLEASE SPECIFY IF THE CLIENT IS IN AN EDUCATIONAL SETTING.
PA61	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA62	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
PA63	THE SKILLS OF A THERAPIST ARE PURPOSEFUL AND SKILLED INTERVENTIONS REQUIRED TO CONTINUALLY DESIGN, IMPLEMENT, REASSESS, MODIFY/GRADE, AND/OR DISCONTINUE A PLAN OF CARE IN A TIMELY MANNER, BASED ON THE COMPLEXITY OF THE CLIENTS MEDICAL CONDITION AND/OR CO
PA64	PLEASE SUBMIT A THERAPY PLAN OF CARE, INCLUDING A CURRENT, DATED EVALUATION.
PA65	A PLAN OF CARE SIGNED AND DATED BY THE PHYSICIAN IS REQUIRED.
PA66	THE SKILLS OF A THERAPIST ARE REQUIRED WHEN ONLY THE THERAPIST CAN SAFELY AND EFFECTIVELY DELIVER THE THERAPEUTIC PROCEDURES BECAUSE OF THEIR UNIQUE KNOWLEDGE, TRAINING, AND EXPERTISE. DESCRIBE THE REASON THAT SOMEONE OTHER THAN A THERAPIST CANNOT SAFELY

Denial Code	Long Description
PA67	PLEASE SPECIFY IF THE CLIENTS WORK SITE DEMANDS GOOD BINAURAL HEARING.
PA68	DESCRIBE THE REASON, BASED ON THE CLIENTS COGNITIVE, PHYSICAL, COMMUNICATION, OR RESOURCE STATUS, THAT A HOME PROGRAM, EQUIPMENT, OR ENVIRONMENTAL ADAPTATIONS ALONE CANNOT MEET CLIENTS NEEDS.
PA69	PLEASE SPECIFY IF THE CLIENT HAS AN ACCOMPANYING DISABILITY THAT ADDS TO THE HEARING PROBLEM.
PA70	DISTINGUISH REQUESTED PROCEDURES AND GOALS FROM OTHER SERVICES THIS CLIENT RECEIVES. THEY MAY NOT BE DUPLICATIVE.
PA71	PLEASE INDICATE THE NUMBER OF DAYS REQUESTED.
PA73	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA74	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA75	PLEASE DOCUMENT CARRYOVER OF THE THERAPY PROGRAM TO NURSING.
PA76	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA79	PROVIDE EVIDENCE OF SIGNIFICANT FUNCTIONAL PROGRESS IN LAST SIX MONTHS.
PA84	THE GRANT DATE OF THIS REQUEST CANNOT BE PRIOR TO THE SIGNATURE DATE OF THE PRESCRIBING PHYSICIAN.
PA86	PROVIDE EVIDENCE OF SKILLS GAINED IN THERAPY CARRYING OVER TO OTHER SETTINGS WITHIN SIX MONTHS.
PA87	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE NUMBER OF SESSIONS REQUESTED.
PA88	THE REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL SCOPE OF PRACTICE.
PA89	PRIOR AUTHORIZATION IS NOT REQUIRED UNTIL LIMITATION OF SERVICE HAS BEEN REACHED.
PA91	PLEASE SUBMIT REQUIRED X-RAYS.
PA92	PLEASE PROVIDE AN EXPLANATION FOR THE MATERIAL SUBMITTED WITH THE REQUEST.
PA95	PLEASE DESCRIBE HOW THE PROVISION OF THIS SERVICE WOULD PREVENT INSTITUTIONALIZATION OF THE CLIENT.
PA96	COULD THE EXISTING DENTURE(S) BE RELINED OR REBASED? IF NOT, PLEASE EXPLAIN WHY NOT.
PA97	REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL STANDARDS OF PRACTICE.
PA98	PLEASE INDICATE IF THE CLIENT IS CURRENTLY BEING TUBE FED.
PB02	PLEASE PROVIDE THE REQUIRED DATED SIGNATURES ON THE ATTACHMENTS.
PB03	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING THE LOSS/DESTRUCTION/THEFT OF THE HEARING AID.
PB04	DESCRIBE THE CLIENTS ABILITY TO STAND OR AMBULATE SUFFICIENTLY TO ACCOMPLISH SELF-CARE ACTIVITIES.
PB07	PLEASE SUBMIT AN ORTHODONTIC STUDY MODEL OR DIAGNOSTIC CASTS.
PB09	PLEASE PROVIDE A PHOTOGRAPH OF THE INVOLVED AREA(S).
PB10	PLEASE PROVIDE AN ESTIMATION (IN GRAMS) OF THE TOTAL AMOUNT OF TISSUE TO BE RESECTED.
PB11	PLEASE SUBMIT THE PLAN OF CARE FOR CO-TREATMENT.
PB12	FURNISH A DETAILED DESCRIPTION FOR THE PROCEDURE CODE REQUESTED.
PB13	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB15	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB18	PLEASE COMPLETE THE ATTACHED OUT-OF-STATE PROVIDER DATA SHEET, F-11001, AND RESUBMIT.
PB20	A SIGNED AND DATED PRESCRIPTION IS REQUIRED WITHIN THREE MONTHS OF RECEIPT BY COLORADO MEDICAID FOR INITIAL REQUESTS AND WITHIN 12 MONTHS OF RECEIPT BY COLORADO MEDICAID FOR SUBSEQUENT REQUESTS.
PB21	PLEASE COMPLETE THE APPROPRIATE PRIOR AUTHORIZATION ATTACHMENT. CONTACT PROVIDER SERVICES OR THE PRIOR AUTHORIZATION UNIT FOR ASSISTANCE.
PB23	PHYSICAL THERAPY ASSISTANT NOTES AND ALL FORMS SUBMITTED MUST BE COSIGNED BY A REGISTERED PHYSICAL THERAPIST.
PB31	ARE YOU REQUESTING A COMPLETE APPLIANCE, OR REPLACEMENT PARTS?
PB32	THE PROCEDURE CODE INDICATED ON THE REQUEST DOES NOT MATCH THE DESCRIPTION OF SERVICE; PLEASE CORRECT AND RESUBMIT.

Denial Code	Long Description
PB35	THE SERVICE REQUESTED DOES NOT REQUIRE PRIOR AUTHORIZATION.
PB41	PLEASE FURNISH A CURRENT MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT, F-11090 (DATED WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID).
PB45	THE CERTIFICATION PERIOD ON THE PLAN OF CARE (POC) DOES NOT COVER THE REQUESTED GRANT/START DATE. PLEASE RESUBMIT YOUR REQUEST WITH A NEW POC.
PB49	A CERTIFIED OCCUPATIONAL THERAPY ASSISTANTS NOTES MUST BE COSIGNED BY AN OCCUPATIONAL THERAPIST REGISTERED.
PB51	ADDITIONAL INFORMATION IS REQUIRED ON PRIOR AUTHORIZATION TO ENABLE PRICING.
PB54	REQUESTED SERVICES DO NOT MATCH SERVICES ON THE PHYSICIANS ORDERS.
PB59	PLEASE PROVIDE AN INDIVIDUAL EDUCATIONAL PLAN (IEP), WHICH HAS BEEN SIGNED BY THE PROVIDER NO EARLIER THAN NINE MONTHS PRIOR TO RECEIPT AT COLORADO MEDICAID; OTHERWISE, DOCUMENT WHY NO IEP EXISTS.
PB65	PLEASE FURNISH THE ANTICIPATED TOTAL CHARGES FOR THIS REQUEST.
PB66	A PHOTOCOPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED; THE DATE MUST BE WITHIN SIX MONTHS OF RECEIPT BY COLORADO MEDICAID.
PB67	THE PRESCRIPTION DATE MUST INCLUDE MONTH, DAY, AND YEAR.
PB68	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID.
PB73	THE SERVICES IDENTIFIED ON THE PLAN OF CARE DO NOT APPEAR APPROPRIATE FOR THE PROCEDURE CODE(S) REQUESTED ON THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018.
PB74	THE CLIENT/PROVIDER DOES NOT HAVE RETROACTIVE ENROLLMENT.
PB75	THE REQUESTED START DATE IS MORE THAN 14 DAYS BEFORE OR 62 DAYS AFTER RECEIPT.
PB82	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
PB83	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A HOME HEALTH AIDE. PLEASE RESUBMIT AS A PERSONAL CARE WORKER OR PROVIDE ADDITIONAL DOCUMENTATION.
PB86	THE SERVICES REQUESTED ARE NOT BEING PROVIDED IN THE CLIENTS RESIDENCE. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL.
PB87	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A NURSE. PLEASE RESUBMIT AS A HOME HEALTH AIDE OR PROVIDE ADDITIONAL DOCUMENTATION.
PB92	PLEASE FURNISH THE CLIENTS COMPLETE ADDRESS.
PB94	IF THE CLIENT IS A RESIDENT OF A NURSING HOME, SUPPLY THE COMPLETE NAME AND ADDRESS OF THE NURSING HOME.
PB99	THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018, MUST BE SIGNED AND DATED.
PC01	PLEASE SUPPLY THE RENDERING PROVIDERS PROVIDER NUMBER.
PC03	THE DRUG ENFORCEMENT ADMINISTRATION NUMBER IS MISSING OR INVALID.
PC06	PLEASE DESCRIBE YOUR PROGRAM; INCLUDE ENTRY DATE, TERMINATION DATE, HOURS PER WEEK, AND NUMBER OF WEEKS OF PRIMARY INTENSIVE SERVICE REQUESTED.
PC07	PLEASE DESCRIBE YOUR "AFTERCARE/FOLLOW-UP" PLANS FOR THIS CLIENT.
PC08	PLEASE SUPPLY DOCUMENTATION OF PREVIOUS SUBSTANCE ABUSE SERVICES WITH DATE(S) AND OUTCOME.
PC09	PLEASE DESCRIBE IN DETAIL THE TREATMENT OBJECTIVES/GOALS FOR THIS CLIENT.
PC10	PLEASE DESCRIBE THE FAMILY SITUATION/DYNAMICS. EXPLAIN HOW THE FAMILY WILL BE INCORPORATED INTO THE CLIENTS PLAN OF CARE.
PC12	PLEASE EXPLAIN IF YOUR SERVICE ENCOURAGES THE CLIENT TO ATTEND SELF-HELP GROUPS.
PC13	PLEASE SUPPLY A SPECIFIC SCHEDULE OF ACTIVITIES, INCLUDING DAY, TIME OF DAY, LENGTH OF SESSION, AND SERVICE TO BE RENDERED DURING THAT TIME.
PC15	PLEASE FURNISH DIAGNOSTIC RATIONALE.
PC17	PLEASE DOCUMENT IF THE CLIENT EVER RECEIVED SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT.
PC19	PLEASE FURNISH MORE EXTENSIVE AND IN-DEPTH HISTORICAL AND PSYCHOSOCIAL DATA.
PC20	PLEASE SUPPLY THE DATE THE CLIENT BECAME TOTALLY ENDENTULOUS.
PC23	PLEASE SUBMIT A PHYSICIANS STATEMENT REGARDING THE MEDICAL NECESSITY OF DENTURES FOR THIS CLIENT. THE PHYSICIANS STATEMENT MUST DOCUMENT THE MEDICAL NEED FOR DENTURES.
PC24	THE SERVICE REQUESTED WAS PREVIOUSLY AUTHORIZED. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT INDICATING THIS FACT IS REQUIRED.

Denial Code	Long Description
PC25	PLEASE SUPPLY SUFFICIENT MITIGATING CIRCUMSTANCES TO WARRANT THE CONSTRUCTION OF NEW DENTURES(S).
PC26	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
PC28	PLEASE SUBMIT A PHYSICIANS STATEMENT INDICATING DENTURES ARE NECESSARY FOR THIS NURSING HOME CLIENT.
PC29	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING LOSS OR DESTRUCTION OF DENTURE(S). INCLUDE SIGNED STATEMENT FROM CLIENT OR FACILITY DIRECTOR REGARDING HOW, WHEN AND WHERE LOST.
PC30	PLEASE PROVIDE COMPLETE INTRAORAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PC31	PLEASE DESCRIBE ANY RELATED DEFORMITIES OF THE FEET.
PC34	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD WITH REQUESTED DME ITEM(S) AND DOCUMENT IF THE CLIENT CAN USE SAFELY AND INDEPENDENTLY.
PC35	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD AND DESCRIBE THE RESULTS AND EFFECTIVENESS OF THE SERVICE REQUESTED.
PC39	PLEASE INDICATE LITER FLOW PER MINUTE, HOURS OF USE PER 24 HOUR PERIOD, AND THE EXPECTED DURATION OF NEED.
PC40	THE ITEM DOES NOT REQUIRE PRIOR AUTHORIZATION UNTIL THE LIFE EXPECTANCY HAS BEEN REACHED.
PC41	PLEASE SUPPLY INFORMATION INDICATING THE NECESSITY OF POSITIONING THE CLIENT'S BODY IN MULTIPLE POSITIONS.
PC42	PLEASE INDICATE IF THE BED HEIGHT MUST BE CHANGED TO ALLOW FOR SAFE TRANSFER OR ADEQUATE BED CARE.
PC43	SUPPLY A PHYSICIANS STATEMENT INDICATING TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR UNIT HAS REDUCED PAIN, IMPROVED/INCREASED THE CLIENTS ACTIVITY LEVEL, AND/OR REDUCED CLIENTS USE OF PAIN MEDICATION.
PC44	A CURRENT AUTHORIZATION FOR THIS SERVICE IS ON FILE FOR ANOTHER PROVIDER. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT OF THAT FACT IS REQUIRED BY THE CLIENT OF FIRST PROVIDER.
PC59	DOCUMENT DECLINE OR PROGRESS IN SPECIFIC, MEASURABLE, OBJECTIVE TERMS.
PC60	DOCUMENT IF CLIENT HAS DEMONSTRATED A GOOD APPOINTMENT COMPLIANCE RECORD.
PC61	THE PHYSICIANS SIGNATURE DATE MUST NOT EXCEED 90 DAYS FROM THE DATE OF RECEIPT BY COLORADO MEDICAID.
PC62	REQUESTS FOR A CONTINUATION OF THERAPY SHOULD NOT BE SUBMITTED MORE THAN FOUR WEEKS PRIOR TO THE EXPIRATION DATE OF THE CURRENT AUTHORIZATION.
PC63	PLEASE FURNISH THE STYLE AND MANUFACTURER OF THE FRAME.
PC64	PLEASE FURNISH THE CLIENTS LENS FORMULA.
PC66	ALL REQUESTS FOR TINTS REQUIRE DOCUMENTATION OF THE VISUAL OR MEDICAL CONDITION RELATED TO PHOTOPHOBIA.
PC67	PLEASE DOCUMENT THE REASON AND JUSTIFICATION FOR REPLACEMENT BEYOND THE FIRST LENS/FRAME.
PC68	DOCUMENT IF ALL REMAINING MAXILLARY AND/OR MANDIBULAR TEETH ARE DECAY-FREE, PROPERLY RESTORED, AND PERIODONTICALLY SOUND.
PC72	SUPPLY MORE DETAIL REGARDING PROGRESS (ATTACHMENT OF GOALS, ETC.). CORRELATE PROGRESS TO PREVIOUS GOALS AND IDENTIFIED LIMITATIONS.
PC77	PLEASE SUBMIT A PLAN OF CARE DESCRIBING THE SERVICES THAT WOULD BE PROVIDED.
PC78	PLEASE DOCUMENT SPECIFIC, MEASURABLE GOALS.
PC82	THE PRIOR AUTHORIZATION (PA) SYSTEM CAN PROCESS ONLY 26 DETAILS PER PA REQUEST. PLEASE RESUBMIT YOUR REQUEST WITH NO MORE THAN 26 DETAILS.
PC83	PLEASE SUPPLY A PHYSICIANS PRESCRIPTION DATED WITHIN ONE MONTH OF REQUESTED SUBSTANCE ABUSE DAY TREATMENT.
PC84	PLEASE PROVIDE INFORMATION INDICATING THIS CLIENT IS APPROPRIATELY DETOXIFIED FROM ALCOHOL AND/OR OTHER DRUGS.
PC85	PLEASE PROVIDE INFORMATION TO INDICATE THE CLIENTS ABILITY TO ABSTAIN FROM ALCOHOL OR DRUGS WHILE IN THE SUBSTANCE ABUSE DAY TREATMENT PROGRAM.

Denial Code	Long Description
PC86	PLEASE INDICATE IF THIS CLIENT IS WILLING TO PARTICIPATE IN AFTERCARE OR CONTINUING CARE SERVICES.
PC87	PROVIDE MORE INFORMATION ON TREATMENT HISTORY; INCLUDE SERVICE PROVIDED, DATES, AND OUTCOME. PROVIDE DETAIL OF PREVIOUS TREATMENT.
PC88	PLEASE PROVIDE MORE RATIONALE FOR THE APPROPRIATENESS AND MEDICAL NECESSITY OF SUBSTANCE ABUSE DAY TREATMENT.
PC89	PROVIDE A TREATMENT PLAN THAT CONTAINS MEASURABLE GOALS AND OBJECTIVES CORRESPONDING TO THE IDENTIFIED DEFICIT.
PC91	PLEASE PROVIDE MORE INFORMATION ON FAMILY INVOLVEMENT TREATMENT.
PC92	PLEASE PROVIDE MORE HISTORY AND EXPLANATION ABOUT THE ISSUE OF ABSTINENCE FOR THIS CLIENT.
PC94	PLEASE PROVIDE THE ANTICIPATED BEGINNING DATE AND/OR THE ESTIMATED SUBSTANCE ABUSE DAY TREATMENT DISCHARGE DATE.
PC95	PLEASE SUPPLY JUSTIFICATION FOR BEGINNING CLIENT IN SERVICE PRIOR TO AUTHORIZATION BEING OBTAINED.
PC96	THE INITIAL THREE HOURS OF SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IN A CALENDAR YEAR DO NOT REQUIRE PRIOR AUTHORIZATION.
PC97	REIMBURSEMENT FOR INITIAL SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IS LIMITED TO THREE HOURS IN A CALENDAR YEAR AND DOES NOT REQUIRE PRIOR AUTHORIZATION.
PC98	THIS DRUG IS CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE BILL USING THE APPROPRIATE NATIONAL DRUG CODE (NDC) OR SUBMIT A COMPLETED DRUG ADDITION REQUEST FORM IF THE NDC IS NOT LISTED IN THE DRUG INDEX.
PC99	THIS DRUG IS NOT CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL, CURRENT ADMINISTRATIVE RULE, OR COLORADO DRUG INDEX FOR COVERAGE LIMITATIONS.
PD01	DOCUMENT THAT CLIENT HAS ACHIEVED GOOD ORAL HYGIENE, PERIODONTAL CASE TYPE 1 OR 2, AND IS MOTIVATED TO MAINTAIN SAME.
PD03	PLEASE PROVIDE AN ARTERIAL BLOOD GAS READING OR PULSE OXIMETRY RESULTS DONE ON ROOM AIR SIGNED AND DATED BY A MEDICAL DOCTOR. THIS SHOULD BE DONE WITHIN 60 DAYS OF REQUESTED SERVICE.
PD04	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 30 DAYS OF RECEIPT BY COLORADO MEDICAID.
PD07	SUBMIT A PHOTOCOPY OF A VALID PRESCRIPTION, ISSUED WITHIN THE PAST YEAR, OR COMPLETE SECTION B OF THE PRIOR AUTHORIZATION/DRUG ATTACHMENT (PA/DGA), F-11049.
PD10	BRAND MEDICALLY NECESSARY MUST BE IN THE PRESCRIBERS OWN HANDWRITING AND WRITTEN DIRECTLY ON THE PRESCRIPTION OR A SEPARATE ORDER ATTACHED TO THE ORIGINAL PRESCRIPTION.
PD12	COMPLETE DENTURES, PARTIAL DENTURES, DENTURE RELINES, AND FIXED PROSTHODONTIC SERVICES ARE NOT COVERED SERVICES FOR ADULTS FOR DATES OF SERVICE ON AND AFTER OCTOBER 1, 1995.
PD22	PLEASE COMPLETE ALL REQUIRED ELEMENTS ON THE PERSONAL CARE SCREENING TOOL (PCST), F-11133.
PD24	THIS PRIOR AUTHORIZATION REQUEST IS UNABLE TO BE PROCESSED. PLEASE RESUBMIT WITH ADDITIONAL REQUIRED FORMS, INCLUDING THE ENTIRE PERSONAL CARE SCREENING TOOL (PCST), F-11133; PERSONAL CARE ADDENDUM, F-11136; AND SUPPORTING DOCUMENTATION, AS DIRECTED.
PD25	THERE IS A PERSONAL CARE SCREENING TOOL (PCST), F-11133, COMPLETED BY ANOTHER AGENCY. CONTACT THE AGENCY TO TRANSFER SCREEN.
PD26	THERE IS A LIMITED TERM CARE FUNCTIONAL SCREEN (LTC-FS) COMPLETED BY ANOTHER AGENCY. THE PERSONAL CARE SCREENING TOOL (PCST), F-11133, INFORMATION IS IN CONFLICT WITH LTC-FS.
PD27	ONLY ONE LEVEL OF FUNCTION MAY BE SELECTED FOR ALL ELEMENTS EXCEPT TOILETING. COLORADO MEDICAID IS UNABLE TO PROCESS THE PRIOR AUTHORIZATION REQUEST.
PD28	NO UNITS MAY BE REQUESTED USING THIS PRIOR AUTHORIZATION PROCESS. PLEASE SUBMIT WITH THE APPROPRIATE ATTACHMENTS FOR REQUESTING SPECIFIC PERSONAL CARE WORKER UNITS.
PD29	CLIENT IS NOT ELIGIBLE FOR THE REQUESTED SERVICE(S) AS OF THE REQUESTED START DATE.
PD30	NO TRAVEL TIME MAY BE AUTHORIZED WHEN NO PERSONAL CARE WORKER SERVICE IS AUTHORIZED.
PD32	PROVIDER NOT CERTIFIED TO RENDER THE SERVICE(S) REQUESTED.

Denial Code	Long Description
PD34	BASED ON THE DOCUMENTATION SUBMITTED, THIS REQUEST CAN NOT BE PRIOR AUTHORIZED. REFER TO THE PA MESSAGES FROM THE CONSULTANT FOR COMPLETE EXPLANATION.
PD98	PLEASE DOCUMENT HOW AND WHEN EACH PREVIOUSLY AUTHORIZED PRO RE NATA VISIT WAS USED.

Referral

Denial Code	Long Description
0201	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
0233	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0235	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0237	CLIENT IDENTIFICATION NUMBER DOES NOT MATCH CLIENTS FIRST NAME.
0238	THE CLIENT IDENTIFICATION NUMBER DOES NOT MATCH THE CLIENTS LAST NAME.
0242	SECONDARY DIAGNOSIS CODE IS INVALID.
0248	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0249	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0251	PROCEDURE CODE MODIFIER IN FIRST POSITION IS INVALID.
0252	THE PROCEDURE CODE MODIFIER IN SECOND POSITION IS INVALID FOR REQUESTED START DATE OR DATE OF RECEIPT.
0253	THE PROCEDURE CODE MODIFIER IN THIRD POSITION IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
0258	THE PRIMARY DIAGNOSIS CODE IS REQUIRED.
0272	THE PRIMARY DIAGNSOSIS CODE IS INVALID.
0400	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0853	HCPCS - ANNUAL UPDATE
0885	NEVER EVENTS MODIFIERS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
0886	NEVER EVENTS DIAGNOSIS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
1000	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
1002	RENDERING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1003	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1007	RENDERING PROVIDER ID IS NOT ON FILE.
1047	THE RENDERING PROVIDERS CERTIFICATION HAS BEEN CANCELLED.
1048	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1801	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
1804	A CERTIFIED SUBSTANCE ABUSE DAY TREATMENT PROVIDER MUST SUBMIT A SUBSTANCE ABUSE DAY TREATMENT PROCEDURE CODE.
1806	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
1808	THE BILLING PROVIDER DOES NOT HAVE THE REQUIRED CERTIFICATION ADDENDUM ON FILE.
1900	THE BILLING PROVIDERS TAXONOMY CODE IS INVALID.
1901	THE RENDERING PROVIDERS TAXONOMY CODE IS INVALID.
1927	A NATIONAL PROVIDER IDENTIFIER IS REQUIRED FOR THE BILLING PROVIDER.
1934	A NATIONAL PROVIDER INDENTIFIER IS REQUIRED FOR THE RENDERING PROVIDER.
1936	THE BILLING PROVIDER NUMBER IS INVALID.
1937	THE RENDERING PROVIDER NUMBER IS INVALID.
1960	INTERNAL PROCESSING IS REQUIRED.
1963	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.

Denial Code	Long Description
1964	THE BILLING PROVIDER INDICATED IS NOT ALLOWABLE AS A BILLING PROVIDER.
1965	RENDERING PROVIDER NUMBER IS MISSING/INVALID FOR THIS PROCEDURE PROVIDER.
1974	PRESCRIBING/REFERRING/ORDERING PROVIDER INDICATED IS NOT CERTIFIED AS A PRESCRIBING/REFERRING/ORDERING PROVIDER.
1975	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
1976	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
2001	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2003	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2017	THE CLIENT IS ENROLLED IN A MEDICAID OR OTHER MANAGED CARE PROGRAM.
2037	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2603	CLIENT LOCKED-IN TO A PROVIDER OR ENROLLED IN A HOSPICE. CONTACT CLIENTS HOSPICE FOR PAYMENT OF SERVICES OR RESUBMIT WITH DOCUMENTATION OF UNRELATED NATURE OF CARE.
3324	THE MODIFIER HAS BEEN DISCONTINUED BY THE CENTERS OF MEDICARE AND MEDICAID SERVICES OR THE AMERICAN MEDICAL ASSOCIATION FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
3337	THE PROCEDURE CODE HAS BEEN TERMINATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AMERICAN MEDICAL ASSOCIATION, OR AMERICAN DENTAL ASSOCIATION FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT. RESUBMIT WITH VALID A PROCEDURE CODE.
3339	THE PROCEDURE BILLED IS NOT PAYABLE ACCORDING TO DEFICIT REDUCTION ACT (DEFRA) GUIDELINES.
3351	THE PROCEDURE IS NOT COVERED FOR CLIENTS WITH A NURSING HOME AUTHORIZATION ON THE REQUESTED START DATE OR DATE OF RECEIPT.
3353	THE PROCEDURE IS NOT A COVERED SERVICE FOR HOME AND COMMUNITY-BASED WAIVER CLIENTS.
4021	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4027	THE DIAGNOSIS CODE IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
4031	THE PROCEDURE SUBMITTED IS NOT APPROPRIATE FOR CLIENTS GENDER.
4032	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4034	THE PROCEDURE CODE HAS AN AGE RESTRICTION.
4036	THE PLACE OF SERVICE CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4040	THE PRIMARY DIAGNOSIS CODE IS NOT ON FILE.
4041	THE SECONDARY DIAGNOSIS IS NOT ON FILE.
4046	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4127	INTERNAL PROCESSING IS REQUIRED.
4131	INTERNAL PROCESSING IS REQUIRED.
4141	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4149	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4150	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4236	ETIOLOGY DIAGNOSIS CODE(S) (E-CODES) ARE INVALID AS THE PRIMARY DIAGNOSIS.
4244	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4245	THE FOURTH POSITION MODIFIER IS INVALID FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT.
4256	THE PROCEDURE CODE AND MODIFIER COMBINATION IS NOT PAYABLE FOR THE CLIENTS BENEFIT PLAN.
4257	THE MODIFIERS SUBMITTED ARE EITHER INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT OR THE MODIFIERS ARE MISSING.
4311	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4315	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4316	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4371	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4372	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4711	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR CLIENTS AGE.
4714	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS AGE.
4731	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS DIAGNOSIS.
4742	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4743	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4744	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.

Denial Code	Long Description
4745	DIAGNOSIS AND/OR PROCEDURE AND/OR PLACE OF SERVICE (POS) CODE IS NOT COVERED FOR EXPRESS ENROLLMENT CLIENTS.
4746	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4801	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4802	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
4821	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
4871	PLEASE REFER TO PA MESSAGES FOR RETURN INFORMATION.
4963	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS GENDER.
4990	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
7500	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
7509	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
P001	THE BILLING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THE SERVICES.
P002	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P003	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P005	THE PRIOR AUTHORIZATION CAN NOT BE END DATED. THE PRIOR AUTHORIZATION STATUS IS NOT APPROVED OR APPROVED WITH REVISIONS.
P006	PLEASE FURNISH THE PROCEDURE CODE AND CORRESPONDING DESCRIPTION.
P008	THE BILLING PROVIDER NUMBER IS INVALID.
P009	THE BILLING PROVIDER NUMBER IS INVALID.
P010	THE REQUESTED END DATE IS INVALID.
P011	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P012	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P013	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P014	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P015	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P016	THE REQUESTED START DATE IS MISSING OR INVALID.
P019	THE REQUESTED START DATE IS MISSING OR INVALID.
P020	THE RENDERING PROVIDER NUMBER IS INVALID.
P021	THE RENDERING PROVIDER NUMBER IS INVALID.
P022	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P023	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P024	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P026	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P027	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P030	FIRST MODIFIER IS INVALID.
P031	FIRST MODIFIER IS INVALID.
P032	SECOND MODIFIER IS INVALID.
P033	SECOND MODIFIER IS INVALID.
P034	THIRD MODIFIER IS INVALID.
P035	THIRD MODIFIER IS INVALID.
P036	FOURTH MODIFIER IS INVALID.
P037	FOURTH MODIFIER IS INVALID.
P038	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P039	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.

Denial Code	Long Description
P040	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P041	CLIENTS FIRST NAME IS MISSING.
P042	CLIENTS LAST NAME IS MISSING.
P043	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P044	BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES REQUESTED.
P045	FIRST MODIFIER IS INVALID.
P046	SECOND MODIFIER IS INVALID.
P047	THIRD MODIFIER IS INVALID.
P048	FOURTH MODIFIER IS INVALID.
P052	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P053	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P054	RENDERING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES FOR THE BENEFIT PLAN.
P055	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P061	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P062	THE CLIENT ID AND/OR NAME INDICATED ON THE PA REQUEST IS INCORRECT. THE CLIENT ID AND/OR NAME HAS BEEN UPDATED. PLEASE VERIFY THE ID AND/OR NAME IS CORRECT.
P064	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
P067	THE FREQUENCY OF HOURS REQUESTED ARE NOT APPROPRIATE FOR THIS CLIENT AND HAVE BEEN MODIFIED ACCORDINGLY.
P120	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAS BEEN REDUCED.
P121	THE SERVICE/ PROCEDURE REQUESTED IS NOT SUPPORTED BY SUBMITTED DOCUMENTATION.
P126	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
P128	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.
P138	SERVICE(S) DO NOT MEET COLORADO MEDICAID GUIDELINES.
P167	REQUESTED DOCUMENTATION HAS NOT BEEN SUBMITTED.
P178	THE SERVICE REQUESTED IS NOT MEDICALLY NECESSARY.
P179	THE MEDICAL NECESSITY FOR THIS SERVICE IS NOT SUPPORTED BY THE SUBMITTED DOCUMENTATION.
P233	THE DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE ADDITIONAL CARE.
P257	THIS CLIENTS FUNCTIONAL ASSESSMENT SCORES PLACE THIS CLIENT OUTSIDE ELIGIBILITY FOR DAY TREATMENT.
P274	OUR RECORDS INDICATE THIS CLIENT IS INVOLVED IN EFFECTIVE AND APPROPRIATE SERVICE ELSEWHERE.
P292	INTENSIVE REHABILITATION HOURS ARE NO LONGER APPROPRIATE AS INDICATED BY HISTORY, DIAGNOSIS, AND/ OR FUNCTIONAL ASSESSMENT SCORES.
P328	THE SERVICES REQUESTED INCLUDE NON-COVERED SERVICES, AND HOURS ARE REDUCED ACCORDINGLY.
P339	THE CLIENTS PAST HISTORY INDICATES REDUCED TREATMENT HOURS ARE WARRANTED.
P342	THE REQUEST DOES NOT MEET GENERALLY ACCEPTED CONDITIONS REQUIRING FLUORIDE TREATMENTS.
P346	SERVICES EXCEED COLORADO MEDICAID LIMITATION AND DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE MEDICAL NECESSITY OF THE SERVICE.
P349	THE SERVICE REQUESTED WAS PERFORMED LESS THAN FIVE YEARS AGO.
P353	THE EXISTING APPLIANCE HAS NOT BEEN WORN FOR THREE YEARS.
P367	THE CLIENT HAS BEEN TOTALLY WITHOUT TEETH AND AN APPLIANCE FOR FIVE YEARS.
P392	THE CLIENT IS MISSING AN ANTERIOR TOOTH AND/OR HAS TWO OR MORE POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P405	THE SERVICE(S) REQUESTED COULD ADEQUATELY BE PERFORMED IN THE DENTAL OFFICE.
P406	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE OF GOOD PERIODONTAL HEALTH (AMERICAN ACADEMY OF PERIODONTOLOGY PERIODONTAL CLASSIFICATION OF TYPE I OR II).
P407	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE VISIBLE ON RADIOGRAPHS THAT AT LEAST 50 PERCENT OF THE CLINICAL CROWN IS INTACT.

Denial Code	Long Description
P409	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING SIX OR MORE TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED, INCLUDING THIRD MOLARS.
P410	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING ONE OR MORE ANTERIOR TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED.
P411	DOCUMENTATION DOES NOT SUPPORT THE NEED FOR PERIODONTIC SERVICES. POCKETS ARE LESS THAN 4MM AND/OR GREATER THAN 6MM FOR CLIENT AND/OR THE CLIENT IS UNDER THE AGE OF 13.
P412	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA.
P413	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA. THIS PA HAS BEEN GRANTED AS APPROVED NOT APPROVED WITH REVISIONS. THE DURATION REQUESTED MAY HAVE BEEN REDUCED TO REFLECT COVERAGE LIMITATIONS, PRESCRIBER ORDERS, CONFLICTI
P417	THE SERVICE(S) REQUESTED COULD BE ADEQUATELY PERFORMED WITH LOCAL ANESTHESIA.
P437	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO POOR ORAL HYGIENE.
P446	THIS IS A DUPLICATE OF AN EXISTING PRIOR AUTHORIZATION (PA) REQUEST. YOU MAY CONTACT PROVIDER SERVICES IF YOU REQUIRE ASSISTANCE. DUPLICATE PA REQUEST
P448	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO DECAY HISTORY.
P449	QUESTIONABLE LONG TERM PROGNOSIS DUE TO GUM AND BONE DISEASE.
P456	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO APPARENT ROOT INFECTION.
P457	OUR RECORDS INDICATE THIS CLIENT HAS EXCEEDED ESTABLISHED PROGRAM LIMITATIONS. COLORADO MEDICAID WILL NOT AUTHORIZE NEW DENTURES.
P458	DOCUMENTATION PROVIDED INDICATES A LESS ELABORATE PROCEDURE SHOULD BE CONSIDERED.
P502	RENTAL ONLY ALLOWED; MEDICAL NEED FOR PURCHASE HAS NOT BEEN DOCUMENTED.
P503	PURCHASE ONLY ALLOWED; MEDICAL NEED FOR RENTAL HAS NOT BEEN DOCUMENTED.
P504	OCCUPATIONAL THERAPY GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P505	THE SERVICE REQUESTED IS INCLUDED IN THE NURSING HOME RATE STRUCTURE.
P511	THIS NATIONAL DRUG CODE IS ONLY BILLABLE AS PART OF A COMPOUND DRUG.
P515	THE PRESENCE OF A HANDICAPPING MALOCCLUSION OR HANDICAPPING DENTOFACIAL DEFORMITY IS NOT SUPPORTED BY THE DOCUMENTATION SUBMITTED.
P521	THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVERED BY COLORADO MEDICAID.
P522	GASTRO-INTESTINAL SURGERY FOR THE PURPOSE OF WEIGHT CONTROL IS COVERED ONLY AS A LIFE THREATENING PROCEDURE.
P523	THE TREATMENT REQUEST IS NOT CONSISTENT WITH THE CLIENT'S DIAGNOSIS.
P524	PSYCHOTHERAPY PROVIDED IN THE CLIENTS HOME IS NOT A COVERED BENEFIT OF COLORADO MEDICAID.
P525	THE INFORMATION PROVIDED IS NOT CONSISTENT WITH THE INTENSITY OF SERVICES REQUESTED.
P526	INTENSIVE MULTIPLE MODALITY TREATMENT IS NOT CONSISTENT WITH THE INFORMATION PROVIDED.
P527	MULTIPLE PROVIDERS OF TREATMENT ARE NOT INDICATED FOR THIS CLIENT.
P528	THE DURATION OF TREATMENT SESSIONS EXCEED CURRENT COLORADO MEDICAID GUIDELINES.
P534	DOCUMENTATION OF POOR PHYSICAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P535	OTHER PHYSICAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P536	THE PHYSICAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P537	USE OF PHYSICAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P538	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF A PHYSICAL THERAPIST.
P539	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS AND LIVING ARRANGEMENT.
P540	GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P541	THE PROCEDURE(S) REQUESTED ARE NOT MEDICAL IN NATURE.
P542	DOCUMENTATION OF POOR OCCUPATIONAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.

Denial Code	Long Description
P543	DOCUMENTATION OF POOR SPEECH THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P546	THE OCCUPATIONAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P547	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF PHYSICAL THERAPY.
P548	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P549	ACTIVITIES TO PROMOTE DIVERSION OR GENERAL MOTIVATION ARE NONCOVERED COLORADO MEDICAID SERVICES.
P550	REVISIONS OF THE REQUEST IS NECESSITATED BY THE CLIENTS MINIMAL PROGRESS.
P551	RESTORATIVE NURSING INVOLVEMENT COULD BE INCREASED.
P552	CLIENTS DEMONSTRATED RESPONSE TO CURRENT THERAPY DOES NOT WARRANT THE INTENSE FREQUENCY REQUESTED.
P553	MAINTENANCE IS TWO TIMES PER WEEK OR LESS.
P554	THE SPEECH THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P555	USE OF OCCUPATIONAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P556	USE OF SPEECH THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P557	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF AN OCCUPATIONAL THERAPIST.
P558	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
P559	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P560	THE MATERIALS/ SERVICES REQUESTED ARE PRINCIPALLY COSMETIC IN NATURE.
P561	THE LENS FORMULA DOES NOT JUSTIFY REPLACEMENT.
P562	THE CHANGE IN THE LENS FORMULA DOES NOT WARRANT MULTIPLE REPLACEMENTS.
P563	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P564	LENSES ONLY ARE APPROVED; PLEASE DISPENSE A CONTRACTED FRAME. THE NON-CONTRACTED FRAME IS NOT MEDICALLY JUSTIFIED.
P565	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P566	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P567	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF OCCUPATIONAL THERAPY.
P568	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF SPEECH THERAPY.
P569	LEVEL, INTENSITY, OR EXTENT OF SERVICE(S) REQUESTED HAS BEEN MODIFIED CONSISTENT WITH MEDICAL NEED AS DEFINED IN THE PLAN OF CARE.
P570	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P571	THE SERVICE ASKED FOR IS NOT COVERED BY COLORADO MEDICAID AS THESE TASKS CAN BE DONE BY NURSES OR ACTIVITY STAFF.
P572	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P573	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.
P574	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P575	MEDICAL NEED FOR EQUIPMENT/ SUPPLY REQUESTED IS NOT SUPPORTED BY DOCUMENTATION SUBMITTED.
P576	OTHER SPEECH THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P577	DOCUMENTATION SUBMITTED IDENTIFIES THAT THE CLIENT HAS FEWER THAN TWO POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P582	LESS EXPENSIVE ALTERNATIVE SERVICES ARE AVAILABLE FOR THIS CLIENT.
P634	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.

Denial Code	Long Description
P711	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING PERIODONTAL SCALING AND ROOT PLANNING.
P712	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING GINGIVECTOMY.
P754	AN APPROVED SUBSTANCE ABUSE DAY TREATMENT PROGRAM CANNOT EXCEED A SIX WEEK PERIOD.
P761	THE CLIENT DOES NOT APPEAR TO BE ABLE OR WILLING TO ABSTAIN FROM ALCOHOL/DRUG USAGE WHILE IN TREATMENT. THEREFORE, SUBSTANCE ABUSE DAY TREATMENT SERVICES ARE NOT APPROVED.
P764	THIS CLIENT HAS COMPLETED INTENSIVE SUBSTANCE ABUSE TREATMENT WITHIN THE PAST 12 MONTHS. THE DOCUMENTATION PROVIDED IS NOT ADEQUATE TO JUSTIFY ADDITIONAL INTENSIVE TREATMENT AT THIS TIME.
P785	A LESS THAN SIX-WEEK HEALING PERIOD HAS BEEN SPECIFIED FOR THIS PRIOR AUTHORIZATION. THEREFORE IT IS NOT NECESSARY TO WAIT THE FULL SIX WEEKS AFTER EXTRACTIONS BEFORE TAKING DENTURE IMPRESSIONS.
P818	SIX-WEEK HEALING TIME IS REQUIRED BETWEEN EDENTULATION AND FINAL IMPRESSIONS. PAYMENT FOR DENTURES WILL BE DENIED OR RECOUPED IF HEALING PERIOD IS NOT OBSERVED.
P849	COLORADO MEDICAID HAS DETERMINED THERE WERE (ARE) SEVERAL HOME HEALTH AGENCIES WILLING TO PROVIDE MEDICALLY NECESSARY SKILLED NURSING SERVICES TO THIS CLIENT.
P864	THE DOCUMENTATION YOU HAVE SUBMITTED DOES NOT MEET THE REQUIREMENTS OF COLORADO MEDICAID.
P873	THE MEDICAL NECESSITY FOR THE HOURS REQUESTED IS NOT SUPPORTED BY THE INFORMATION SUBMITTED.
P874	THE DOCUMENTATION SUBMITTED INDICATES THE TASKS SPECIFIED CAN BE COMPLETED DURING THE VISITS APPROVED.
P878	THE DOCUMENTATION SUBMITTED DOES NOT INDICATE THAT MEDICALLY ORIENTED TASKS ARE MEDICALLY NECESSARY; THEREFORE PERSONAL CARE SERVICES HAVE BEEN APPROVED.
P880	THE QUANTITY OF SERVICES AUTHORIZED FOR THIS CLIENTS PERSONAL CARE HAS BEEN AMENDED BASED ON INFORMATION RECEIVED FROM ONE OR MORE OF THESE SOURCES: THE CLIENT, THEIR PHYSICIAN, AND/OR THE IN-HOME VISIT BY STAFF OF THE OIG (OFFICE OF INSPECTOR GENERAL).
P885	THE USE OF THIS DRUG FOR THE INTENDED PURPOSE IS NOT COVERED BY COLORADO MEDICAID, CONSISTENT WITH COLORADO ADMINISTRATIVE CODE AND FEDERAL LAW.
P924	THE MEDICAL RECORDS SUBMITTED WITH THE CURRENT REQUEST CONFLICT OR DISAGREE WITH OUR MEDICAL RECORDS ON THIS CLIENT.
P950	INDEPENDENT NURSES, PLEASE NOTE PAYABLE SERVICES MAY NOT EXCEED 12 HOURS/DAY OR 60 HOURS/WEEK.
P951	SERVICES CAN ONLY BE AUTHORIZED THROUGH ONE YEAR FROM THE PRESCRIPTION DATE.
P952	LEAD INSPECTION IS A COVERED COLORADO MEDICAID SERVICE WHEN THE CHILD HAS BEEN SHOWN TO HAVE LEAD POISONING (E.G., CHILD HAS A BLOOD LEAD LEVEL > 19 UG/DL OR TWO CONSECUTIVE BLOOD LEAD LEVELS OF 15-19 UG/DL DONE AT LEAST 90 DAYS APART). THE INSPECTION MUS
P953	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P954	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P956	THE REQUEST CAN ONLY BE BACKDATED A MAXIMUM OF 14 DAYS FROM FIRST DATE RECEIVED BY COLORADO MEDICAID.
P957	COMPLETE PERIODONTAL CHARTING AT TIME OF SERVICE, AND SUBMIT CHARTING, COPY OF OPERATIVE REPORT, TOGETHER WITH A COPY OF THE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF), F-11035, TO PA UNIT ATTENTION DENTAL CONTSULTANT.
P958	NOTE THAT CODE D4341 HAS BEEN CHANGED. REFER TO THE DECISION NOTICE FOR AUTHORIZED QUANTITY.
P960	YOUR PA HAS BEEN APPROVED FOR 90 DAYS. THE 90 DAY APPROVAL DOES NOT IMPLY THE PA REQUEST MEETS PRIOR AUTHORIZATION CRITERIA. AFTER ADDITIONAL INFORMATION IS AVAILABLE IN INTERCHANGE, COLORADO MEDICAID WILL CREATE AN AMENDMENT REQUEST TO EXTEND THE PA FOR
P961	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.

Denial Code	Long Description
P962	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
PA10	THE REQUESTED END DATE IS INVALID.
PA12	PLEASE FURNISH A WRITTEN DESCRIPTION OF THE CLIENTS DIAGNOSIS.
PA13	PROVIDE DIAGNOSES WITH DATES OF ONSET.
PA14	IDENTIFY PROBLEMS TO BE TREATED.
PA15	THE AUDIOLOGISTS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1), F-11020, AND PRIOR AUTHORIZATION REQUEST/HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2), F-11021.
PA16	THE PHYSICIANS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION/PHYSICIAN OTOLOGICAL REPORT (PA/POR), F-11019.
PA17	SUBMIT BRIEF HISTORY WITH REFERRAL INFORMATION, LIVING SITUATION, FUNCTIONAL STATUS, AND OTHER PERTINENT INFORMATION. WHAT CHANGE OF STATUS RESULTED IN REFERRAL AT THIS TIME?
PA18	PLEASE FURNISH THE CLIENTS HEIGHT AND WEIGHT.
PA19	PLEASE SUBMIT CLINICAL INFORMATION SUFFICIENT TO VERIFY THE NEED FOR THE REQUESTED SERVICE(S).
PA20	PLEASE RESUBMIT WITH COMPLETE PERIODONTAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PA21	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL EDUCATIONAL PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA22	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL PROGRAM PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA23	REFER TO THE DURABLE MEDICAL EQUIPMENT INDEX FOR APPROPRIATE CODE AND DESCRIPTION. DO NOT USE AN "UNLISTED" CODE.
PA24	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUALIZED FAMILY SERVICE PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA25	INFORMATION ON THE REQUEST FORM IS ILLEGIBLE, AND THE REQUEST CANNOT BE PROCESSED.
PA26	RE-EVALUATE YOUR GOALS. EMPHASIS SHOULD BE ON FUNCTIONAL SELF-CARE. GOALS MUST BE RELATED TO FUNCTIONAL OUTCOME.
PA27	PLEASE CLARIFY THE NUMBER OF HOURS PER WEEK REQUESTED.
PA28	PLEASE CLARIFY THE NUMBER OF HOURS PER DAY REQUESTED.
PA29	PLEASE CLARIFY THE NUMBER OF VISITS PER DAY REQUESTED.
PA30	ATTACH SUPPORTIVE DOCUMENTATION; HOME EXERCISE PROGRAM AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA31	THE DIAGNOSIS CODE INDICATED ON THE REQUEST DOES NOT CORRESPOND TO THE DIAGNOSIS CODE DESCRIPTION.
PA32	PLEASE SUBMIT ADDITIONAL INFORMATION SUFFICIENT TO VERIFY APPROPRIATENESS AND NEED FOR TRANSPLANT.
PA33	PLEASE SUBMIT THE INITIAL AND PROGRESSIVE OBJECTIVE FINDINGS.
PA34	ATTACH SUPPORTIVE DOCUMENTATION, FACILITY PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA35	PLEASE SUBMIT THE CLIENTS ORIGINAL COMPLAINTS AND EXAMINATION FINDINGS.
PA36	ATTACH SUPPORTIVE DOCUMENTATION, IN-HOME AUTISM PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA37	PLEASE SUBMIT YOUR TREATMENT PLAN FOR THIS CLIENT.
PA38	ATTACH SUPPORTIVE DOCUMENTATION AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA39	INITIAL EVALUATIONS MUST BE PERFORMED BY AN OCCUPATIONAL THERAPIST REGISTERED (OTR), PER AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA) STANDARDS.
PA41	IDENTIFY THE PLACE OF SERVICE AND ITS EFFECT ON SUPPORTING THE DESIRED TREATMENT OUTCOME.
PA42	PLEASE INDICATE THE HOURS OF USE OF OXYGEN PER 24-HOUR PERIOD.
PA43	PROVIDE BASELINE DOCUMENTATION FOR THIS CLIENTS LIMITATIONS USING UNITS OF MEASUREMENT THAT ARE APPLIED CONSISTENTLY WHEN REPORTING STATUS.

Denial Code	Long Description
PA44	IDENTIFY FUNCTIONAL LIMITATIONS AS THEY ARE RELATED TO IDENTIFIED CONDITIONS.
PA46	CORRELATE PLAN OF CARE TO REQUESTED PROCEDURE CODES.
PA47	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE FREQUENCY/DURATION REQUESTED.
PA48	PLEASE PROVIDE THE NAME AND CREDENTIALS OF THE RENDERING PROVIDER.
PA50	COLORADO MEDICAID RECORDS INDICATE THE CLIENT OWNS A WHEELCHAIR. DOCUMENT THE REASON AND NEED FOR REPLACEMENT AND COST TO REPAIR CURRENT WHEELCHAIR.
PA51	PLEASE DISTINGUISH PRIMARY AND SUPPORTIVE MODALITIES.
PA52	PLEASE SUBMIT A PROGRESS REPORT.
PA53	MULTIPLE FAMILY CLIENTS TREATMENT BY THE SAME PROVIDER REQUIRES FURTHER INFORMATION DOCUMENTING COORDINATION OF TREATMENT PLAN.
PA54	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE MINUTES REQUESTED.
PA55	MEDICAL NECESSITY OF TREATMENT REQUIRES ADDITIONAL DOCUMENTATION.
PA56	GIVEN AGE, DIAGNOSES, CURRENT LEVEL OF FUNCTION, PAST RESPONSE TO TREATMENT, AND LIVING SITUATION, EXPAND ON POTENTIAL FOR SIGNIFICANT FUNCTIONAL PROGRESS WITHIN THE NEXT SIX MONTHS. EMPHASIZE WHY PROGRESS IS EXPECTED WITH SERVICES AT THIS TIME.
PA57	SUBMIT THE INITIAL FINDINGS. INCLUDE A COMPREHENSIVE EVALUATION.
PA58	SUBMIT PROGRESSIVE, OBJECTIVE FINDINGS. INCLUDE A PERTINENT RE-EVALUATION.
PA59	PLEASE SUPPLY INFORMATION REGARDING THE CLIENTS MEDICATION REQUIREMENTS, IF ANY.
PA60	PLEASE SPECIFY IF THE CLIENT IS IN AN EDUCATIONAL SETTING.
PA61	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA62	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
PA63	THE SKILLS OF A THERAPIST ARE PURPOSEFUL AND SKILLED INTERVENTIONS REQUIRED TO CONTINUALLY DESIGN, IMPLEMENT, REASSESS, MODIFY/GRADE, AND/OR DISCONTINUE A PLAN OF CARE IN A TIMELY MANNER, BASED ON THE COMPLEXITY OF THE CLIENTS MEDICAL CONDITION AND/OR CO
PA64	PLEASE SUBMIT A THERAPY PLAN OF CARE, INCLUDING A CURRENT, DATED EVALUATION.
PA65	A PLAN OF CARE SIGNED AND DATED BY THE PHYSICIAN IS REQUIRED.
PA66	THE SKILLS OF A THERAPIST ARE REQUIRED WHEN ONLY THE THERAPIST CAN SAFELY AND EFFECTIVELY DELIVER THE THERAPEUTIC PROCEDURES BECAUSE OF THEIR UNIQUE KNOWLEDGE, TRAINING, AND EXPERTISE. DESCRIBE THE REASON THAT SOMEONE OTHER THAN A THERAPIST CANNOT SAFELY
PA67	PLEASE SPECIFY IF THE CLIENTS WORK SITE DEMANDS GOOD BINAURAL HEARING.
PA68	DESCRIBE THE REASON, BASED ON THE CLIENTS COGNITIVE, PHYSICAL, COMMUNICATION, OR RESOURCE STATUS, THAT A HOME PROGRAM, EQUIPMENT, OR ENVIRONMENTAL ADAPTATIONS ALONE CANNOT MEET CLIENTS NEEDS.
PA69	PLEASE SPECIFY IF THE CLIENT HAS AN ACCOMPANYING DISABILITY THAT ADDS TO THE HEARING PROBLEM.
PA70	DISTINGUISH REQUESTED PROCEDURES AND GOALS FROM OTHER SERVICES THIS CLIENT RECEIVES. THEY MAY NOT BE DUPLICATIVE.
PA71	PLEASE INDICATE THE NUMBER OF DAYS REQUESTED.
PA73	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA74	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA75	PLEASE DOCUMENT CARRYOVER OF THE THERAPY PROGRAM TO NURSING.
PA76	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA79	PROVIDE EVIDENCE OF SIGNIFICANT FUNCTIONAL PROGRESS IN LAST SIX MONTHS.
PA84	THE GRANT DATE OF THIS REQUEST CANNOT BE PRIOR TO THE SIGNATURE DATE OF THE PRESCRIBING PHYSICIAN.
PA86	PROVIDE EVIDENCE OF SKILLS GAINED IN THERAPY CARRYING OVER TO OTHER SETTINGS WITHIN SIX MONTHS.

Denial Code	Long Description
PA87	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE NUMBER OF SESSIONS REQUESTED.
PA88	THE REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL SCOPE OF PRACTICE.
PA89	PRIOR AUTHORIZATION IS NOT REQUIRED UNTIL LIMITATION OF SERVICE HAS BEEN REACHED.
PA91	PLEASE SUBMIT REQUIRED X-RAYS.
PA92	PLEASE PROVIDE AN EXPLANATION FOR THE MATERIAL SUBMITTED WITH THE REQUEST.
PA95	PLEASE DESCRIBE HOW THE PROVISION OF THIS SERVICE WOULD PREVENT INSTITUTIONALIZATION OF THE CLIENT.
PA96	COULD THE EXISTING DENTURE(S) BE RELINED OR REBASED? IF NOT, PLEASE EXPLAIN WHY NOT.
PA97	REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL STANDARDS OF PRACTICE.
PA98	PLEASE INDICATE IF THE CLIENT IS CURRENTLY BEING TUBE FED.
PB02	PLEASE PROVIDE THE REQUIRED DATED SIGNATURES ON THE ATTACHMENTS.
PB03	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING THE LOSS/DESTRUCTION/THEFT OF THE HEARING AID.
PB04	DESCRIBE THE CLIENTS ABILITY TO STAND OR AMBULATE SUFFICIENTLY TO ACCOMPLISH SELF-CARE ACTIVITIES.
PB07	PLEASE SUBMIT AN ORTHODONTIC STUDY MODEL OR DIAGNOSTIC CASTS.
PB09	PLEASE PROVIDE A PHOTOGRAPH OF THE INVOLVED AREA(S).
PB10	PLEASE PROVIDE AN ESTIMATION (IN GRAMS) OF THE TOTAL AMOUNT OF TISSUE TO BE RESECTED.
PB11	PLEASE SUBMIT THE PLAN OF CARE FOR CO-TREATMENT.
PB12	FURNISH A DETAILED DESCRIPTION FOR THE PROCEDURE CODE REQUESTED.
PB13	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB15	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB18	PLEASE COMPLETE THE ATTACHED OUT-OF-STATE PROVIDER DATA SHEET, F-11001, AND RESUBMIT.
PB20	A SIGNED AND DATED PRESCRIPTION IS REQUIRED WITHIN THREE MONTHS OF RECEIPT BY COLORADO MEDICAID FOR INITIAL REQUESTS AND WITHIN 12 MONTHS OF RECEIPT BY COLORADO MEDICAID FOR SUBSEQUENT REQUESTS.
PB21	PLEASE COMPLETE THE APPROPRIATE PRIOR AUTHORIZATION ATTACHMENT. CONTACT PROVIDER SERVICES OR THE PRIOR AUTHORIZATION UNIT FOR ASSISTANCE.
PB23	PHYSICAL THERAPY ASSISTANT NOTES AND ALL FORMS SUBMITTED MUST BE COSIGNED BY A REGISTERED PHYSICAL THERAPIST.
PB31	ARE YOU REQUESTING A COMPLETE APPLIANCE, OR REPLACEMENT PARTS?
PB32	THE PROCEDURE CODE INDICATED ON THE REQUEST DOES NOT MATCH THE DESCRIPTION OF SERVICE; PLEASE CORRECT AND RESUBMIT.
PB35	THE SERVICE REQUESTED DOES NOT REQUIRE PRIOR AUTHORIZATION.
PB41	PLEASE FURNISH A CURRENT MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT, F-11090 (DATED WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID).
PB45	THE CERTIFICATION PERIOD ON THE PLAN OF CARE (POC) DOES NOT COVER THE REQUESTED GRANT/START DATE. PLEASE RESUBMIT YOUR REQUEST WITH A NEW POC.
PB49	A CERTIFIED OCCUPATIONAL THERAPY ASSISTANTS NOTES MUST BE COSIGNED BY AN OCCUPATIONAL THERAPIST REGISTERED.
PB51	ADDITIONAL INFORMATION IS REQUIRED ON PRIOR AUTHORIZATION TO ENABLE PRICING.
PB54	REQUESTED SERVICES DO NOT MATCH SERVICES ON THE PHYSICIANS ORDERS.
PB59	PLEASE PROVIDE AN INDIVIDUAL EDUCATIONAL PLAN (IEP), WHICH HAS BEEN SIGNED BY THE PROVIDER NO EARLIER THAN NINE MONTHS PRIOR TO RECEIPT AT COLORADO MEDICAID; OTHERWISE, DOCUMENT WHY NO IEP EXISTS.
PB65	PLEASE FURNISH THE ANTICIPATED TOTAL CHARGES FOR THIS REQUEST.
PB66	A PHOTOCOPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED; THE DATE MUST BE WITHIN SIX MONTHS OF RECEIPT BY COLORADO MEDICAID.
PB67	THE PRESCRIPTION DATE MUST INCLUDE MONTH, DAY, AND YEAR.
PB68	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID.
PB73	THE SERVICES IDENTIFIED ON THE PLAN OF CARE DO NOT APPEAR APPROPRIATE FOR THE PROCEDURE CODE(S) REQUESTED ON THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018.

Denial Code	Long Description
PB74	THE CLIENT/PROVIDER DOES NOT HAVE RETROACTIVE ENROLLMENT.
PB75	THE REQUESTED START DATE IS MORE THAN 14 DAYS BEFORE OR 62 DAYS AFTER RECEIPT.
PB82	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
PB83	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A HOME HEALTH AIDE. PLEASE RESUBMIT AS A PERSONAL CARE WORKER OR PROVIDE ADDITIONAL DOCUMENTATION.
PB86	THE SERVICES REQUESTED ARE NOT BEING PROVIDED IN THE CLIENTS RESIDENCE. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL.
PB87	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A NURSE. PLEASE RESUBMIT AS A HOME HEALTH AIDE OR PROVIDE ADDITIONAL DOCUMENTATION.
PB92	PLEASE FURNISH THE CLIENTS COMPLETE ADDRESS.
PB94	IF THE CLIENT IS A RESIDENT OF A NURSING HOME, SUPPLY THE COMPLETE NAME AND ADDRESS OF THE NURSING HOME.
PB99	THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018, MUST BE SIGNED AND DATED.
PC01	PLEASE SUPPLY THE RENDERING PROVIDERS PROVIDER NUMBER.
PC03	THE DRUG ENFORCEMENT ADMINISTRATION NUMBER IS MISSING OR INVALID.
PC06	PLEASE DESCRIBE YOUR PROGRAM; INCLUDE ENTRY DATE, TERMINATION DATE, HOURS PER WEEK, AND NUMBER OF WEEKS OF PRIMARY INTENSIVE SERVICE REQUESTED.
PC07	PLEASE DESCRIBE YOUR "AFTERCARE/FOLLOW-UP" PLANS FOR THIS CLIENT.
PC08	PLEASE SUPPLY DOCUMENTATION OF PREVIOUS SUBSTANCE ABUSE SERVICES WITH DATE(S) AND OUTCOME.
PC09	PLEASE DESCRIBE IN DETAIL THE TREATMENT OBJECTIVES/GOALS FOR THIS CLIENT.
PC10	PLEASE DESCRIBE THE FAMILY SITUATION/DYNAMICS. EXPLAIN HOW THE FAMILY WILL BE INCORPORATED INTO THE CLIENTS PLAN OF CARE.
PC12	PLEASE EXPLAIN IF YOUR SERVICE ENCOURAGES THE CLIENT TO ATTEND SELF-HELP GROUPS.
PC13	PLEASE SUPPLY A SPECIFIC SCHEDULE OF ACTIVITIES, INCLUDING DAY, TIME OF DAY, LENGTH OF SESSION, AND SERVICE TO BE RENDERED DURING THAT TIME.
PC15	PLEASE FURNISH DIAGNOSTIC RATIONALE.
PC17	PLEASE DOCUMENT IF THE CLIENT EVER RECEIVED SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT.
PC19	PLEASE FURNISH MORE EXTENSIVE AND IN-DEPTH HISTORICAL AND PSYCHOSOCIAL DATA.
PC20	PLEASE SUPPLY THE DATE THE CLIENT BECAME TOTALLY ENDENTULOUS.
PC23	PLEASE SUBMIT A PHYSICIANS STATEMENT REGARDING THE MEDICAL NECESSITY OF DENTURES FOR THIS CLIENT. THE PHYSICIANS STATEMENT MUST DOCUMENT THE MEDICAL NEED FOR DENTURES.
PC24	THE SERVICE REQUESTED WAS PREVIOUSLY AUTHORIZED. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT INDICATING THIS FACT IS REQUIRED.
PC25	PLEASE SUPPLY SUFFICIENT MITIGATING CIRCUMSTANCES TO WARRANT THE CONSTRUCTION OF NEW DENTURES(S).
PC26	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
PC28	PLEASE SUBMIT A PHYSICIANS STATEMENT INDICATING DENTURES ARE NECESSARY FOR THIS NURSING HOME CLIENT.
PC29	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING LOSS OR DESTRUCTION OF DENTURE(S). INCLUDE SIGNED STATEMENT FROM CLIENT OR FACILITY DIRECTOR REGARDING HOW, WHEN AND WHERE LOST.
PC30	PLEASE PROVIDE COMPLETE INTRAORAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PC31	PLEASE DESCRIBE ANY RELATED DEFORMITIES OF THE FEET.
PC34	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD WITH REQUESTED DME ITEM(S) AND DOCUMENT IF THE CLIENT CAN USE SAFELY AND INDEPENDENTLY.
PC35	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD AND DESCRIBE THE RESULTS AND EFFECTIVENESS OF THE SERVICE REQUESTED.
PC39	PLEASE INDICATE LITER FLOW PER MINUTE, HOURS OF USE PER 24 HOUR PERIOD, AND THE EXPECTED DURATION OF NEED.
PC40	THE ITEM DOES NOT REQUIRE PRIOR AUTHORIZATION UNTIL THE LIFE EXPECTANCY HAS BEEN REACHED.
PC41	PLEASE SUPPLY INFORMATION INDICATING THE NECESSITY OF POSITIONING THE CLIENT'S BODY IN MULTIPLE POSITIONS.

Denial Code	Long Description
PC42	PLEASE INDICATE IF THE BED HEIGHT MUST BE CHANGED TO ALLOW FOR SAFE TRANSFER OR ADEQUATE BED CARE.
PC43	SUPPLY A PHYSICIANS STATEMENT INDICATING TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR UNIT HAS REDUCED PAIN, IMPROVED/INCREASED THE CLIENTS ACTIVITY LEVEL, AND/OR REDUCED CLIENTS USE OF PAIN MEDICATION.
PC44	A CURRENT AUTHORIZATION FOR THIS SERVICE IS ON FILE FOR ANOTHER PROVIDER. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT OF THAT FACT IS REQUIRED BY THE CLIENT OF FIRST PROVIDER.
PC59	DOCUMENT DECLINE OR PROGRESS IN SPECIFIC, MEASURABLE, OBJECTIVE TERMS.
PC60	DOCUMENT IF CLIENT HAS DEMONSTRATED A GOOD APPOINTMENT COMPLIANCE RECORD.
PC61	THE PHYSICIANS SIGNATURE DATE MUST NOT EXCEED 90 DAYS FROM THE DATE OF RECEIPT BY COLORADO MEDICAID.
PC62	REQUESTS FOR A CONTINUATION OF THERAPY SHOULD NOT BE SUBMITTED MORE THAN FOUR WEEKS PRIOR TO THE EXPIRATION DATE OF THE CURRENT AUTHORIZATION.
PC63	PLEASE FURNISH THE STYLE AND MANUFACTURER OF THE FRAME.
PC64	PLEASE FURNISH THE CLIENTS LENS FORMULA.
PC66	ALL REQUESTS FOR TINTS REQUIRE DOCUMENTATION OF THE VISUAL OR MEDICAL CONDITION RELATED TO PHOTOPHOBIA.
PC67	PLEASE DOCUMENT THE REASON AND JUSTIFICATION FOR REPLACEMENT BEYOND THE FIRST LENS/FRAME.
PC68	DOCUMENT IF ALL REMAINING MAXILLARY AND/OR MANDIBULAR TEETH ARE DECAY-FREE, PROPERLY RESTORED, AND PERIODONTICALLY SOUND.
PC72	SUPPLY MORE DETAIL REGARDING PROGRESS (ATTACHMENT OF GOALS, ETC.). CORRELATE PROGRESS TO PREVIOUS GOALS AND IDENTIFIED LIMITATIONS.
PC77	PLEASE SUBMIT A PLAN OF CARE DESCRIBING THE SERVICES THAT WOULD BE PROVIDED.
PC78	PLEASE DOCUMENT SPECIFIC, MEASURABLE GOALS.
PC82	THE PRIOR AUTHORIZATION (PA) SYSTEM CAN PROCESS ONLY 26 DETAILS PER PA REQUEST. PLEASE RESUBMIT YOUR REQUEST WITH NO MORE THAN 26 DETAILS.
PC83	PLEASE SUPPLY A PHYSICIANS PRESCRIPTION DATED WITHIN ONE MONTH OF REQUESTED SUBSTANCE ABUSE DAY TREATMENT.
PC84	PLEASE PROVIDE INFORMATION INDICATING THIS CLIENT IS APPROPRIATELY DETOXIFIED FROM ALCOHOL AND/OR OTHER DRUGS.
PC85	PLEASE PROVIDE INFORMATION TO INDICATE THE CLIENTS ABILITY TO ABSTAIN FROM ALCOHOL OR DRUGS WHILE IN THE SUBSTANCE ABUSE DAY TREATMENT PROGRAM.
PC86	PLEASE INDICATE IF THIS CLIENT IS WILLING TO PARTICIPATE IN AFTERCARE OR CONTINUING CARE SERVICES.
PC87	PROVIDE MORE INFORMATION ON TREATMENT HISTORY; INCLUDE SERVICE PROVIDED, DATES, AND OUTCOME. PROVIDE DETAIL OF PREVIOUS TREATMENT.
PC88	PLEASE PROVIDE MORE RATIONALE FOR THE APPROPRIATENESS AND MEDICAL NECESSITY OF SUBSTANCE ABUSE DAY TREATMENT.
PC89	PROVIDE A TREATMENT PLAN THAT CONTAINS MEASURABLE GOALS AND OBJECTIVES CORRESPONDING TO THE IDENTIFIED DEFICIT.
PC91	PLEASE PROVIDE MORE INFORMATION ON FAMILY INVOLVEMENT TREATMENT.
PC92	PLEASE PROVIDE MORE HISTORY AND EXPLANATION ABOUT THE ISSUE OF ABSTINENCE FOR THIS CLIENT.
PC94	PLEASE PROVIDE THE ANTICIPATED BEGINNING DATE AND/OR THE ESTIMATED SUBSTANCE ABUSE DAY TREATMENT DISCHARGE DATE.
PC95	PLEASE SUPPLY JUSTIFICATION FOR BEGINNING CLIENT IN SERVICE PRIOR TO AUTHORIZATION BEING OBTAINED.
PC96	THE INITIAL THREE HOURS OF SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IN A CALENDAR YEAR DO NOT REQUIRE PRIOR AUTHORIZATION.
PC97	REIMBURSEMENT FOR INITIAL SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IS LIMITED TO THREE HOURS IN A CALENDAR YEAR AND DOES NOT REQUIRE PRIOR AUTHORIZATION.
PC98	THIS DRUG IS CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE BILL USING THE APPROPRIATE NATIONAL DRUG CODE (NDC) OR SUBMIT A COMPLETED DRUG ADDITION REQUEST FORM IF THE NDC IS NOT LISTED IN THE DRUG INDEX.

Denial Code	Long Description
PC99	THIS DRUG IS NOT CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL, CURRENT ADMINISTRATIVE RULE, OR COLORADO DRUG INDEX FOR COVERAGE LIMITATIONS.
PD01	DOCUMENT THAT CLIENT HAS ACHIEVED GOOD ORAL HYGIENE, PERIODONTAL CASE TYPE 1 OR 2, AND IS MOTIVATED TO MAINTAIN SAME.
PD03	PLEASE PROVIDE AN ARTERIAL BLOOD GAS READING OR PULSE OXIMETRY RESULTS DONE ON ROOM AIR SIGNED AND DATED BY A MEDICAL DOCTOR. THIS SHOULD BE DONE WITHIN 60 DAYS OF REQUESTED SERVICE.
PD04	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 30 DAYS OF RECEIPT BY COLORADO MEDICAID.
PD07	SUBMIT A PHOTOCOPY OF A VALID PRESCRIPTION, ISSUED WITHIN THE PAST YEAR, OR COMPLETE SECTION B OF THE PRIOR AUTHORIZATION/DRUG ATTACHMENT (PA/DGA), F-11049.
PD10	BRAND MEDICALLY NECESSARY MUST BE IN THE PRESCRIBERS OWN HANDWRITING AND WRITTEN DIRECTLY ON THE PRESCRIPTION OR A SEPARATE ORDER ATTACHED TO THE ORIGINAL PRESCRIPTION.
PD12	COMPLETE DENTURES, PARTIAL DENTURES, DENTURE RELINES, AND FIXED PROSTHODONTIC SERVICES ARE NOT COVERED SERVICES FOR ADULTS FOR DATES OF SERVICE ON AND AFTER OCTOBER 1, 1995.
PD22	PLEASE COMPLETE ALL REQUIRED ELEMENTS ON THE PERSONAL CARE SCREENING TOOL (PCST), F-11133.
PD24	THIS PRIOR AUTHORIZATION REQUEST IS UNABLE TO BE PROCESSED. PLEASE RESUBMIT WITH ADDITIONAL REQUIRED FORMS, INCLUDING THE ENTIRE PERSONAL CARE SCREENING TOOL (PCST), F-11133; PERSONAL CARE ADDENDUM, F-11136; AND SUPPORTING DOCUMENTATION, AS DIRECTED.
PD25	THERE IS A PERSONAL CARE SCREENING TOOL (PCST), F-11133, COMPLETED BY ANOTHER AGENCY. CONTACT THE AGENCY TO TRANSFER SCREEN.
PD26	THERE IS A LIMITED TERM CARE FUNCTIONAL SCREEN (LTC-FS) COMPLETED BY ANOTHER AGENCY. THE PERSONAL CARE SCREENING TOOL (PCST), F-11133, INFORMATION IS IN CONFLICT WITH LTC-FS.
PD27	ONLY ONE LEVEL OF FUNCTION MAY BE SELECTED FOR ALL ELEMENTS EXCEPT TOILETING. COLORADO MEDICAID IS UNABLE TO PROCESS THE PRIOR AUTHORIZATION REQUEST.
PD28	NO UNITS MAY BE REQUESTED USING THIS PRIOR AUTHORIZATION PROCESS. PLEASE SUBMIT WITH THE APPROPRIATE ATTACHMENTS FOR REQUESTING SPECIFIC PERSONAL CARE WORKER UNITS.
PD29	CLIENT IS NOT ELIGIBLE FOR THE REQUESTED SERVICE(S) AS OF THE REQUESTED START DATE.
PD30	NO TRAVEL TIME MAY BE AUTHORIZED WHEN NO PERSONAL CARE WORKER SERVICE IS AUTHORIZED.
PD32	PROVIDER NOT CERTIFIED TO RENDER THE SERVICE(S) REQUESTED.
PD34	BASED ON THE DOCUMENTATION SUBMITTED, THIS REQUEST CAN NOT BE PRIOR AUTHORIZED. REFER TO THE PA MESSAGES FROM THE CONSULTANT FOR COMPLETE EXPLANATION.
PD98	PLEASE DOCUMENT HOW AND WHEN EACH PREVIOUSLY AUTHORIZED PRO RE NATA VISIT WAS USED.

Reconstructive Surgery

Denial Code	Long Description
0201	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
0233	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0235	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0237	CLIENT IDENTIFICATION NUMBER DOES NOT MATCH CLIENTS FIRST NAME.
0238	THE CLIENT IDENTIFICATION NUMBER DOES NOT MATCH THE CLIENTS LAST NAME.
0242	SECONDARY DIAGNOSIS CODE IS INVALID.
0248	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0249	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0251	PROCEDURE CODE MODIFIER IN FIRST POSITION IS INVALID.

Denial Code	Long Description
0252	THE PROCEDURE CODE MODIFIER IN SECOND POSITION IS INVALID FOR REQUESTED START DATE OR DATE OF RECEIPT.
0253	THE PROCEDURE CODE MODIFIER IN THIRD POSITION IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
0258	THE PRIMARY DIAGNOSIS CODE IS REQUIRED.
0272	THE PRIMARY DIAGNSOSIS CODE IS INVALID.
0400	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0853	HCPCS - ANNUAL UPDATE
0885	NEVER EVENTS MODIFIERS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
0886	NEVER EVENTS DIAGNOSIS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
1000	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
1002	RENDERING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1003	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1007	RENDERING PROVIDER ID IS NOT ON FILE.
1047	THE RENDERING PROVIDERS CERTIFICATION HAS BEEN CANCELLED.
1048	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1801	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
1804	A CERTIFIED SUBSTANCE ABUSE DAY TREATMENT PROVIDER MUST SUBMIT A SUBSTANCE ABUSE DAY TREATMENT PROCEDURE CODE.
1806	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
1808	THE BILLING PROVIDER DOES NOT HAVE THE REQUIRED CERTIFICATION ADDENDUM ON FILE.
1900	THE BILLING PROVIDERS TAXONOMY CODE IS INVALID.
1901	THE RENDERING PROVIDERS TAXONOMY CODE IS INVALID.
1927	A NATIONAL PROVIDER IDENTIFIER IS REQUIRED FOR THE BILLING PROVIDER.
1934	A NATIONAL PROVIDER INDENTIFIER IS REQUIRED FOR THE RENDERING PROVIDER.
1936	THE BILLING PROVIDER NUMBER IS INVALID.
1937	THE RENDERING PROVIDER NUMBER IS INVALID.
1960	INTERNAL PROCESSING IS REQUIRED.
1963	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.
1964	THE BILLING PROVIDER INDICATED IS NOT ALLOWABLE AS A BILLING PROVIDER.
1965	RENDERING PROVIDER NUMBER IS MISSING/INVALID FOR THIS PROCEDURE PROVIDER.
1974	PRESCRIBING/REFERRING/ORDERING PROVIDER INDICATED IS NOT CERTIFIED AS A PRESCRIBING/REFERRING/ORDERING PROVIDER.
1975	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
1976	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
2001	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2003	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2017	THE CLIENT IS ENROLLED IN A MEDICAID OR OTHER MANAGED CARE PROGRAM.
2037	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2603	CLIENT LOCKED-IN TO A PROVIDER OR ENROLLED IN A HOSPICE. CONTACT CLIENTS HOSPICE FOR PAYMENT OF SERVICES OR RESUBMIT WITH DOCUMENTATION OF UNRELATED NATURE OF CARE.
3324	THE MODIFIER HAS BEEN DISCONTINUED BY THE CENTERS OF MEDICARE AND MEDICAID SERVICES OR THE AMERICAN MEDICAL ASSOCIATION FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
3337	THE PROCEDURE CODE HAS BEEN TERMINATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AMERICAN MEDICAL ASSOCIATION, OR AMERICAN DENTAL ASSOCIATION FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT. RESUBMIT WITH VALID A PROCEDURE CODE.
3339	THE PROCEDURE BILLED IS NOT PAYABLE ACCORDING TO DEFICIT REDUCTION ACT (DEFRA) GUIDELINES.
3351	THE PROCEDURE IS NOT COVERED FOR CLIENTS WITH A NURSING HOME AUTHORIZATION ON THE REQUESTED START DATE OR DATE OF RECEIPT.
3353	THE PROCEDURE IS NOT A COVERED SERVICE FOR HOME AND COMMUNITY-BASED WAIVER CLIENTS.
4021	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4027	THE DIAGNOSIS CODE IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.

Denial Code	Long Description
4031	THE PROCEDURE SUBMITTED IS NOT APPROPRIATE FOR CLIENTS GENDER.
4032	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4034	THE PROCEDURE CODE HAS AN AGE RESTRICTION.
4036	THE PLACE OF SERVICE CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4040	THE PRIMARY DIAGNOSIS CODE IS NOT ON FILE.
4041	THE SECONDARY DIAGNOSIS IS NOT ON FILE.
4046	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4127	INTERNAL PROCESSING IS REQUIRED.
4131	INTERNAL PROCESSING IS REQUIRED.
4141	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4149	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4150	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4236	ETIOLOGY DIAGNOSIS CODE(S) (E-CODES) ARE INVALID AS THE PRIMARY DIAGNOSIS.
4244	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4245	THE FOURTH POSITION MODIFIER IS INVALID FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT.
4256	THE PROCEDURE CODE AND MODIFIER COMBINATION IS NOT PAYABLE FOR THE CLIENTS BENEFIT PLAN.
4257	THE MODIFIERS SUBMITTED ARE EITHER INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT OR THE MODIFIERS ARE MISSING.
4311	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4315	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4316	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4371	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4372	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4711	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR CLIENTS AGE.
4714	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS AGE.
4731	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS DIAGNOSIS.
4742	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4743	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4744	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4745	DIAGNOSIS AND/OR PROCEDURE AND/OR PLACE OF SERVICE (POS) CODE IS NOT COVERED FOR EXPRESS ENROLLMENT CLIENTS.
4746	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4801	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4802	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
4821	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
4871	PLEASE REFER TO PA MESSAGES FOR RETURN INFORMATION.
4963	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS GENDER.
4990	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
7500	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
7509	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
P001	THE BILLING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THE SERVICES.
P002	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P003	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P005	THE PRIOR AUTHORIZATION CAN NOT BE END DATED. THE PRIOR AUTHORIZATION STATUS IS NOT APPROVED OR APPROVED WITH REVISIONS.
P006	PLEASE FURNISH THE PROCEDURE CODE AND CORRESPONDING DESCRIPTION.
P008	THE BILLING PROVIDER NUMBER IS INVALID.
P009	THE BILLING PROVIDER NUMBER IS INVALID.

Denial Code	Long Description
P010	THE REQUESTED END DATE IS INVALID.
P011	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P012	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P013	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P014	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P015	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P016	THE REQUESTED START DATE IS MISSING OR INVALID.
P019	THE REQUESTED START DATE IS MISSING OR INVALID.
P020	THE RENDERING PROVIDER NUMBER IS INVALID.
P021	THE RENDERING PROVIDER NUMBER IS INVALID.
P022	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P023	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P024	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P026	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P027	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P030	FIRST MODIFIER IS INVALID.
P031	FIRST MODIFIER IS INVALID.
P032	SECOND MODIFIER IS INVALID.
P033	SECOND MODIFIER IS INVALID.
P034	THIRD MODIFIER IS INVALID.
P035	THIRD MODIFIER IS INVALID.
P036	FOURTH MODIFIER IS INVALID.
P037	FOURTH MODIFIER IS INVALID.
P038	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P039	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P040	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P041	CLIENTS FIRST NAME IS MISSING.
P042	CLIENTS LAST NAME IS MISSING.
P043	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P044	BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES REQUESTED.
P045	FIRST MODIFIER IS INVALID.
P046	SECOND MODIFIER IS INVALID.
P047	THIRD MODIFIER IS INVALID.
P048	FOURTH MODIFIER IS INVALID.
P052	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P053	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P054	RENDERING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES FOR THE BENEFIT PLAN.
P055	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P061	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P062	THE CLIENT ID AND/OR NAME INDICATED ON THE PA REQUEST IS INCORRECT. THE CLIENT ID AND/OR NAME HAS BEEN UPDATED. PLEASE VERIFY THE ID AND/OR NAME IS CORRECT.
P064	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
P067	THE FREQUENCY OF HOURS REQUESTED ARE NOT APPROPRIATE FOR THIS CLIENT AND HAVE BEEN MODIFIED ACCORDINGLY.
P079	BILLING PROVIDER IS ON PAYMENT SUSPENSION DUE TO CREDIBLE ALLEGATION OF FRAUD.

Denial Code	Long Description
P120	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAS BEEN REDUCED.
P121	THE SERVICE/ PROCEDURE REQUESTED IS NOT SUPPORTED BY SUBMITTED DOCUMENTATION.
P126	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
P128	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.
P138	SERVICE(S) DO NOT MEET COLORADO MEDICAID GUIDELINES.
P167	REQUESTED DOCUMENTATION HAS NOT BEEN SUBMITTED.
P178	THE SERVICE REQUESTED IS NOT MEDICALLY NECESSARY.
P179	THE MEDICAL NECESSITY FOR THIS SERVICE IS NOT SUPPORTED BY THE SUBMITTED DOCUMENTATION.
P233	THE DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE ADDITIONAL CARE.
P257	THIS CLIENTS FUNCTIONAL ASSESSMENT SCORES PLACE THIS CLIENT OUTSIDE ELIGIBILITY FOR DAY TREATMENT.
P274	OUR RECORDS INDICATE THIS CLIENT IS INVOLVED IN EFFECTIVE AND APPROPRIATE SERVICE ELSEWHERE.
P292	INTENSIVE REHABILITATION HOURS ARE NO LONGER APPROPRIATE AS INDICATED BY HISTORY, DIAGNOSIS, AND/ OR FUNCTIONAL ASSESSMENT SCORES.
P328	THE SERVICES REQUESTED INCLUDE NON-COVERED SERVICES, AND HOURS ARE REDUCED ACCORDINGLY.
P339	THE CLIENTS PAST HISTORY INDICATES REDUCED TREATMENT HOURS ARE WARRANTED.
P342	THE REQUEST DOES NOT MEET GENERALLY ACCEPTED CONDITIONS REQUIRING FLUORIDE TREATMENTS.
P346	SERVICES EXCEED COLORADO MEDICAID LIMITATION AND DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE MEDICAL NECESSITY OF THE SERVICE.
P349	THE SERVICE REQUESTED WAS PERFORMED LESS THAN FIVE YEARS AGO.
P353	THE EXISTING APPLIANCE HAS NOT BEEN WORN FOR THREE YEARS.
P367	THE CLIENT HAS BEEN TOTALLY WITHOUT TEETH AND AN APPLIANCE FOR FIVE YEARS.
P392	THE CLIENT IS MISSING AN ANTERIOR TOOTH AND/OR HAS TWO OR MORE POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P405	THE SERVICE(S) REQUESTED COULD ADEQUATELY BE PERFORMED IN THE DENTAL OFFICE.
P406	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE OF GOOD PERIODONTAL HEALTH (AMERICAN ACADEMY OF PERIODONTOLOGY PERIODONTAL CLASSIFICATION OF TYPE I OR II).
P407	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE VISIBLE ON RADIOGRAPHS THAT AT LEAST 50 PERCENT OF THE CLINICAL CROWN IS INTACT.
P409	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING SIX OR MORE TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED, INCLUDING THIRD MOLARS.
P410	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING ONE OR MORE ANTERIOR TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED.
P411	DOCUMENTATION DOES NOT SUPPORT THE NEED FOR PERIODONTIC SERVICES. POCKETS ARE LESS THAN 4MM AND/OR GREATER THAN 6MM FOR CLIENT AND/OR THE CLIENT IS UNDER THE AGE OF 13.
P412	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA.
P413	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA. THIS PA HAS BEEN GRANTED AS APPROVED NOT APPROVED WITH REVISIONS. THE DURATION REQUESTED MAY HAVE BEEN REDUCED TO REFLECT COVERAGE LIMITATIONS, PRESCRIBER ORDERS, CONFLICTI
P417	THE SERVICE(S) REQUESTED COULD BE ADEQUATELY PERFORMED WITH LOCAL ANESTHESIA.
P437	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO POOR ORAL HYGIENE.
P444	THIS LINE ITEM IS A DUPLICATE OF ANOTHER LINE ITEM ON THIS PRIOR AUTHORIZATION (PA) REQUEST. PLEASE CORRECT.
P446	THIS IS A DUPLICATE OF AN EXISTING PRIOR AUTHORIZATION (PA) REQUEST. YOU MAY CONTACT PROVIDER SERVICES IF YOU REQUIRE ASSISTANCE. DUPLICATE PA REQUEST
P448	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO DECAY HISTORY.
P449	QUESTIONABLE LONG TERM PROGNOSIS DUE TO GUM AND BONE DISEASE.
P456	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO APPARENT ROOT INFECTION.
P457	OUR RECORDS INDICATE THIS CLIENT HAS EXCEEDED ESTABLISHED PROGRAM LIMITATIONS. COLORADO MEDICAID WILL NOT AUTHORIZE NEW DENTURES.
P458	DOCUMENTATION PROVIDED INDICATES A LESS ELABORATE PROCEDURE SHOULD BE CONSIDERED.
P502	RENTAL ONLY ALLOWED; MEDICAL NEED FOR PURCHASE HAS NOT BEEN DOCUMENTED.

Denial Code	Long Description
P503	PURCHASE ONLY ALLOWED; MEDICAL NEED FOR RENTAL HAS NOT BEEN DOCUMENTED.
P504	OCCUPATIONAL THERAPY GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P505	THE SERVICE REQUESTED IS INCLUDED IN THE NURSING HOME RATE STRUCTURE.
P511	THIS NATIONAL DRUG CODE IS ONLY BILLABLE AS PART OF A COMPOUND DRUG.
P515	THE PRESENCE OF A HANDICAPPING MALOCCLUSION OR HANDICAPPING DENTOFACIAL DEFORMITY IS NOT SUPPORTED BY THE DOCUMENTATION SUBMITTED.
P521	THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVERED BY COLORADO MEDICAID.
P522	GASTRO-INTESTINAL SURGERY FOR THE PURPOSE OF WEIGHT CONTROL IS COVERED ONLY AS A LIFE THREATENING PROCEDURE.
P523	THE TREATMENT REQUEST IS NOT CONSISTENT WITH THE CLIENT'S DIAGNOSIS.
P524	PSYCHOTHERAPY PROVIDED IN THE CLIENTS HOME IS NOT A COVERED BENEFIT OF COLORADO MEDICAID.
P525	THE INFORMATION PROVIDED IS NOT CONSISTENT WITH THE INTENSITY OF SERVICES REQUESTED.
P526	INTENSIVE MULTIPLE MODALITY TREATMENT IS NOT CONSISTENT WITH THE INFORMATION PROVIDED.
P527	MULTIPLE PROVIDERS OF TREATMENT ARE NOT INDICATED FOR THIS CLIENT.
P528	THE DURATION OF TREATMENT SESSIONS EXCEED CURRENT COLORADO MEDICAID GUIDELINES.
P534	DOCUMENTATION OF POOR PHYSICAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P535	OTHER PHYSICAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P536	THE PHYSICAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P537	USE OF PHYSICAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P538	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF A PHYSICAL THERAPIST.
P539	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS AND LIVING ARRANGEMENT.
P540	GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P541	THE PROCEDURE(S) REQUESTED ARE NOT MEDICAL IN NATURE.
P542	DOCUMENTATION OF POOR OCCUPATIONAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P543	DOCUMENTATION OF POOR SPEECH THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P544	OTHER OCCUPATIONAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P546	THE OCCUPATIONAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P547	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF PHYSICAL THERAPY.
P548	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P549	ACTIVITIES TO PROMOTE DIVERSION OR GENERAL MOTIVATION ARE NONCOVERED COLORADO MEDICAID SERVICES.
P550	REVISIONS OF THE REQUEST IS NECESSITATED BY THE CLIENTS MINIMAL PROGRESS.
P551	RESTORATIVE NURSING INVOLVEMENT COULD BE INCREASED.
P552	CLIENTS DEMONSTRATED RESPONSE TO CURRENT THERAPY DOES NOT WARRANT THE INTENSE FREQUENCY REQUESTED.
P553	MAINTENANCE IS TWO TIMES PER WEEK OR LESS.
P554	THE SPEECH THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P555	USE OF OCCUPATIONAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P556	USE OF SPEECH THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P557	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF AN OCCUPATIONAL THERAPIST.

Denial Code	Long Description
P558	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
P559	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P560	THE MATERIALS/ SERVICES REQUESTED ARE PRINCIPALLY COSMETIC IN NATURE.
P561	THE LENS FORMULA DOES NOT JUSTIFY REPLACEMENT.
P562	THE CHANGE IN THE LENS FORMULA DOES NOT WARRANT MULTIPLE REPLACEMENTS.
P563	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P564	LENSES ONLY ARE APPROVED; PLEASE DISPENSE A CONTRACTED FRAME. THE NON-CONTRACTED FRAME IS NOT MEDICALLY JUSTIFIED.
P565	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P566	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P567	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF OCCUPATIONAL THERAPY.
P568	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF SPEECH THERAPY.
P569	LEVEL, INTENSITY, OR EXTENT OF SERVICE(S) REQUESTED HAS BEEN MODIFIED CONSISTENT WITH MEDICAL NEED AS DEFINED IN THE PLAN OF CARE.
P570	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P571	THE SERVICE ASKED FOR IS NOT COVERED BY COLORADO MEDICAID AS THESE TASKS CAN BE DONE BY NURSES OR ACTIVITY STAFF.
P572	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P573	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.
P574	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P575	MEDICAL NEED FOR EQUIPMENT/ SUPPLY REQUESTED IS NOT SUPPORTED BY DOCUMENTATION SUBMITTED.
P576	OTHER SPEECH THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P577	DOCUMENTATION SUBMITTED IDENTIFIES THAT THE CLIENT HAS FEWER THAN TWO POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P582	LESS EXPENSIVE ALTERNATIVE SERVICES ARE AVAILABLE FOR THIS CLIENT.
P634	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P711	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING PERIODONTAL SCALING AND ROOT PLANNING.
P712	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING GINGIVECTOMY.
P754	AN APPROVED SUBSTANCE ABUSE DAY TREATMENT PROGRAM CANNOT EXCEED A SIX WEEK PERIOD.
P761	THE CLIENT DOES NOT APPEAR TO BE ABLE OR WILLING TO ABSTAIN FROM ALCOHOL/DRUG USAGE WHILE IN TREATMENT. THEREFORE, SUBSTANCE ABUSE DAY TREATMENT SERVICES ARE NOT APPROVED.
P764	THIS CLIENT HAS COMPLETED INTENSIVE SUBSTANCE ABUSE TREATMENT WITHIN THE PAST 12 MONTHS. THE DOCUMENTATION PROVIDED IS NOT ADEQUATE TO JUSTIFY ADDITIONAL INTENSIVE TREATMENT AT THIS TIME.
P785	A LESS THAN SIX-WEEK HEALING PERIOD HAS BEEN SPECIFIED FOR THIS PRIOR AUTHORIZATION. THEREFORE IT IS NOT NECESSARY TO WAIT THE FULL SIX WEEKS AFTER EXTRACTIONS BEFORE TAKING DENTURE IMPRESSIONS.
P818	SIX-WEEK HEALING TIME IS REQUIRED BETWEEN EDENTULATION AND FINAL IMPRESSIONS. PAYMENT FOR DENTURES WILL BE DENIED OR RECOUPED IF HEALING PERIOD IS NOT OBSERVED.
P849	COLORADO MEDICAID HAS DETERMINED THERE WERE (ARE) SEVERAL HOME HEALTH AGENCIES WILLING TO PROVIDE MEDICALLY NECESSARY SKILLED NURSING SERVICES TO THIS CLIENT.
P864	THE DOCUMENTATION YOU HAVE SUBMITTED DOES NOT MEET THE REQUIREMENTS OF COLORADO MEDICAID.
P873	THE MEDICAL NECESSITY FOR THE HOURS REQUESTED IS NOT SUPPORTED BY THE INFORMATION SUBMITTED.

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P874	THE DOCUMENTATION SUBMITTED INDICATES THE TASKS SPECIFIED CAN BE COMPLETED DURING THE VISITS APPROVED.
P878	THE DOCUMENTATION SUBMITTED DOES NOT INDICATE THAT MEDICALLY ORIENTED TASKS ARE MEDICALLY NECESSARY; THEREFORE PERSONAL CARE SERVICES HAVE BEEN APPROVED.
P880	THE QUANTITY OF SERVICES AUTHORIZED FOR THIS CLIENTS PERSONAL CARE HAS BEEN AMENDED BASED ON INFORMATION RECEIVED FROM ONE OR MORE OF THESE SOURCES: THE CLIENT, THEIR PHYSICIAN, AND/OR THE IN-HOME VISIT BY STAFF OF THE OIG (OFFICE OF INSPECTOR GENERAL).
P885	THE USE OF THIS DRUG FOR THE INTENDED PURPOSE IS NOT COVERED BY COLORADO MEDICAID, CONSISTENT WITH COLORADO ADMINISTRATIVE CODE AND FEDERAL LAW.
P924	THE MEDICAL RECORDS SUBMITTED WITH THE CURRENT REQUEST CONFLICT OR DISAGREE WITH OUR MEDICAL RECORDS ON THIS CLIENT.
P950	INDEPENDENT NURSES, PLEASE NOTE PAYABLE SERVICES MAY NOT EXCEED 12 HOURS/DAY OR 60 HOURS/WEEK.
P951	SERVICES CAN ONLY BE AUTHORIZED THROUGH ONE YEAR FROM THE PRESCRIPTION DATE.
P952	LEAD INSPECTION IS A COVERED COLORADO MEDICAID SERVICE WHEN THE CHILD HAS BEEN SHOWN TO HAVE LEAD POISONING (E.G., CHILD HAS A BLOOD LEAD LEVEL > 19 UG/DL OR TWO CONSECUTIVE BLOOD LEAD LEVELS OF 15-19 UG/DL DONE AT LEAST 90 DAYS APART). THE INSPECTION MUS
P953	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P954	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P956	THE REQUEST CAN ONLY BE BACKDATED A MAXIMUM OF 14 DAYS FROM FIRST DATE RECEIVED BY COLORADO MEDICAID.
P957	COMPLETE PERIODONTAL CHARTING AT TIME OF SERVICE, AND SUBMIT CHARTING, COPY OF OPERATIVE REPORT, TOGETHER WITH A COPY OF THE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF), F-11035, TO PA UNIT ATTENTION DENTAL CONTSULTANT.
P958	NOTE THAT CODE D4341 HAS BEEN CHANGED. REFER TO THE DECISION NOTICE FOR AUTHORIZED QUANTITY.
P960	YOUR PA HAS BEEN APPROVED FOR 90 DAYS. THE 90 DAY APPROVAL DOES NOT IMPLY THE PA REQUEST MEETS PRIOR AUTHORIZATION CRITERIA. AFTER ADDITIONAL INFORMATION IS AVAILABLE IN INTERCHANGE, COLORADO MEDICAID WILL CREATE AN AMENDMENT REQUEST TO EXTEND THE PA FOR
P961	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P962	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
PA10	THE REQUESTED END DATE IS INVALID.
PA12	PLEASE FURNISH A WRITTEN DESCRIPTION OF THE CLIENTS DIAGNOSIS.
PA13	PROVIDE DIAGNOSES WITH DATES OF ONSET.
PA14	IDENTIFY PROBLEMS TO BE TREATED.
PA15	THE AUDIOLOGISTS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1), F-11020, AND PRIOR AUTHORIZATION REQUEST/HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2), F-11021.
PA16	THE PHYSICIANS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION/PHYSICIAN OTOLOGICAL REPORT (PA/POR), F-11019.
PA17	SUBMIT BRIEF HISTORY WITH REFERRAL INFORMATION, LIVING SITUATION, FUNCTIONAL STATUS, AND OTHER PERTINENT INFORMATION. WHAT CHANGE OF STATUS RESULTED IN REFERRAL AT THIS TIME?
PA18	PLEASE FURNISH THE CLIENTS HEIGHT AND WEIGHT.
PA19	PLEASE SUBMIT CLINICAL INFORMATION SUFFICIENT TO VERIFY THE NEED FOR THE REQUESTED SERVICE(S).
PA20	PLEASE RESUBMIT WITH COMPLETE PERIODONTAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PA21	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL EDUCATIONAL PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.

Denial Code	Long Description
PA22	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL PROGRAM PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA23	REFER TO THE DURABLE MEDICAL EQUIPMENT INDEX FOR APPROPRIATE CODE AND DESCRIPTION. DO NOT USE AN "UNLISTED" CODE.
PA24	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUALIZED FAMILY SERVICE PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA25	INFORMATION ON THE REQUEST FORM IS ILLEGIBLE, AND THE REQUEST CANNOT BE PROCESSED.
PA26	RE-EVALUATE YOUR GOALS. EMPHASIS SHOULD BE ON FUNCTIONAL SELF-CARE. GOALS MUST BE RELATED TO FUNCTIONAL OUTCOME.
PA27	PLEASE CLARIFY THE NUMBER OF HOURS PER WEEK REQUESTED.
PA28	PLEASE CLARIFY THE NUMBER OF HOURS PER DAY REQUESTED.
PA29	PLEASE CLARIFY THE NUMBER OF VISITS PER DAY REQUESTED.
PA30	ATTACH SUPPORTIVE DOCUMENTATION; HOME EXERCISE PROGRAM AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA31	THE DIAGNOSIS CODE INDICATED ON THE REQUEST DOES NOT CORRESPOND TO THE DIAGNOSIS CODE DESCRIPTION.
PA32	PLEASE SUBMIT ADDITIONAL INFORMATION SUFFICIENT TO VERIFY APPROPRIATENESS AND NEED FOR TRANSPLANT.
PA33	PLEASE SUBMIT THE INITIAL AND PROGRESSIVE OBJECTIVE FINDINGS.
PA34	ATTACH SUPPORTIVE DOCUMENTATION, FACILITY PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA35	PLEASE SUBMIT THE CLIENTS ORIGINAL COMPLAINTS AND EXAMINATION FINDINGS.
PA36	ATTACH SUPPORTIVE DOCUMENTATION, IN-HOME AUTISM PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA37	PLEASE SUBMIT YOUR TREATMENT PLAN FOR THIS CLIENT.
PA38	ATTACH SUPPORTIVE DOCUMENTATION AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA39	INITIAL EVALUATIONS MUST BE PERFORMED BY AN OCCUPATIONAL THERAPIST REGISTERED (OTR), PER AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA) STANDARDS.
PA41	IDENTIFY THE PLACE OF SERVICE AND ITS EFFECT ON SUPPORTING THE DESIRED TREATMENT OUTCOME.
PA42	PLEASE INDICATE THE HOURS OF USE OF OXYGEN PER 24-HOUR PERIOD.
PA43	PROVIDE BASELINE DOCUMENTATION FOR THIS CLIENTS LIMITATIONS USING UNITS OF MEASUREMENT THAT ARE APPLIED CONSISTENTLY WHEN REPORTING STATUS.
PA44	IDENTIFY FUNCTIONAL LIMITATIONS AS THEY ARE RELATED TO IDENTIFIED CONDITIONS.
PA46	CORRELATE PLAN OF CARE TO REQUESTED PROCEDURE CODES.
PA47	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE FREQUENCY/DURATION REQUESTED.
PA48	PLEASE PROVIDE THE NAME AND CREDENTIALS OF THE RENDERING PROVIDER.
PA50	COLORADO MEDICAID RECORDS INDICATE THE CLIENT OWNS A WHEELCHAIR. DOCUMENT THE REASON AND NEED FOR REPLACEMENT AND COST TO REPAIR CURRENT WHEELCHAIR.
PA51	PLEASE DISTINGUISH PRIMARY AND SUPPORTIVE MODALITIES.
PA52	PLEASE SUBMIT A PROGRESS REPORT.
PA53	MULTIPLE FAMILY CLIENTS TREATMENT BY THE SAME PROVIDER REQUIRES FURTHER INFORMATION DOCUMENTING COORDINATION OF TREATMENT PLAN.
PA54	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE MINUTES REQUESTED.
PA55	MEDICAL NECESSITY OF TREATMENT REQUIRES ADDITIONAL DOCUMENTATION.
PA56	GIVEN AGE, DIAGNOSES, CURRENT LEVEL OF FUNCTION, PAST RESPONSE TO TREATMENT, AND LIVING SITUATION, EXPAND ON POTENTIAL FOR SIGNIFICANT FUNCTIONAL PROGRESS WITHIN THE NEXT SIX MONTHS. EMPHASIZE WHY PROGRESS IS EXPECTED WITH SERVICES AT THIS TIME.
PA57	SUBMIT THE INITIAL FINDINGS. INCLUDE A COMPREHENSIVE EVALUATION.
PA58	SUBMIT PROGRESSIVE, OBJECTIVE FINDINGS. INCLUDE A PERTINENT RE-EVALUATION.
PA59	PLEASE SUPPLY INFORMATION REGARDING THE CLIENTS MEDICATION REQUIREMENTS, IF ANY.
PA60	PLEASE SPECIFY IF THE CLIENT IS IN AN EDUCATIONAL SETTING.

Denial Code	Long Description
PA61	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA62	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
PA63	THE SKILLS OF A THERAPIST ARE PURPOSEFUL AND SKILLED INTERVENTIONS REQUIRED TO CONTINUALLY DESIGN, IMPLEMENT, REASSESS, MODIFY/GRADE, AND/OR DISCONTINUE A PLAN OF CARE IN A TIMELY MANNER, BASED ON THE COMPLEXITY OF THE CLIENTS MEDICAL CONDITION AND/OR CO
PA64	PLEASE SUBMIT A THERAPY PLAN OF CARE, INCLUDING A CURRENT, DATED EVALUATION.
PA65	A PLAN OF CARE SIGNED AND DATED BY THE PHYSICIAN IS REQUIRED.
PA66	THE SKILLS OF A THERAPIST ARE REQUIRED WHEN ONLY THE THERAPIST CAN SAFELY AND EFFECTIVELY DELIVER THE THERAPEUTIC PROCEDURES BECAUSE OF THEIR UNIQUE KNOWLEDGE, TRAINING, AND EXPERTISE. DESCRIBE THE REASON THAT SOMEONE OTHER THAN A THERAPIST CANNOT SAFELY
PA67	PLEASE SPECIFY IF THE CLIENTS WORK SITE DEMANDS GOOD BINAURAL HEARING.
PA68	DESCRIBE THE REASON, BASED ON THE CLIENTS COGNITIVE, PHYSICAL, COMMUNICATION, OR RESOURCE STATUS, THAT A HOME PROGRAM, EQUIPMENT, OR ENVIRONMENTAL ADAPTATIONS ALONE CANNOT MEET CLIENTS NEEDS.
PA69	PLEASE SPECIFY IF THE CLIENT HAS AN ACCOMPANYING DISABILITY THAT ADDS TO THE HEARING PROBLEM.
PA70	DISTINGUISH REQUESTED PROCEDURES AND GOALS FROM OTHER SERVICES THIS CLIENT RECEIVES. THEY MAY NOT BE DUPLICATIVE.
PA71	PLEASE INDICATE THE NUMBER OF DAYS REQUESTED.
PA73	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA74	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA75	PLEASE DOCUMENT CARRYOVER OF THE THERAPY PROGRAM TO NURSING.
PA76	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA79	PROVIDE EVIDENCE OF SIGNIFICANT FUNCTIONAL PROGRESS IN LAST SIX MONTHS.
PA84	THE GRANT DATE OF THIS REQUEST CANNOT BE PRIOR TO THE SIGNATURE DATE OF THE PRESCRIBING PHYSICIAN.
PA86	PROVIDE EVIDENCE OF SKILLS GAINED IN THERAPY CARRYING OVER TO OTHER SETTINGS WITHIN SIX MONTHS.
PA87	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE NUMBER OF SESSIONS REQUESTED.
PA88	THE REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL SCOPE OF PRACTICE.
PA89	PRIOR AUTHORIZATION IS NOT REQUIRED UNTIL LIMITATION OF SERVICE HAS BEEN REACHED.
PA91	PLEASE SUBMIT REQUIRED X-RAYS.
PA92	PLEASE PROVIDE AN EXPLANATION FOR THE MATERIAL SUBMITTED WITH THE REQUEST.
PA95	PLEASE DESCRIBE HOW THE PROVISION OF THIS SERVICE WOULD PREVENT INSTITUTIONALIZATION OF THE CLIENT.
PA96	COULD THE EXISTING DENTURE(S) BE RELINED OR REBASED? IF NOT, PLEASE EXPLAIN WHY NOT.
PA97	REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL STANDARDS OF PRACTICE.
PA98	PLEASE INDICATE IF THE CLIENT IS CURRENTLY BEING TUBE FED.
PB02	PLEASE PROVIDE THE REQUIRED DATED SIGNATURES ON THE ATTACHMENTS.
PB03	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING THE LOSS/DESTRUCTION/THEFT OF THE HEARING AID.
PB04	DESCRIBE THE CLIENTS ABILITY TO STAND OR AMBULATE SUFFICIENTLY TO ACCOMPLISH SELF-CARE ACTIVITIES.
PB07	PLEASE SUBMIT AN ORTHODONTIC STUDY MODEL OR DIAGNOSTIC CASTS.
PB09	PLEASE PROVIDE A PHOTOGRAPH OF THE INVOLVED AREA(S).
PB10	PLEASE PROVIDE AN ESTIMATION (IN GRAMS) OF THE TOTAL AMOUNT OF TISSUE TO BE RESECTED.
PB11	PLEASE SUBMIT THE PLAN OF CARE FOR CO-TREATMENT.
PB12	FURNISH A DETAILED DESCRIPTION FOR THE PROCEDURE CODE REQUESTED.
PB13	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.

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PB15	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB18	PLEASE COMPLETE THE ATTACHED OUT-OF-STATE PROVIDER DATA SHEET, F-11001, AND RESUBMIT.
PB20	A SIGNED AND DATED PRESCRIPTION IS REQUIRED WITHIN THREE MONTHS OF RECEIPT BY COLORADO MEDICAID FOR INITIAL REQUESTS AND WITHIN 12 MONTHS OF RECEIPT BY COLORADO MEDICAID FOR SUBSEQUENT REQUESTS.
PB21	PLEASE COMPLETE THE APPROPRIATE PRIOR AUTHORIZATION ATTACHMENT. CONTACT PROVIDER SERVICES OR THE PRIOR AUTHORIZATION UNIT FOR ASSISTANCE.
PB23	PHYSICAL THERAPY ASSISTANT NOTES AND ALL FORMS SUBMITTED MUST BE COSIGNED BY A REGISTERED PHYSICAL THERAPIST.
PB31	ARE YOU REQUESTING A COMPLETE APPLIANCE, OR REPLACEMENT PARTS?
PB32	THE PROCEDURE CODE INDICATED ON THE REQUEST DOES NOT MATCH THE DESCRIPTION OF SERVICE; PLEASE CORRECT AND RESUBMIT.
PB35	THE SERVICE REQUESTED DOES NOT REQUIRE PRIOR AUTHORIZATION.
PB41	PLEASE FURNISH A CURRENT MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT, F-11090 (DATED WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID).
PB45	THE CERTIFICATION PERIOD ON THE PLAN OF CARE (POC) DOES NOT COVER THE REQUESTED GRANT/START DATE. PLEASE RESUBMIT YOUR REQUEST WITH A NEW POC.
PB49	A CERTIFIED OCCUPATIONAL THERAPY ASSISTANTS NOTES MUST BE COSIGNED BY AN OCCUPATIONAL THERAPIST REGISTERED.
PB51	ADDITIONAL INFORMATION IS REQUIRED ON PRIOR AUTHORIZATION TO ENABLE PRICING.
PB54	REQUESTED SERVICES DO NOT MATCH SERVICES ON THE PHYSICIANS ORDERS.
PB59	PLEASE PROVIDE AN INDIVIDUAL EDUCATIONAL PLAN (IEP), WHICH HAS BEEN SIGNED BY THE PROVIDER NO EARLIER THAN NINE MONTHS PRIOR TO RECEIPT AT COLORADO MEDICAID; OTHERWISE, DOCUMENT WHY NO IEP EXISTS.
PB65	PLEASE FURNISH THE ANTICIPATED TOTAL CHARGES FOR THIS REQUEST.
PB66	A PHOTOCOPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED; THE DATE MUST BE WITHIN SIX MONTHS OF RECEIPT BY COLORADO MEDICAID.
PB67	THE PRESCRIPTION DATE MUST INCLUDE MONTH, DAY, AND YEAR.
PB68	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID.
PB73	THE SERVICES IDENTIFIED ON THE PLAN OF CARE DO NOT APPEAR APPROPRIATE FOR THE PROCEDURE CODE(S) REQUESTED ON THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018.
PB74	THE CLIENT/PROVIDER DOES NOT HAVE RETROACTIVE ENROLLMENT.
PB75	THE REQUESTED START DATE IS MORE THAN 14 DAYS BEFORE OR 62 DAYS AFTER RECEIPT.
PB82	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
PB83	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A HOME HEALTH AIDE. PLEASE RESUBMIT AS A PERSONAL CARE WORKER OR PROVIDE ADDITIONAL DOCUMENTATION.
PB86	THE SERVICES REQUESTED ARE NOT BEING PROVIDED IN THE CLIENTS RESIDENCE. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL.
PB87	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A NURSE. PLEASE RESUBMIT AS A HOME HEALTH AIDE OR PROVIDE ADDITIONAL DOCUMENTATION.
PB92	PLEASE FURNISH THE CLIENTS COMPLETE ADDRESS.
PB94	IF THE CLIENT IS A RESIDENT OF A NURSING HOME, SUPPLY THE COMPLETE NAME AND ADDRESS OF THE NURSING HOME.
PB99	THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018, MUST BE SIGNED AND DATED.
PC01	PLEASE SUPPLY THE RENDERING PROVIDERS PROVIDER NUMBER.
PC03	THE DRUG ENFORCEMENT ADMINISTRATION NUMBER IS MISSING OR INVALID.
PC06	PLEASE DESCRIBE YOUR PROGRAM; INCLUDE ENTRY DATE, TERMINATION DATE, HOURS PER WEEK, AND NUMBER OF WEEKS OF PRIMARY INTENSIVE SERVICE REQUESTED.
PC07	PLEASE DESCRIBE YOUR "AFTERCARE/FOLLOW-UP" PLANS FOR THIS CLIENT.
PC08	PLEASE SUPPLY DOCUMENTATION OF PREVIOUS SUBSTANCE ABUSE SERVICES WITH DATE(S) AND OUTCOME.
PC09	PLEASE DESCRIBE IN DETAIL THE TREATMENT OBJECTIVES/GOALS FOR THIS CLIENT.

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PC10	PLEASE DESCRIBE THE FAMILY SITUATION/DYNAMICS. EXPLAIN HOW THE FAMILY WILL BE INCORPORATED INTO THE CLIENTS PLAN OF CARE.
PC12	PLEASE EXPLAIN IF YOUR SERVICE ENCOURAGES THE CLIENT TO ATTEND SELF-HELP GROUPS.
PC13	PLEASE SUPPLY A SPECIFIC SCHEDULE OF ACTIVITIES, INCLUDING DAY, TIME OF DAY, LENGTH OF SESSION, AND SERVICE TO BE RENDERED DURING THAT TIME.
PC15	PLEASE FURNISH DIAGNOSTIC RATIONALE.
PC17	PLEASE DOCUMENT IF THE CLIENT EVER RECEIVED SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT.
PC19	PLEASE FURNISH MORE EXTENSIVE AND IN-DEPTH HISTORICAL AND PSYCHOSOCIAL DATA.
PC20	PLEASE SUPPLY THE DATE THE CLIENT BECAME TOTALLY ENDENTULOUS.
PC23	PLEASE SUBMIT A PHYSICIANS STATEMENT REGARDING THE MEDICAL NECESSITY OF DENTURES FOR THIS CLIENT. THE PHYSICIANS STATEMENT MUST DOCUMENT THE MEDICAL NEED FOR DENTURES.
PC24	THE SERVICE REQUESTED WAS PREVIOUSLY AUTHORIZED. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT INDICATING THIS FACT IS REQUIRED.
PC25	PLEASE SUPPLY SUFFICIENT MITIGATING CIRCUMSTANCES TO WARRANT THE CONSTRUCTION OF NEW DENTURES(S).
PC26	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
PC28	PLEASE SUBMIT A PHYSICIANS STATEMENT INDICATING DENTURES ARE NECESSARY FOR THIS NURSING HOME CLIENT.
PC29	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING LOSS OR DESTRUCTION OF DENTURE(S). INCLUDE SIGNED STATEMENT FROM CLIENT OR FACILITY DIRECTOR REGARDING HOW, WHEN AND WHERE LOST.
PC30	PLEASE PROVIDE COMPLETE INTRAORAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PC31	PLEASE DESCRIBE ANY RELATED DEFORMITIES OF THE FEET.
PC34	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD WITH REQUESTED DME ITEM(S) AND DOCUMENT IF THE CLIENT CAN USE SAFELY AND INDEPENDENTLY.
PC35	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD AND DESCRIBE THE RESULTS AND EFFECTIVENESS OF THE SERVICE REQUESTED.
PC39	PLEASE INDICATE LITER FLOW PER MINUTE, HOURS OF USE PER 24 HOUR PERIOD, AND THE EXPECTED DURATION OF NEED.
PC40	THE ITEM DOES NOT REQUIRE PRIOR AUTHORIZATION UNTIL THE LIFE EXPECTANCY HAS BEEN REACHED.
PC41	PLEASE SUPPLY INFORMATION INDICATING THE NECESSITY OF POSITIONING THE CLIENT'S BODY IN MULTIPLE POSITIONS.
PC42	PLEASE INDICATE IF THE BED HEIGHT MUST BE CHANGED TO ALLOW FOR SAFE TRANSFER OR ADEQUATE BED CARE.
PC43	SUPPLY A PHYSICIANS STATEMENT INDICATING TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR UNIT HAS REDUCED PAIN, IMPROVED/INCREASED THE CLIENTS ACTIVITY LEVEL, AND/OR REDUCED CLIENTS USE OF PAIN MEDICATION.
PC44	A CURRENT AUTHORIZATION FOR THIS SERVICE IS ON FILE FOR ANOTHER PROVIDER. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT OF THAT FACT IS REQUIRED BY THE CLIENT OF FIRST PROVIDER.
PC59	DOCUMENT DECLINE OR PROGRESS IN SPECIFIC, MEASURABLE, OBJECTIVE TERMS.
PC60	DOCUMENT IF CLIENT HAS DEMONSTRATED A GOOD APPOINTMENT COMPLIANCE RECORD.
PC61	THE PHYSICIANS SIGNATURE DATE MUST NOT EXCEED 90 DAYS FROM THE DATE OF RECEIPT BY COLORADO MEDICAID.
PC62	REQUESTS FOR A CONTINUATION OF THERAPY SHOULD NOT BE SUBMITTED MORE THAN FOUR WEEKS PRIOR TO THE EXPIRATION DATE OF THE CURRENT AUTHORIZATION.
PC63	PLEASE FURNISH THE STYLE AND MANUFACTURER OF THE FRAME.
PC64	PLEASE FURNISH THE CLIENTS LENS FORMULA.
PC66	ALL REQUESTS FOR TINTS REQUIRE DOCUMENTATION OF THE VISUAL OR MEDICAL CONDITION RELATED TO PHOTOPHOBIA.
PC67	PLEASE DOCUMENT THE REASON AND JUSTIFICATION FOR REPLACEMENT BEYOND THE FIRST LENS/FRAME.
PC68	DOCUMENT IF ALL REMAINING MAXILLARY AND/OR MANDIBULAR TEETH ARE DECAY-FREE, PROPERLY RESTORED, AND PERIODONTICALLY SOUND.

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PC72	SUPPLY MORE DETAIL REGARDING PROGRESS (ATTACHMENT OF GOALS, ETC.). CORRELATE PROGRESS TO PREVIOUS GOALS AND IDENTIFIED LIMITATIONS.
PC77	PLEASE SUBMIT A PLAN OF CARE DESCRIBING THE SERVICES THAT WOULD BE PROVIDED.
PC78	PLEASE DOCUMENT SPECIFIC, MEASURABLE GOALS.
PC82	THE PRIOR AUTHORIZATION (PA) SYSTEM CAN PROCESS ONLY 26 DETAILS PER PA REQUEST. PLEASE RESUBMIT YOUR REQUEST WITH NO MORE THAN 26 DETAILS.
PC83	PLEASE SUPPLY A PHYSICIANS PRESCRIPTION DATED WITHIN ONE MONTH OF REQUESTED SUBSTANCE ABUSE DAY TREATMENT.
PC84	PLEASE PROVIDE INFORMATION INDICATING THIS CLIENT IS APPROPRIATELY DETOXIFIED FROM ALCOHOL AND/OR OTHER DRUGS.
PC85	PLEASE PROVIDE INFORMATION TO INDICATE THE CLIENTS ABILITY TO ABSTAIN FROM ALCOHOL OR DRUGS WHILE IN THE SUBSTANCE ABUSE DAY TREATMENT PROGRAM.
PC86	PLEASE INDICATE IF THIS CLIENT IS WILLING TO PARTICIPATE IN AFTERCARE OR CONTINUING CARE SERVICES.
PC87	PROVIDE MORE INFORMATION ON TREATMENT HISTORY; INCLUDE SERVICE PROVIDED, DATES, AND OUTCOME. PROVIDE DETAIL OF PREVIOUS TREATMENT.
PC88	PLEASE PROVIDE MORE RATIONALE FOR THE APPROPRIATENESS AND MEDICAL NECESSITY OF SUBSTANCE ABUSE DAY TREATMENT.
PC89	PROVIDE A TREATMENT PLAN THAT CONTAINS MEASURABLE GOALS AND OBJECTIVES CORRESPONDING TO THE IDENTIFIED DEFICIT.
PC91	PLEASE PROVIDE MORE INFORMATION ON FAMILY INVOLVEMENT TREATMENT.
PC92	PLEASE PROVIDE MORE HISTORY AND EXPLANATION ABOUT THE ISSUE OF ABSTINENCE FOR THIS CLIENT.
PC94	PLEASE PROVIDE THE ANTICIPATED BEGINNING DATE AND/OR THE ESTIMATED SUBSTANCE ABUSE DAY TREATMENT DISCHARGE DATE.
PC95	PLEASE SUPPLY JUSTIFICATION FOR BEGINNING CLIENT IN SERVICE PRIOR TO AUTHORIZATION BEING OBTAINED.
PC96	THE INITIAL THREE HOURS OF SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IN A CALENDAR YEAR DO NOT REQUIRE PRIOR AUTHORIZATION.
PC97	REIMBURSEMENT FOR INITIAL SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IS LIMITED TO THREE HOURS IN A CALENDAR YEAR AND DOES NOT REQUIRE PRIOR AUTHORIZATION.
PC98	THIS DRUG IS CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE BILL USING THE APPROPRIATE NATIONAL DRUG CODE (NDC) OR SUBMIT A COMPLETED DRUG ADDITION REQUEST FORM IF THE NDC IS NOT LISTED IN THE DRUG INDEX.
PC99	THIS DRUG IS NOT CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL, CURRENT ADMINISTRATIVE RULE, OR COLORADO DRUG INDEX FOR COVERAGE LIMITATIONS.
PD01	DOCUMENT THAT CLIENT HAS ACHIEVED GOOD ORAL HYGIENE, PERIODONTAL CASE TYPE 1 OR 2, AND IS MOTIVATED TO MAINTAIN SAME.
PD03	PLEASE PROVIDE AN ARTERIAL BLOOD GAS READING OR PULSE OXIMETRY RESULTS DONE ON ROOM AIR SIGNED AND DATED BY A MEDICAL DOCTOR. THIS SHOULD BE DONE WITHIN 60 DAYS OF REQUESTED SERVICE.
PD04	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 30 DAYS OF RECEIPT BY COLORADO MEDICAID.
PD07	SUBMIT A PHOTOCOPY OF A VALID PRESCRIPTION, ISSUED WITHIN THE PAST YEAR, OR COMPLETE SECTION B OF THE PRIOR AUTHORIZATION/DRUG ATTACHMENT (PA/DGA), F-11049.
PD10	BRAND MEDICALLY NECESSARY MUST BE IN THE PRESCRIBERS OWN HANDWRITING AND WRITTEN DIRECTLY ON THE PRESCRIPTION OR A SEPARATE ORDER ATTACHED TO THE ORIGINAL PRESCRIPTION.
PD12	COMPLETE DENTURES, PARTIAL DENTURES, DENTURE RELINES, AND FIXED PROSTHODONTIC SERVICES ARE NOT COVERED SERVICES FOR ADULTS FOR DATES OF SERVICE ON AND AFTER OCTOBER 1, 1995.
PD22	PLEASE COMPLETE ALL REQUIRED ELEMENTS ON THE PERSONAL CARE SCREENING TOOL (PCST), F-11133.
PD24	THIS PRIOR AUTHORIZATION REQUEST IS UNABLE TO BE PROCESSED. PLEASE RESUBMIT WITH ADDITIONAL REQUIRED FORMS, INCLUDING THE ENTIRE PERSONAL CARE SCREENING TOOL (PCST), F-11133; PERSONAL CARE ADDENDUM, F-11136; AND SUPPORTING DOCUMENTATION, AS DIRECTED.

Denial Code	Long Description
PD25	THERE IS A PERSONAL CARE SCREENING TOOL (PCST), F-11133, COMPLETED BY ANOTHER AGENCY. CONTACT THE AGENCY TO TRANSFER SCREEN.
PD26	THERE IS A LIMITED TERM CARE FUNCTIONAL SCREEN (LTC-FS) COMPLETED BY ANOTHER AGENCY. THE PERSONAL CARE SCREENING TOOL (PCST), F-11133, INFORMATION IS IN CONFLICT WITH LTC-FS.
PD27	ONLY ONE LEVEL OF FUNCTION MAY BE SELECTED FOR ALL ELEMENTS EXCEPT TOILETING. COLORADO MEDICAID IS UNABLE TO PROCESS THE PRIOR AUTHORIZATION REQUEST.
PD28	NO UNITS MAY BE REQUESTED USING THIS PRIOR AUTHORIZATION PROCESS. PLEASE SUBMIT WITH THE APPROPRIATE ATTACHMENTS FOR REQUESTING SPECIFIC PERSONAL CARE WORKER UNITS.
PD29	CLIENT IS NOT ELIGIBLE FOR THE REQUESTED SERVICE(S) AS OF THE REQUESTED START DATE.
PD30	NO TRAVEL TIME MAY BE AUTHORIZED WHEN NO PERSONAL CARE WORKER SERVICE IS AUTHORIZED.
PD32	PROVIDER NOT CERTIFIED TO RENDER THE SERVICE(S) REQUESTED.
PD34	BASED ON THE DOCUMENTATION SUBMITTED, THIS REQUEST CAN NOT BE PRIOR AUTHORIZED. REFER TO THE PA MESSAGES FROM THE CONSULTANT FOR COMPLETE EXPLANATION.
PD98	PLEASE DOCUMENT HOW AND WHEN EACH PREVIOUSLY AUTHORIZED PRO RE NATA VISIT WAS USED.

Supported Living Services (SLS) State Plan

Denial Code	Long Description
0201	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
0233	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0235	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0237	CLIENT IDENTIFICATION NUMBER DOES NOT MATCH CLIENTS FIRST NAME.
0238	THE CLIENT IDENTIFICATION NUMBER DOES NOT MATCH THE CLIENTS LAST NAME.
0242	SECONDARY DIAGNOSIS CODE IS INVALID.
0248	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0249	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0251	PROCEDURE CODE MODIFIER IN FIRST POSITION IS INVALID.
0252	THE PROCEDURE CODE MODIFIER IN SECOND POSITION IS INVALID FOR REQUESTED START DATE OR DATE OF RECEIPT.
0253	THE PROCEDURE CODE MODIFIER IN THIRD POSITION IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
0258	THE PRIMARY DIAGNOSIS CODE IS REQUIRED.
0272	THE PRIMARY DIAGNSOSIS CODE IS INVALID.
0400	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0853	HCPCS - ANNUAL UPDATE
0885	NEVER EVENTS MODIFIERS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
0886	NEVER EVENTS DIAGNOSIS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
1000	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
1002	RENDERING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1003	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1007	RENDERING PROVIDER ID IS NOT ON FILE.
1047	THE RENDERING PROVIDERS CERTIFICATION HAS BEEN CANCELLED.
1048	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1801	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.

Denial Code	Long Description
1804	A CERTIFIED SUBSTANCE ABUSE DAY TREATMENT PROVIDER MUST SUBMIT A SUBSTANCE ABUSE DAY TREATMENT PROCEDURE CODE.
1806	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
1808	THE BILLING PROVIDER DOES NOT HAVE THE REQUIRED CERTIFICATION ADDENDUM ON FILE.
1900	THE BILLING PROVIDERS TAXONOMY CODE IS INVALID.
1901	THE RENDERING PROVIDERS TAXONOMY CODE IS INVALID.
1927	A NATIONAL PROVIDER IDENTIFIER IS REQUIRED FOR THE BILLING PROVIDER.
1934	A NATIONAL PROVIDER INDENTIFIER IS REQUIRED FOR THE RENDERING PROVIDER.
1936	THE BILLING PROVIDER NUMBER IS INVALID.
1937	THE RENDERING PROVIDER NUMBER IS INVALID.
1960	INTERNAL PROCESSING IS REQUIRED.
1963	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.
1964	THE BILLING PROVIDER INDICATED IS NOT ALLOWABLE AS A BILLING PROVIDER.
1965	RENDERING PROVIDER NUMBER IS MISSING/INVALID FOR THIS PROCEDURE PROVIDER.
1974	PRESCRIBING/REFERRING/ORDERING PROVIDER INDICATED IS NOT CERTIFIED AS A PRESCRIBING/REFERRING/ORDERING PROVIDER.
1975	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
1976	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
2001	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2003	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2017	THE CLIENT IS ENROLLED IN A MEDICAID OR OTHER MANAGED CARE PROGRAM.
2037	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2603	CLIENT LOCKED-IN TO A PROVIDER OR ENROLLED IN A HOSPICE. CONTACT CLIENTS HOSPICE FOR PAYMENT OF SERVICES OR RESUBMIT WITH DOCUMENTATION OF UNRELATED NATURE OF CARE.
3324	THE MODIFIER HAS BEEN DISCONTINUED BY THE CENTERS OF MEDICARE AND MEDICAID SERVICES OR THE AMERICAN MEDICAL ASSOCIATION FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
3337	THE PROCEDURE CODE HAS BEEN TERMINATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AMERICAN MEDICAL ASSOCIATION, OR AMERICAN DENTAL ASSOCIATION FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT. RESUBMIT WITH VALID A PROCEDURE CODE.
3339	THE PROCEDURE BILLED IS NOT PAYABLE ACCORDING TO DEFICIT REDUCTION ACT (DEFRA) GUIDELINES.
3351	THE PROCEDURE IS NOT COVERED FOR CLIENTS WITH A NURSING HOME AUTHORIZATION ON THE REQUESTED START DATE OR DATE OF RECEIPT.
3353	THE PROCEDURE IS NOT A COVERED SERVICE FOR HOME AND COMMUNITY-BASED WAIVER CLIENTS.
4021	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4027	THE DIAGNOSIS CODE IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
4031	THE PROCEDURE SUBMITTED IS NOT APPROPRIATE FOR CLIENTS GENDER.
4032	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4034	THE PROCEDURE CODE HAS AN AGE RESTRICTION.
4036	THE PLACE OF SERVICE CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4040	THE PRIMARY DIAGNOSIS CODE IS NOT ON FILE.
4041	THE SECONDARY DIAGNOSIS IS NOT ON FILE.
4046	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4127	INTERNAL PROCESSING IS REQUIRED.
4131	INTERNAL PROCESSING IS REQUIRED.
4141	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4149	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4150	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4236	ETIOLOGY DIAGNOSIS CODE(S) (E-CODES) ARE INVALID AS THE PRIMARY DIAGNOSIS.
4244	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4245	THE FOURTH POSITION MODIFIER IS INVALID FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT.
4256	THE PROCEDURE CODE AND MODIFIER COMBINATION IS NOT PAYABLE FOR THE CLIENTS BENEFIT PLAN.
4257	THE MODIFIERS SUBMITTED ARE EITHER INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT OR THE MODIFIERS ARE MISSING.

Denial Code	Long Description
4311	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4315	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4316	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4371	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4372	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4711	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR CLIENTS AGE.
4714	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS AGE.
4731	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS DIAGNOSIS.
4742	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4743	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4744	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4745	DIAGNOSIS AND/OR PROCEDURE AND/OR PLACE OF SERVICE (POS) CODE IS NOT COVERED FOR EXPRESS ENROLLMENT CLIENTS.
4746	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4801	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4802	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
4821	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
4871	PLEASE REFER TO PA MESSAGES FOR RETURN INFORMATION.
4963	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS GENDER.
4990	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
7500	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
7509	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
P001	THE BILLING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THE SERVICES.
P002	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P003	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P005	THE PRIOR AUTHORIZATION CAN NOT BE END DATED. THE PRIOR AUTHORIZATION STATUS IS NOT APPROVED OR APPROVED WITH REVISIONS.
P006	PLEASE FURNISH THE PROCEDURE CODE AND CORRESPONDING DESCRIPTION.
P008	THE BILLING PROVIDER NUMBER IS INVALID.
P009	THE BILLING PROVIDER NUMBER IS INVALID.
P010	THE REQUESTED END DATE IS INVALID.
P011	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P012	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P013	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P014	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P015	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P016	THE REQUESTED START DATE IS MISSING OR INVALID.
P019	THE REQUESTED START DATE IS MISSING OR INVALID.
P020	THE RENDERING PROVIDER NUMBER IS INVALID.
P021	THE RENDERING PROVIDER NUMBER IS INVALID.
P022	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P023	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P024	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P026	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P027	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.

Denial Code	Long Description
P030	FIRST MODIFIER IS INVALID.
P031	FIRST MODIFIER IS INVALID.
P032	SECOND MODIFIER IS INVALID.
P033	SECOND MODIFIER IS INVALID.
P034	THIRD MODIFIER IS INVALID.
P035	THIRD MODIFIER IS INVALID.
P036	FOURTH MODIFIER IS INVALID.
P037	FOURTH MODIFIER IS INVALID.
P038	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P039	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P040	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P041	CLIENTS FIRST NAME IS MISSING.
P042	CLIENTS LAST NAME IS MISSING.
P043	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P044	BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES REQUESTED.
P045	FIRST MODIFIER IS INVALID.
P046	SECOND MODIFIER IS INVALID.
P047	THIRD MODIFIER IS INVALID.
P048	FOURTH MODIFIER IS INVALID.
P052	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P053	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P054	RENDERING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES FOR THE BENEFIT PLAN.
P055	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P061	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P062	THE CLIENT ID AND/OR NAME INDICATED ON THE PA REQUEST IS INCORRECT. THE CLIENT ID AND/OR NAME HAS BEEN UPDATED. PLEASE VERIFY THE ID AND/OR NAME IS CORRECT.
P064	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
P067	THE FREQUENCY OF HOURS REQUESTED ARE NOT APPROPRIATE FOR THIS CLIENT AND HAVE BEEN MODIFIED ACCORDINGLY.
P079	BILLING PROVIDER IS ON PAYMENT SUSPENSION DUE TO CREDIBLE ALLEGATION OF FRAUD.
P120	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAS BEEN REDUCED.
P121	THE SERVICE/ PROCEDURE REQUESTED IS NOT SUPPORTED BY SUBMITTED DOCUMENTATION.
P126	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
P128	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.
P138	SERVICE(S) DO NOT MEET COLORADO MEDICAID GUIDELINES.
P167	REQUESTED DOCUMENTATION HAS NOT BEEN SUBMITTED.
P178	THE SERVICE REQUESTED IS NOT MEDICALLY NECESSARY.
P179	THE MEDICAL NECESSITY FOR THIS SERVICE IS NOT SUPPORTED BY THE SUBMITTED DOCUMENTATION.
P233	THE DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE ADDITIONAL CARE.
P257	THIS CLIENTS FUNCTIONAL ASSESSMENT SCORES PLACE THIS CLIENT OUTSIDE ELIGIBILITY FOR DAY TREATMENT.
P274	OUR RECORDS INDICATE THIS CLIENT IS INVOLVED IN EFFECTIVE AND APPROPRIATE SERVICE ELSEWHERE.
P292	INTENSIVE REHABILITATION HOURS ARE NO LONGER APPROPRIATE AS INDICATED BY HISTORY, DIAGNOSIS, AND/ OR FUNCTIONAL ASSESSMENT SCORES.
P328	THE SERVICES REQUESTED INCLUDE NON-COVERED SERVICES, AND HOURS ARE REDUCED ACCORDINGLY.
P339	THE CLIENTS PAST HISTORY INDICATES REDUCED TREATMENT HOURS ARE WARRANTED.
P342	THE REQUEST DOES NOT MEET GENERALLY ACCEPTED CONDITIONS REQUIRING FLUORIDE TREATMENTS.

Denial Code	Long Description
P346	SERVICES EXCEED COLORADO MEDICAID LIMITATION AND DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE MEDICAL NECESSITY OF THE SERVICE.
P349	THE SERVICE REQUESTED WAS PERFORMED LESS THAN FIVE YEARS AGO.
P353	THE EXISTING APPLIANCE HAS NOT BEEN WORN FOR THREE YEARS.
P367	THE CLIENT HAS BEEN TOTALLY WITHOUT TEETH AND AN APPLIANCE FOR FIVE YEARS.
P392	THE CLIENT IS MISSING AN ANTERIOR TOOTH AND/OR HAS TWO OR MORE POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P405	THE SERVICE(S) REQUESTED COULD ADEQUATELY BE PERFORMED IN THE DENTAL OFFICE.
P406	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE OF GOOD PERIODONTAL HEALTH (AMERICAN ACADEMY OF PERIODONTOLOGY PERIODONTAL CLASSIFICATION OF TYPE I OR II).
P407	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE VISIBLE ON RADIOGRAPHS THAT AT LEAST 50 PERCENT OF THE CLINICAL CROWN IS INTACT.
P409	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING SIX OR MORE TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED, INCLUDING THIRD MOLARS.
P410	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING ONE OR MORE ANTERIOR TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED.
P411	DOCUMENTATION DOES NOT SUPPORT THE NEED FOR PERIODONTIC SERVICES. POCKETS ARE LESS THAN 4MM AND/OR GREATER THAN 6MM FOR CLIENT AND/OR THE CLIENT IS UNDER THE AGE OF 13.
P412	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA.
P413	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA. THIS PA HAS BEEN GRANTED AS APPROVED NOT APPROVED WITH REVISIONS. THE DURATION REQUESTED MAY HAVE BEEN REDUCED TO REFLECT COVERAGE LIMITATIONS, PRESCRIBER ORDERS, CONFLICTI
P417	THE SERVICE(S) REQUESTED COULD BE ADEQUATELY PERFORMED WITH LOCAL ANESTHESIA.
P437	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO POOR ORAL HYGIENE.
P444	THIS LINE ITEM IS A DUPLICATE OF ANOTHER LINE ITEM ON THIS PRIOR AUTHORIZATION (PA) REQUEST. PLEASE CORRECT.
P446	THIS IS A DUPLICATE OF AN EXISTING PRIOR AUTHORIZATION (PA) REQUEST. YOU MAY CONTACT PROVIDER SERVICES IF YOU REQUIRE ASSISTANCE. DUPLICATE PA REQUEST
P448	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO DECAY HISTORY.
P449	QUESTIONABLE LONG TERM PROGNOSIS DUE TO GUM AND BONE DISEASE.
P456	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO APPARENT ROOT INFECTION.
P457	OUR RECORDS INDICATE THIS CLIENT HAS EXCEEDED ESTABLISHED PROGRAM LIMITATIONS. COLORADO MEDICAID WILL NOT AUTHORIZE NEW DENTURES.
P458	DOCUMENTATION PROVIDED INDICATES A LESS ELABORATE PROCEDURE SHOULD BE CONSIDERED.
P502	RENTAL ONLY ALLOWED; MEDICAL NEED FOR PURCHASE HAS NOT BEEN DOCUMENTED.
P503	PURCHASE ONLY ALLOWED; MEDICAL NEED FOR RENTAL HAS NOT BEEN DOCUMENTED.
P504	OCCUPATIONAL THERAPY GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P505	THE SERVICE REQUESTED IS INCLUDED IN THE NURSING HOME RATE STRUCTURE.
P511	THIS NATIONAL DRUG CODE IS ONLY BILLABLE AS PART OF A COMPOUND DRUG.
P515	THE PRESENCE OF A HANDICAPPING MALOCCLUSION OR HANDICAPPING DENTOFACIAL DEFORMITY IS NOT SUPPORTED BY THE DOCUMENTATION SUBMITTED.
P521	THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVERED BY COLORADO MEDICAID.
P522	GASTRO-INTESTINAL SURGERY FOR THE PURPOSE OF WEIGHT CONTROL IS COVERED ONLY AS A LIFE THREATENING PROCEDURE.
P523	THE TREATMENT REQUEST IS NOT CONSISTENT WITH THE CLIENT'S DIAGNOSIS.
P524	PSYCHOTHERAPY PROVIDED IN THE CLIENTS HOME IS NOT A COVERED BENEFIT OF COLORADO MEDICAID.
P525	THE INFORMATION PROVIDED IS NOT CONSISTENT WITH THE INTENSITY OF SERVICES REQUESTED.
P526	INTENSIVE MULTIPLE MODALITY TREATMENT IS NOT CONSISTENT WITH THE INFORMATION PROVIDED.
P527	MULTIPLE PROVIDERS OF TREATMENT ARE NOT INDICATED FOR THIS CLIENT.
P528	THE DURATION OF TREATMENT SESSIONS EXCEED CURRENT COLORADO MEDICAID GUIDELINES.

Denial Code	Long Description
P534	DOCUMENTATION OF POOR PHYSICAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P535	OTHER PHYSICAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P536	THE PHYSICAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P537	USE OF PHYSICAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P538	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF A PHYSICAL THERAPIST.
P539	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS AND LIVING ARRANGEMENT.
P540	GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P541	THE PROCEDURE(S) REQUESTED ARE NOT MEDICAL IN NATURE.
P542	DOCUMENTATION OF POOR OCCUPATIONAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P543	DOCUMENTATION OF POOR SPEECH THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P544	OTHER OCCUPATIONAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P546	THE OCCUPATIONAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P547	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF PHYSICAL THERAPY.
P548	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P549	ACTIVITIES TO PROMOTE DIVERSION OR GENERAL MOTIVATION ARE NONCOVERED COLORADO MEDICAID SERVICES.
P550	REVISIONS OF THE REQUEST IS NECESSITATED BY THE CLIENTS MINIMAL PROGRESS.
P551	RESTORATIVE NURSING INVOLVEMENT COULD BE INCREASED.
P552	CLIENTS DEMONSTRATED RESPONSE TO CURRENT THERAPY DOES NOT WARRANT THE INTENSE FREQUENCY REQUESTED.
P553	MAINTENANCE IS TWO TIMES PER WEEK OR LESS.
P554	THE SPEECH THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P555	USE OF OCCUPATIONAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P556	USE OF SPEECH THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P557	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF AN OCCUPATIONAL THERAPIST.
P558	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
P559	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P560	THE MATERIALS/ SERVICES REQUESTED ARE PRINCIPALLY COSMETIC IN NATURE.
P561	THE LENS FORMULA DOES NOT JUSTIFY REPLACEMENT.
P562	THE CHANGE IN THE LENS FORMULA DOES NOT WARRANT MULTIPLE REPLACEMENTS.
P563	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P564	LENSES ONLY ARE APPROVED; PLEASE DISPENSE A CONTRACTED FRAME. THE NON-CONTRACTED FRAME IS NOT MEDICALLY JUSTIFIED.
P565	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P566	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P567	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF OCCUPATIONAL THERAPY.
P568	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF SPEECH THERAPY.
P569	LEVEL, INTENSITY, OR EXTENT OF SERVICE(S) REQUESTED HAS BEEN MODIFIED CONSISTENT WITH MEDICAL NEED AS DEFINED IN THE PLAN OF CARE.

Denial Code	Long Description
P570	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P571	THE SERVICE ASKED FOR IS NOT COVERED BY COLORADO MEDICAID AS THESE TASKS CAN BE DONE BY NURSES OR ACTIVITY STAFF.
P572	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P573	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.
P574	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P575	MEDICAL NEED FOR EQUIPMENT/ SUPPLY REQUESTED IS NOT SUPPORTED BY DOCUMENTATION SUBMITTED.
P576	OTHER SPEECH THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P577	DOCUMENTATION SUBMITTED IDENTIFIES THAT THE CLIENT HAS FEWER THAN TWO POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P582	LESS EXPENSIVE ALTERNATIVE SERVICES ARE AVAILABLE FOR THIS CLIENT.
P634	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P711	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING PERIODONTAL SCALING AND ROOT PLANNING.
P712	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING GINGIVECTOMY.
P754	AN APPROVED SUBSTANCE ABUSE DAY TREATMENT PROGRAM CANNOT EXCEED A SIX WEEK PERIOD.
P761	THE CLIENT DOES NOT APPEAR TO BE ABLE OR WILLING TO ABSTAIN FROM ALCOHOL/DRUG USAGE WHILE IN TREATMENT. THEREFORE, SUBSTANCE ABUSE DAY TREATMENT SERVICES ARE NOT APPROVED.
P764	THIS CLIENT HAS COMPLETED INTENSIVE SUBSTANCE ABUSE TREATMENT WITHIN THE PAST 12 MONTHS. THE DOCUMENTATION PROVIDED IS NOT ADEQUATE TO JUSTIFY ADDITIONAL INTENSIVE TREATMENT AT THIS TIME.
P785	A LESS THAN SIX-WEEK HEALING PERIOD HAS BEEN SPECIFIED FOR THIS PRIOR AUTHORIZATION. THEREFORE IT IS NOT NECESSARY TO WAIT THE FULL SIX WEEKS AFTER EXTRACTIONS BEFORE TAKING DENTURE IMPRESSIONS.
P818	SIX-WEEK HEALING TIME IS REQUIRED BETWEEN EDENTULATION AND FINAL IMPRESSIONS. PAYMENT FOR DENTURES WILL BE DENIED OR RECOUPED IF HEALING PERIOD IS NOT OBSERVED.
P849	COLORADO MEDICAID HAS DETERMINED THERE WERE (ARE) SEVERAL HOME HEALTH AGENCIES WILLING TO PROVIDE MEDICALLY NECESSARY SKILLED NURSING SERVICES TO THIS CLIENT.
P864	THE DOCUMENTATION YOU HAVE SUBMITTED DOES NOT MEET THE REQUIREMENTS OF COLORADO MEDICAID.
P873	THE MEDICAL NECESSITY FOR THE HOURS REQUESTED IS NOT SUPPORTED BY THE INFORMATION SUBMITTED.
P874	THE DOCUMENTATION SUBMITTED INDICATES THE TASKS SPECIFIED CAN BE COMPLETED DURING THE VISITS APPROVED.
P878	THE DOCUMENTATION SUBMITTED DOES NOT INDICATE THAT MEDICALLY ORIENTED TASKS ARE MEDICALLY NECESSARY; THEREFORE PERSONAL CARE SERVICES HAVE BEEN APPROVED.
P880	THE QUANTITY OF SERVICES AUTHORIZED FOR THIS CLIENTS PERSONAL CARE HAS BEEN AMENDED BASED ON INFORMATION RECEIVED FROM ONE OR MORE OF THESE SOURCES: THE CLIENT, THEIR PHYSICIAN, AND/OR THE IN-HOME VISIT BY STAFF OF THE OIG (OFFICE OF INSPECTOR GENERAL).
P885	THE USE OF THIS DRUG FOR THE INTENDED PURPOSE IS NOT COVERED BY COLORADO MEDICAID, CONSISTENT WITH COLORADO ADMINISTRATIVE CODE AND FEDERAL LAW.
P924	THE MEDICAL RECORDS SUBMITTED WITH THE CURRENT REQUEST CONFLICT OR DISAGREE WITH OUR MEDICAL RECORDS ON THIS CLIENT.
P950	INDEPENDENT NURSES, PLEASE NOTE PAYABLE SERVICES MAY NOT EXCEED 12 HOURS/DAY OR 60 HOURS/WEEK.
P951	SERVICES CAN ONLY BE AUTHORIZED THROUGH ONE YEAR FROM THE PRESCRIPTION DATE.
P952	LEAD INSPECTION IS A COVERED COLORADO MEDICAID SERVICE WHEN THE CHILD HAS BEEN SHOWN TO HAVE LEAD POISONING (E.G., CHILD HAS A BLOOD LEAD LEVEL > 19 UG/DL OR TWO CONSECUTIVE BLOOD LEAD LEVELS OF 15-19 UG/DL DONE AT LEAST 90 DAYS APART). THE INSPECTION MUS

Denial Code	Long Description
P953	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P954	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P956	THE REQUEST CAN ONLY BE BACKDATED A MAXIMUM OF 14 DAYS FROM FIRST DATE RECEIVED BY COLORADO MEDICAID.
P957	COMPLETE PERIODONTAL CHARTING AT TIME OF SERVICE, AND SUBMIT CHARTING, COPY OF OPERATIVE REPORT, TOGETHER WITH A COPY OF THE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF), F-11035, TO PA UNIT ATTENTION DENTAL CONTSULTANT.
P958	NOTE THAT CODE D4341 HAS BEEN CHANGED. REFER TO THE DECISION NOTICE FOR AUTHORIZED QUANTITY.
P960	YOUR PA HAS BEEN APPROVED FOR 90 DAYS. THE 90 DAY APPROVAL DOES NOT IMPLY THE PA REQUEST MEETS PRIOR AUTHORIZATION CRITERIA. AFTER ADDITIONAL INFORMATION IS AVAILABLE IN INTERCHANGE, COLORADO MEDICAID WILL CREATE AN AMENDMENT REQUEST TO EXTEND THE PA FOR
P961	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P962	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
PA10	THE REQUESTED END DATE IS INVALID.
PA12	PLEASE FURNISH A WRITTEN DESCRIPTION OF THE CLIENTS DIAGNOSIS.
PA13	PROVIDE DIAGNOSES WITH DATES OF ONSET.
PA14	IDENTIFY PROBLEMS TO BE TREATED.
PA15	THE AUDIOLOGISTS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1), F-11020, AND PRIOR AUTHORIZATION REQUEST/HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2), F-11021.
PA16	THE PHYSICIANS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION/PHYSICIAN OTOLOGICAL REPORT (PA/POR), F-11019.
PA17	SUBMIT BRIEF HISTORY WITH REFERRAL INFORMATION, LIVING SITUATION, FUNCTIONAL STATUS, AND OTHER PERTINENT INFORMATION. WHAT CHANGE OF STATUS RESULTED IN REFERRAL AT THIS TIME?
PA18	PLEASE FURNISH THE CLIENTS HEIGHT AND WEIGHT.
PA19	PLEASE SUBMIT CLINICAL INFORMATION SUFFICIENT TO VERIFY THE NEED FOR THE REQUESTED SERVICE(S).
PA20	PLEASE RESUBMIT WITH COMPLETE PERIODONTAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PA21	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL EDUCATIONAL PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA22	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL PROGRAM PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA23	REFER TO THE DURABLE MEDICAL EQUIPMENT INDEX FOR APPROPRIATE CODE AND DESCRIPTION. DO NOT USE AN "UNLISTED" CODE.
PA24	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUALIZED FAMILY SERVICE PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA25	INFORMATION ON THE REQUEST FORM IS ILLEGIBLE, AND THE REQUEST CANNOT BE PROCESSED.
PA26	RE-EVALUATE YOUR GOALS. EMPHASIS SHOULD BE ON FUNCTIONAL SELF-CARE. GOALS MUST BE RELATED TO FUNCTIONAL OUTCOME.
PA27	PLEASE CLARIFY THE NUMBER OF HOURS PER WEEK REQUESTED.
PA28	PLEASE CLARIFY THE NUMBER OF HOURS PER DAY REQUESTED.
PA29	PLEASE CLARIFY THE NUMBER OF VISITS PER DAY REQUESTED.
PA30	ATTACH SUPPORTIVE DOCUMENTATION; HOME EXERCISE PROGRAM AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA31	THE DIAGNOSIS CODE INDICATED ON THE REQUEST DOES NOT CORRESPOND TO THE DIAGNOSIS CODE DESCRIPTION.

Denial Code	Long Description
PA32	PLEASE SUBMIT ADDITIONAL INFORMATION SUFFICIENT TO VERIFY APPROPRIATENESS AND NEED FOR TRANSPLANT.
PA33	PLEASE SUBMIT THE INITIAL AND PROGRESSIVE OBJECTIVE FINDINGS.
PA34	ATTACH SUPPORTIVE DOCUMENTATION, FACILITY PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA35	PLEASE SUBMIT THE CLIENTS ORIGINAL COMPLAINTS AND EXAMINATION FINDINGS.
PA36	ATTACH SUPPORTIVE DOCUMENTATION, IN-HOME AUTISM PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA37	PLEASE SUBMIT YOUR TREATMENT PLAN FOR THIS CLIENT.
PA38	ATTACH SUPPORTIVE DOCUMENTATION AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA39	INITIAL EVALUATIONS MUST BE PERFORMED BY AN OCCUPATIONAL THERAPIST REGISTERED (OTR), PER AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA) STANDARDS.
PA41	IDENTIFY THE PLACE OF SERVICE AND ITS EFFECT ON SUPPORTING THE DESIRED TREATMENT OUTCOME.
PA42	PLEASE INDICATE THE HOURS OF USE OF OXYGEN PER 24-HOUR PERIOD.
PA43	PROVIDE BASELINE DOCUMENTATION FOR THIS CLIENTS LIMITATIONS USING UNITS OF MEASUREMENT THAT ARE APPLIED CONSISTENTLY WHEN REPORTING STATUS.
PA44	IDENTIFY FUNCTIONAL LIMITATIONS AS THEY ARE RELATED TO IDENTIFIED CONDITIONS.
PA46	CORRELATE PLAN OF CARE TO REQUESTED PROCEDURE CODES.
PA47	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE FREQUENCY/DURATION REQUESTED.
PA48	PLEASE PROVIDE THE NAME AND CREDENTIALS OF THE RENDERING PROVIDER.
PA50	COLORADO MEDICAID RECORDS INDICATE THE CLIENT OWNS A WHEELCHAIR. DOCUMENT THE REASON AND NEED FOR REPLACEMENT AND COST TO REPAIR CURRENT WHEELCHAIR.
PA51	PLEASE DISTINGUISH PRIMARY AND SUPPORTIVE MODALITIES.
PA52	PLEASE SUBMIT A PROGRESS REPORT.
PA53	MULTIPLE FAMILY CLIENTS TREATMENT BY THE SAME PROVIDER REQUIRES FURTHER INFORMATION DOCUMENTING COORDINATION OF TREATMENT PLAN.
PA54	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE MINUTES REQUESTED.
PA55	MEDICAL NECESSITY OF TREATMENT REQUIRES ADDITIONAL DOCUMENTATION.
PA56	GIVEN AGE, DIAGNOSES, CURRENT LEVEL OF FUNCTION, PAST RESPONSE TO TREATMENT, AND LIVING SITUATION, EXPAND ON POTENTIAL FOR SIGNIFICANT FUNCTIONAL PROGRESS WITHIN THE NEXT SIX MONTHS. EMPHASIZE WHY PROGRESS IS EXPECTED WITH SERVICES AT THIS TIME.
PA57	SUBMIT THE INITIAL FINDINGS. INCLUDE A COMPREHENSIVE EVALUATION.
PA58	SUBMIT PROGRESSIVE, OBJECTIVE FINDINGS. INCLUDE A PERTINENT RE-EVALUATION.
PA59	PLEASE SUPPLY INFORMATION REGARDING THE CLIENTS MEDICATION REQUIREMENTS, IF ANY.
PA60	PLEASE SPECIFY IF THE CLIENT IS IN AN EDUCATIONAL SETTING.
PA61	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA62	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
PA63	THE SKILLS OF A THERAPIST ARE PURPOSEFUL AND SKILLED INTERVENTIONS REQUIRED TO CONTINUALLY DESIGN, IMPLEMENT, REASSESS, MODIFY/GRADE, AND/OR DISCONTINUE A PLAN OF CARE IN A TIMELY MANNER, BASED ON THE COMPLEXITY OF THE CLIENTS MEDICAL CONDITION AND/OR CO
PA64	PLEASE SUBMIT A THERAPY PLAN OF CARE, INCLUDING A CURRENT, DATED EVALUATION.
PA65	A PLAN OF CARE SIGNED AND DATED BY THE PHYSICIAN IS REQUIRED.
PA66	THE SKILLS OF A THERAPIST ARE REQUIRED WHEN ONLY THE THERAPIST CAN SAFELY AND EFFECTIVELY DELIVER THE THERAPEUTIC PROCEDURES BECAUSE OF THEIR UNIQUE KNOWLEDGE, TRAINING, AND EXPERTISE. DESCRIBE THE REASON THAT SOMEONE OTHER THAN A THERAPIST CANNOT SAFELY
PA67	PLEASE SPECIFY IF THE CLIENTS WORK SITE DEMANDS GOOD BINAURAL HEARING.
PA68	DESCRIBE THE REASON, BASED ON THE CLIENTS COGNITIVE, PHYSICAL, COMMUNICATION, OR RESOURCE STATUS, THAT A HOME PROGRAM, EQUIPMENT, OR ENVIRONMENTAL ADAPTATIONS ALONE CANNOT MEET CLIENTS NEEDS.

Denial Code	Long Description
PA69	PLEASE SPECIFY IF THE CLIENT HAS AN ACCOMPANYING DISABILITY THAT ADDS TO THE HEARING PROBLEM.
PA70	DISTINGUISH REQUESTED PROCEDURES AND GOALS FROM OTHER SERVICES THIS CLIENT RECEIVES. THEY MAY NOT BE DUPLICATIVE.
PA71	PLEASE INDICATE THE NUMBER OF DAYS REQUESTED.
PA73	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA74	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA75	PLEASE DOCUMENT CARRYOVER OF THE THERAPY PROGRAM TO NURSING.
PA76	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA79	PROVIDE EVIDENCE OF SIGNIFICANT FUNCTIONAL PROGRESS IN LAST SIX MONTHS.
PA84	THE GRANT DATE OF THIS REQUEST CANNOT BE PRIOR TO THE SIGNATURE DATE OF THE PRESCRIBING PHYSICIAN.
PA86	PROVIDE EVIDENCE OF SKILLS GAINED IN THERAPY CARRYING OVER TO OTHER SETTINGS WITHIN SIX MONTHS.
PA87	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE NUMBER OF SESSIONS REQUESTED.
PA88	THE REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL SCOPE OF PRACTICE.
PA89	PRIOR AUTHORIZATION IS NOT REQUIRED UNTIL LIMITATION OF SERVICE HAS BEEN REACHED.
PA91	PLEASE SUBMIT REQUIRED X-RAYS.
PA92	PLEASE PROVIDE AN EXPLANATION FOR THE MATERIAL SUBMITTED WITH THE REQUEST.
PA95	PLEASE DESCRIBE HOW THE PROVISION OF THIS SERVICE WOULD PREVENT INSTITUTIONALIZATION OF THE CLIENT.
PA96	COULD THE EXISTING DENTURE(S) BE RELINED OR REBASED? IF NOT, PLEASE EXPLAIN WHY NOT.
PA97	REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL STANDARDS OF PRACTICE.
PA98	PLEASE INDICATE IF THE CLIENT IS CURRENTLY BEING TUBE FED.
PB02	PLEASE PROVIDE THE REQUIRED DATED SIGNATURES ON THE ATTACHMENTS.
PB03	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING THE LOSS/DESTRUCTION/THEFT OF THE HEARING AID.
PB04	DESCRIBE THE CLIENTS ABILITY TO STAND OR AMBULATE SUFFICIENTLY TO ACCOMPLISH SELF-CARE ACTIVITIES.
PB07	PLEASE SUBMIT AN ORTHODONTIC STUDY MODEL OR DIAGNOSTIC CASTS.
PB09	PLEASE PROVIDE A PHOTOGRAPH OF THE INVOLVED AREA(S).
PB10	PLEASE PROVIDE AN ESTIMATION (IN GRAMS) OF THE TOTAL AMOUNT OF TISSUE TO BE RESECTED.
PB11	PLEASE SUBMIT THE PLAN OF CARE FOR CO-TREATMENT.
PB12	FURNISH A DETAILED DESCRIPTION FOR THE PROCEDURE CODE REQUESTED.
PB13	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB15	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB18	PLEASE COMPLETE THE ATTACHED OUT-OF-STATE PROVIDER DATA SHEET, F-11001, AND RESUBMIT.
PB20	A SIGNED AND DATED PRESCRIPTION IS REQUIRED WITHIN THREE MONTHS OF RECEIPT BY COLORADO MEDICAID FOR INITIAL REQUESTS AND WITHIN 12 MONTHS OF RECEIPT BY COLORADO MEDICAID FOR SUBSEQUENT REQUESTS.
PB21	PLEASE COMPLETE THE APPROPRIATE PRIOR AUTHORIZATION ATTACHMENT. CONTACT PROVIDER SERVICES OR THE PRIOR AUTHORIZATION UNIT FOR ASSISTANCE.
PB23	PHYSICAL THERAPY ASSISTANT NOTES AND ALL FORMS SUBMITTED MUST BE COSIGNED BY A REGISTERED PHYSICAL THERAPIST.
PB31	ARE YOU REQUESTING A COMPLETE APPLIANCE, OR REPLACEMENT PARTS?
PB32	THE PROCEDURE CODE INDICATED ON THE REQUEST DOES NOT MATCH THE DESCRIPTION OF SERVICE; PLEASE CORRECT AND RESUBMIT.
PB35	THE SERVICE REQUESTED DOES NOT REQUIRE PRIOR AUTHORIZATION.
PB41	PLEASE FURNISH A CURRENT MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT, F-11090 (DATED WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID).

Denial Code	Long Description
PB45	THE CERTIFICATION PERIOD ON THE PLAN OF CARE (POC) DOES NOT COVER THE REQUESTED GRANT/START DATE. PLEASE RESUBMIT YOUR REQUEST WITH A NEW POC.
PB49	A CERTIFIED OCCUPATIONAL THERAPY ASSISTANTS NOTES MUST BE COSIGNED BY AN OCCUPATIONAL THERAPIST REGISTERED.
PB51	ADDITIONAL INFORMATION IS REQUIRED ON PRIOR AUTHORIZATION TO ENABLE PRICING.
PB54	REQUESTED SERVICES DO NOT MATCH SERVICES ON THE PHYSICIANS ORDERS.
PB59	PLEASE PROVIDE AN INDIVIDUAL EDUCATIONAL PLAN (IEP), WHICH HAS BEEN SIGNED BY THE PROVIDER NO EARLIER THAN NINE MONTHS PRIOR TO RECEIPT AT COLORADO MEDICAID; OTHERWISE, DOCUMENT WHY NO IEP EXISTS.
PB65	PLEASE FURNISH THE ANTICIPATED TOTAL CHARGES FOR THIS REQUEST.
PB66	A PHOTOCOPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED; THE DATE MUST BE WITHIN SIX MONTHS OF RECEIPT BY COLORADO MEDICAID.
PB67	THE PRESCRIPTION DATE MUST INCLUDE MONTH, DAY, AND YEAR.
PB68	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID.
PB73	THE SERVICES IDENTIFIED ON THE PLAN OF CARE DO NOT APPEAR APPROPRIATE FOR THE PROCEDURE CODE(S) REQUESTED ON THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018.
PB74	THE CLIENT/PROVIDER DOES NOT HAVE RETROACTIVE ENROLLMENT.
PB75	THE REQUESTED START DATE IS MORE THAN 14 DAYS BEFORE OR 62 DAYS AFTER RECEIPT.
PB82	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
PB83	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A HOME HEALTH AIDE. PLEASE RESUBMIT AS A PERSONAL CARE WORKER OR PROVIDE ADDITIONAL DOCUMENTATION.
PB86	THE SERVICES REQUESTED ARE NOT BEING PROVIDED IN THE CLIENTS RESIDENCE. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL.
PB87	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A NURSE. PLEASE RESUBMIT AS A HOME HEALTH AIDE OR PROVIDE ADDITIONAL DOCUMENTATION.
PB92	PLEASE FURNISH THE CLIENTS COMPLETE ADDRESS.
PB94	IF THE CLIENT IS A RESIDENT OF A NURSING HOME, SUPPLY THE COMPLETE NAME AND ADDRESS OF THE NURSING HOME.
PB99	THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018, MUST BE SIGNED AND DATED.
PC01	PLEASE SUPPLY THE RENDERING PROVIDERS PROVIDER NUMBER.
PC03	THE DRUG ENFORCEMENT ADMINISTRATION NUMBER IS MISSING OR INVALID.
PC06	PLEASE DESCRIBE YOUR PROGRAM; INCLUDE ENTRY DATE, TERMINATION DATE, HOURS PER WEEK, AND NUMBER OF WEEKS OF PRIMARY INTENSIVE SERVICE REQUESTED.
PC07	PLEASE DESCRIBE YOUR "AFTERCARE/FOLLOW-UP" PLANS FOR THIS CLIENT.
PC08	PLEASE SUPPLY DOCUMENTATION OF PREVIOUS SUBSTANCE ABUSE SERVICES WITH DATE(S) AND OUTCOME.
PC09	PLEASE DESCRIBE IN DETAIL THE TREATMENT OBJECTIVES/GOALS FOR THIS CLIENT.
PC10	PLEASE DESCRIBE THE FAMILY SITUATION/DYNAMICS. EXPLAIN HOW THE FAMILY WILL BE INCORPORATED INTO THE CLIENTS PLAN OF CARE.
PC12	PLEASE EXPLAIN IF YOUR SERVICE ENCOURAGES THE CLIENT TO ATTEND SELF-HELP GROUPS.
PC13	PLEASE SUPPLY A SPECIFIC SCHEDULE OF ACTIVITIES, INCLUDING DAY, TIME OF DAY, LENGTH OF SESSION, AND SERVICE TO BE RENDERED DURING THAT TIME.
PC15	PLEASE FURNISH DIAGNOSTIC RATIONALE.
PC17	PLEASE DOCUMENT IF THE CLIENT EVER RECEIVED SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT.
PC19	PLEASE FURNISH MORE EXTENSIVE AND IN-DEPTH HISTORICAL AND PSYCHOSOCIAL DATA.
PC20	PLEASE SUPPLY THE DATE THE CLIENT BECAME TOTALLY ENDENTULOUS.
PC23	PLEASE SUBMIT A PHYSICIANS STATEMENT REGARDING THE MEDICAL NECESSITY OF DENTURES FOR THIS CLIENT. THE PHYSICIANS STATEMENT MUST DOCUMENT THE MEDICAL NEED FOR DENTURES.
PC24	THE SERVICE REQUESTED WAS PREVIOUSLY AUTHORIZED. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT INDICATING THIS FACT IS REQUIRED.
PC25	PLEASE SUPPLY SUFFICIENT MITIGATING CIRCUMSTANCES TO WARRANT THE CONSTRUCTION OF NEW DENTURES(S).

Denial Code	Long Description
PC26	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
PC28	PLEASE SUBMIT A PHYSICIANS STATEMENT INDICATING DENTURES ARE NECESSARY FOR THIS NURSING HOME CLIENT.
PC29	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING LOSS OR DESTRUCTION OF DENTURE(S). INCLUDE SIGNED STATEMENT FROM CLIENT OR FACILITY DIRECTOR REGARDING HOW, WHEN AND WHERE LOST.
PC30	PLEASE PROVIDE COMPLETE INTRAORAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PC31	PLEASE DESCRIBE ANY RELATED DEFORMITIES OF THE FEET.
PC34	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD WITH REQUESTED DME ITEM(S) AND DOCUMENT IF THE CLIENT CAN USE SAFELY AND INDEPENDENTLY.
PC35	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD AND DESCRIBE THE RESULTS AND EFFECTIVENESS OF THE SERVICE REQUESTED.
PC39	PLEASE INDICATE LITER FLOW PER MINUTE, HOURS OF USE PER 24 HOUR PERIOD, AND THE EXPECTED DURATION OF NEED.
PC40	THE ITEM DOES NOT REQUIRE PRIOR AUTHORIZATION UNTIL THE LIFE EXPECTANCY HAS BEEN REACHED.
PC41	PLEASE SUPPLY INFORMATION INDICATING THE NECESSITY OF POSITIONING THE CLIENT'S BODY IN MULTIPLE POSITIONS.
PC42	PLEASE INDICATE IF THE BED HEIGHT MUST BE CHANGED TO ALLOW FOR SAFE TRANSFER OR ADEQUATE BED CARE.
PC43	SUPPLY A PHYSICIANS STATEMENT INDICATING TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR UNIT HAS REDUCED PAIN, IMPROVED/INCREASED THE CLIENTS ACTIVITY LEVEL, AND/OR REDUCED CLIENTS USE OF PAIN MEDICATION.
PC44	A CURRENT AUTHORIZATION FOR THIS SERVICE IS ON FILE FOR ANOTHER PROVIDER. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT OF THAT FACT IS REQUIRED BY THE CLIENT OF FIRST PROVIDER.
PC59	DOCUMENT DECLINE OR PROGRESS IN SPECIFIC, MEASURABLE, OBJECTIVE TERMS.
PC60	DOCUMENT IF CLIENT HAS DEMONSTRATED A GOOD APPOINTMENT COMPLIANCE RECORD.
PC61	THE PHYSICIANS SIGNATURE DATE MUST NOT EXCEED 90 DAYS FROM THE DATE OF RECEIPT BY COLORADO MEDICAID.
PC62	REQUESTS FOR A CONTINUATION OF THERAPY SHOULD NOT BE SUBMITTED MORE THAN FOUR WEEKS PRIOR TO THE EXPIRATION DATE OF THE CURRENT AUTHORIZATION.
PC63	PLEASE FURNISH THE STYLE AND MANUFACTURER OF THE FRAME.
PC64	PLEASE FURNISH THE CLIENTS LENS FORMULA.
PC66	ALL REQUESTS FOR TINTS REQUIRE DOCUMENTATION OF THE VISUAL OR MEDICAL CONDITION RELATED TO PHOTOPHOBIA.
PC67	PLEASE DOCUMENT THE REASON AND JUSTIFICATION FOR REPLACEMENT BEYOND THE FIRST LENS/FRAME.
PC68	DOCUMENT IF ALL REMAINING MAXILLARY AND/OR MANDIBULAR TEETH ARE DECAY-FREE, PROPERLY RESTORED, AND PERIODONTICALLY SOUND.
PC72	SUPPLY MORE DETAIL REGARDING PROGRESS (ATTACHMENT OF GOALS, ETC.). CORRELATE PROGRESS TO PREVIOUS GOALS AND IDENTIFIED LIMITATIONS.
PC77	PLEASE SUBMIT A PLAN OF CARE DESCRIBING THE SERVICES THAT WOULD BE PROVIDED.
PC78	PLEASE DOCUMENT SPECIFIC, MEASURABLE GOALS.
PC82	THE PRIOR AUTHORIZATION (PA) SYSTEM CAN PROCESS ONLY 26 DETAILS PER PA REQUEST. PLEASE RESUBMIT YOUR REQUEST WITH NO MORE THAN 26 DETAILS.
PC83	PLEASE SUPPLY A PHYSICIANS PRESCRIPTION DATED WITHIN ONE MONTH OF REQUESTED SUBSTANCE ABUSE DAY TREATMENT.
PC84	PLEASE PROVIDE INFORMATION INDICATING THIS CLIENT IS APPROPRIATELY DETOXIFIED FROM ALCOHOL AND/OR OTHER DRUGS.
PC85	PLEASE PROVIDE INFORMATION TO INDICATE THE CLIENTS ABILITY TO ABSTAIN FROM ALCOHOL OR DRUGS WHILE IN THE SUBSTANCE ABUSE DAY TREATMENT PROGRAM.
PC86	PLEASE INDICATE IF THIS CLIENT IS WILLING TO PARTICIPATE IN AFTERCARE OR CONTINUING CARE SERVICES.

Denial Code	Long Description
PC87	PROVIDE MORE INFORMATION ON TREATMENT HISTORY; INCLUDE SERVICE PROVIDED, DATES, AND OUTCOME. PROVIDE DETAIL OF PREVIOUS TREATMENT.
PC88	PLEASE PROVIDE MORE RATIONALE FOR THE APPROPRIATENESS AND MEDICAL NECESSITY OF SUBSTANCE ABUSE DAY TREATMENT.
PC89	PROVIDE A TREATMENT PLAN THAT CONTAINS MEASURABLE GOALS AND OBJECTIVES CORRESPONDING TO THE IDENTIFIED DEFICIT.
PC91	PLEASE PROVIDE MORE INFORMATION ON FAMILY INVOLVEMENT TREATMENT.
PC92	PLEASE PROVIDE MORE HISTORY AND EXPLANATION ABOUT THE ISSUE OF ABSTINENCE FOR THIS CLIENT.
PC94	PLEASE PROVIDE THE ANTICIPATED BEGINNING DATE AND/OR THE ESTIMATED SUBSTANCE ABUSE DAY TREATMENT DISCHARGE DATE.
PC95	PLEASE SUPPLY JUSTIFICATION FOR BEGINNING CLIENT IN SERVICE PRIOR TO AUTHORIZATION BEING OBTAINED.
PC96	THE INITIAL THREE HOURS OF SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IN A CALENDAR YEAR DO NOT REQUIRE PRIOR AUTHORIZATION.
PC97	REIMBURSEMENT FOR INITIAL SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IS LIMITED TO THREE HOURS IN A CALENDAR YEAR AND DOES NOT REQUIRE PRIOR AUTHORIZATION.
PC98	THIS DRUG IS CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE BILL USING THE APPROPRIATE NATIONAL DRUG CODE (NDC) OR SUBMIT A COMPLETED DRUG ADDITION REQUEST FORM IF THE NDC IS NOT LISTED IN THE DRUG INDEX.
PC99	THIS DRUG IS NOT CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL, CURRENT ADMINISTRATIVE RULE, OR COLORADO DRUG INDEX FOR COVERAGE LIMITATIONS.
PD01	DOCUMENT THAT CLIENT HAS ACHIEVED GOOD ORAL HYGIENE, PERIODONTAL CASE TYPE 1 OR 2, AND IS MOTIVATED TO MAINTAIN SAME.
PD03	PLEASE PROVIDE AN ARTERIAL BLOOD GAS READING OR PULSE OXIMETRY RESULTS DONE ON ROOM AIR SIGNED AND DATED BY A MEDICAL DOCTOR. THIS SHOULD BE DONE WITHIN 60 DAYS OF REQUESTED SERVICE.
PD04	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 30 DAYS OF RECEIPT BY COLORADO MEDICAID.
PD07	SUBMIT A PHOTOCOPY OF A VALID PRESCRIPTION, ISSUED WITHIN THE PAST YEAR, OR COMPLETE SECTION B OF THE PRIOR AUTHORIZATION/DRUG ATTACHMENT (PA/DGA), F-11049.
PD10	BRAND MEDICALLY NECESSARY MUST BE IN THE PRESCRIBERS OWN HANDWRITING AND WRITTEN DIRECTLY ON THE PRESCRIPTION OR A SEPARATE ORDER ATTACHED TO THE ORIGINAL PRESCRIPTION.
PD12	COMPLETE DENTURES, PARTIAL DENTURES, DENTURE RELINES, AND FIXED PROSTHODONTIC SERVICES ARE NOT COVERED SERVICES FOR ADULTS FOR DATES OF SERVICE ON AND AFTER OCTOBER 1, 1995.
PD22	PLEASE COMPLETE ALL REQUIRED ELEMENTS ON THE PERSONAL CARE SCREENING TOOL (PCST), F-11133.
PD24	THIS PRIOR AUTHORIZATION REQUEST IS UNABLE TO BE PROCESSED. PLEASE RESUBMIT WITH ADDITIONAL REQUIRED FORMS, INCLUDING THE ENTIRE PERSONAL CARE SCREENING TOOL (PCST), F-11133; PERSONAL CARE ADDENDUM, F-11136; AND SUPPORTING DOCUMENTATION, AS DIRECTED.
PD25	THERE IS A PERSONAL CARE SCREENING TOOL (PCST), F-11133, COMPLETED BY ANOTHER AGENCY. CONTACT THE AGENCY TO TRANSFER SCREEN.
PD26	THERE IS A LIMITED TERM CARE FUNCTIONAL SCREEN (LTC-FS) COMPLETED BY ANOTHER AGENCY. THE PERSONAL CARE SCREENING TOOL (PCST), F-11133, INFORMATION IS IN CONFLICT WITH LTC-FS.
PD27	ONLY ONE LEVEL OF FUNCTION MAY BE SELECTED FOR ALL ELEMENTS EXCEPT TOILETING. COLORADO MEDICAID IS UNABLE TO PROCESS THE PRIOR AUTHORIZATION REQUEST.
PD28	NO UNITS MAY BE REQUESTED USING THIS PRIOR AUTHORIZATION PROCESS. PLEASE SUBMIT WITH THE APPROPRIATE ATTACHMENTS FOR REQUESTING SPECIFIC PERSONAL CARE WORKER UNITS.
PD29	CLIENT IS NOT ELIGIBLE FOR THE REQUESTED SERVICE(S) AS OF THE REQUESTED START DATE.
PD30	NO TRAVEL TIME MAY BE AUTHORIZED WHEN NO PERSONAL CARE WORKER SERVICE IS AUTHORIZED.
PD32	PROVIDER NOT CERTIFIED TO RENDER THE SERVICE(S) REQUESTED.
PD34	BASED ON THE DOCUMENTATION SUBMITTED, THIS REQUEST CAN NOT BE PRIOR AUTHORIZED. REFER TO THE PA MESSAGES FROM THE CONSULTANT FOR COMPLETE EXPLANATION.
PD98	PLEASE DOCUMENT HOW AND WHEN EACH PREVIOUSLY AUTHORIZED PRO RE NATA VISIT WAS USED.

Substance Abuse Day Treatment

Denial Code	Long Description
0201	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
0233	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0235	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0237	CLIENT IDENTIFICATION NUMBER DOES NOT MATCH CLIENTS FIRST NAME.
0238	THE CLIENT IDENTIFICATION NUMBER DOES NOT MATCH THE CLIENTS LAST NAME.
0242	SECONDARY DIAGNOSIS CODE IS INVALID.
0248	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0249	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0251	PROCEDURE CODE MODIFIER IN FIRST POSITION IS INVALID.
0252	THE PROCEDURE CODE MODIFIER IN SECOND POSITION IS INVALID FOR REQUESTED START DATE OR DATE OF RECEIPT.
0253	THE PROCEDURE CODE MODIFIER IN THIRD POSITION IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
0258	THE PRIMARY DIAGNOSIS CODE IS REQUIRED.
0272	THE PRIMARY DIAGNSOSIS CODE IS INVALID.
0400	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0853	HCPCS - ANNUAL UPDATE
0885	NEVER EVENTS MODIFIERS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
0886	NEVER EVENTS DIAGNOSIS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
1000	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
1002	RENDERING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1003	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1007	RENDERING PROVIDER ID IS NOT ON FILE.
1047	THE RENDERING PROVIDERS CERTIFICATION HAS BEEN CANCELLED.
1048	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1801	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
1804	A CERTIFIED SUBSTANCE ABUSE DAY TREATMENT PROVIDER MUST SUBMIT A SUBSTANCE ABUSE DAY TREATMENT PROCEDURE CODE.
1806	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
1808	THE BILLING PROVIDER DOES NOT HAVE THE REQUIRED CERTIFICATION ADDENDUM ON FILE.
1900	THE BILLING PROVIDERS TAXONOMY CODE IS INVALID.
1901	THE RENDERING PROVIDERS TAXONOMY CODE IS INVALID.
1927	A NATIONAL PROVIDER IDENTIFIER IS REQUIRED FOR THE BILLING PROVIDER.
1934	A NATIONAL PROVIDER INDENTIFIER IS REQUIRED FOR THE RENDERING PROVIDER.
1936	THE BILLING PROVIDER NUMBER IS INVALID.
1937	THE RENDERING PROVIDER NUMBER IS INVALID.
1960	INTERNAL PROCESSING IS REQUIRED.
1963	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.
1964	THE BILLING PROVIDER INDICATED IS NOT ALLOWABLE AS A BILLING PROVIDER.
1965	RENDERING PROVIDER NUMBER IS MISSING/INVALID FOR THIS PROCEDURE PROVIDER.
1974	PRESCRIBING/REFERRING/ORDERING PROVIDER INDICATED IS NOT CERTIFIED AS A PRESCRIBING/REFERRING/ORDERING PROVIDER.
1975	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
1976	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
2001	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.

Denial Code	Long Description
2003	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2017	THE CLIENT IS ENROLLED IN A MEDICAID OR OTHER MANAGED CARE PROGRAM.
2037	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2603	CLIENT LOCKED-IN TO A PROVIDER OR ENROLLED IN A HOSPICE. CONTACT CLIENTS HOSPICE FOR PAYMENT OF SERVICES OR RESUBMIT WITH DOCUMENTATION OF UNRELATED NATURE OF CARE.
3324	THE MODIFIER HAS BEEN DISCONTINUED BY THE CENTERS OF MEDICARE AND MEDICAID SERVICES OR THE AMERICAN MEDICAL ASSOCIATION FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
3337	THE PROCEDURE CODE HAS BEEN TERMINATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AMERICAN MEDICAL ASSOCIATION, OR AMERICAN DENTAL ASSOCIATION FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT. RESUBMIT WITH VALID A PROCEDURE CODE.
3339	THE PROCEDURE BILLED IS NOT PAYABLE ACCORDING TO DEFICIT REDUCTION ACT (DEFRA) GUIDELINES.
3351	THE PROCEDURE IS NOT COVERED FOR CLIENTS WITH A NURSING HOME AUTHORIZATION ON THE REQUESTED START DATE OR DATE OF RECEIPT.
3353	THE PROCEDURE IS NOT A COVERED SERVICE FOR HOME AND COMMUNITY-BASED WAIVER CLIENTS.
4021	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4027	THE DIAGNOSIS CODE IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
4031	THE PROCEDURE SUBMITTED IS NOT APPROPRIATE FOR CLIENTS GENDER.
4032	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4034	THE PROCEDURE CODE HAS AN AGE RESTRICTION.
4036	THE PLACE OF SERVICE CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4040	THE PRIMARY DIAGNOSIS CODE IS NOT ON FILE.
4041	THE SECONDARY DIAGNOSIS IS NOT ON FILE.
4046	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4127	INTERNAL PROCESSING IS REQUIRED.
4131	INTERNAL PROCESSING IS REQUIRED.
4141	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4149	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4150	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4236	ETIOLOGY DIAGNOSIS CODE(S) (E-CODES) ARE INVALID AS THE PRIMARY DIAGNOSIS.
4244	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4245	THE FOURTH POSITION MODIFIER IS INVALID FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT.
4256	THE PROCEDURE CODE AND MODIFIER COMBINATION IS NOT PAYABLE FOR THE CLIENTS BENEFIT PLAN.
4257	THE MODIFIERS SUBMITTED ARE EITHER INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT OR THE MODIFIERS ARE MISSING.
4311	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4315	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4316	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4371	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4372	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4714	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS AGE.
4731	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS DIAGNOSIS.
4742	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4743	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4744	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4745	DIAGNOSIS AND/OR PROCEDURE AND/OR PLACE OF SERVICE (POS) CODE IS NOT COVERED FOR EXPRESS ENROLLMENT CLIENTS.
4746	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4801	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4802	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
4821	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.

Denial Code	Long Description
4871	PLEASE REFER TO PA MESSAGES FOR RETURN INFORMATION.
4963	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS GENDER.
4990	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
7500	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
7509	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
P001	THE BILLING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THE SERVICES.
P002	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P003	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P005	THE PRIOR AUTHORIZATION CAN NOT BE END DATED. THE PRIOR AUTHORIZATION STATUS IS NOT APPROVED OR APPROVED WITH REVISIONS.
P006	PLEASE FURNISH THE PROCEDURE CODE AND CORRESPONDING DESCRIPTION.
P008	THE BILLING PROVIDER NUMBER IS INVALID.
P009	THE BILLING PROVIDER NUMBER IS INVALID.
P010	THE REQUESTED END DATE IS INVALID.
P011	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P012	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P013	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P014	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P015	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P016	THE REQUESTED START DATE IS MISSING OR INVALID.
P019	THE REQUESTED START DATE IS MISSING OR INVALID.
P020	THE RENDERING PROVIDER NUMBER IS INVALID.
P021	THE RENDERING PROVIDER NUMBER IS INVALID.
P022	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P023	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P024	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P026	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P027	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P030	FIRST MODIFIER IS INVALID.
P031	FIRST MODIFIER IS INVALID.
P032	SECOND MODIFIER IS INVALID.
P033	SECOND MODIFIER IS INVALID.
P034	THIRD MODIFIER IS INVALID.
P035	THIRD MODIFIER IS INVALID.
P036	FOURTH MODIFIER IS INVALID.
P037	FOURTH MODIFIER IS INVALID.
P038	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P039	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P040	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P041	CLIENTS FIRST NAME IS MISSING.
P042	CLIENTS LAST NAME IS MISSING.
P043	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P044	BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES REQUESTED.
P045	FIRST MODIFIER IS INVALID.
P046	SECOND MODIFIER IS INVALID.
P047	THIRD MODIFIER IS INVALID.

Denial Code	Long Description
P048	FOURTH MODIFIER IS INVALID.
P052	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P053	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P054	RENDERING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES FOR THE BENEFIT PLAN.
P055	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P061	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P062	THE CLIENT ID AND/OR NAME INDICATED ON THE PA REQUEST IS INCORRECT. THE CLIENT ID AND/OR NAME HAS BEEN UPDATED. PLEASE VERIFY THE ID AND/OR NAME IS CORRECT.
P064	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
P067	THE FREQUENCY OF HOURS REQUESTED ARE NOT APPROPRIATE FOR THIS CLIENT AND HAVE BEEN MODIFIED ACCORDINGLY.
P079	BILLING PROVIDER IS ON PAYMENT SUSPENSION DUE TO CREDIBLE ALLEGATION OF FRAUD.
P120	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAS BEEN REDUCED.
P121	THE SERVICE/ PROCEDURE REQUESTED IS NOT SUPPORTED BY SUBMITTED DOCUMENTATION.
P126	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
P128	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.
P138	SERVICE(S) DO NOT MEET COLORADO MEDICAID GUIDELINES.
P167	REQUESTED DOCUMENTATION HAS NOT BEEN SUBMITTED.
P178	THE SERVICE REQUESTED IS NOT MEDICALLY NECESSARY.
P179	THE MEDICAL NECESSITY FOR THIS SERVICE IS NOT SUPPORTED BY THE SUBMITTED DOCUMENTATION.
P233	THE DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE ADDITIONAL CARE.
P257	THIS CLIENTS FUNCTIONAL ASSESSMENT SCORES PLACE THIS CLIENT OUTSIDE ELIGIBILITY FOR DAY TREATMENT.
P274	OUR RECORDS INDICATE THIS CLIENT IS INVOLVED IN EFFECTIVE AND APPROPRIATE SERVICE ELSEWHERE.
P292	INTENSIVE REHABILITATION HOURS ARE NO LONGER APPROPRIATE AS INDICATED BY HISTORY, DIAGNOSIS, AND/ OR FUNCTIONAL ASSESSMENT SCORES.
P328	THE SERVICES REQUESTED INCLUDE NON-COVERED SERVICES, AND HOURS ARE REDUCED ACCORDINGLY.
P339	THE CLIENTS PAST HISTORY INDICATES REDUCED TREATMENT HOURS ARE WARRANTED.
P342	THE REQUEST DOES NOT MEET GENERALLY ACCEPTED CONDITIONS REQUIRING FLUORIDE TREATMENTS.
P346	SERVICES EXCEED COLORADO MEDICAID LIMITATION AND DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE MEDICAL NECESSITY OF THE SERVICE.
P349	THE SERVICE REQUESTED WAS PERFORMED LESS THAN FIVE YEARS AGO.
P353	THE EXISTING APPLIANCE HAS NOT BEEN WORN FOR THREE YEARS.
P367	THE CLIENT HAS BEEN TOTALLY WITHOUT TEETH AND AN APPLIANCE FOR FIVE YEARS.
P392	THE CLIENT IS MISSING AN ANTERIOR TOOTH AND/OR HAS TWO OR MORE POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P405	THE SERVICE(S) REQUESTED COULD ADEQUATELY BE PERFORMED IN THE DENTAL OFFICE.
P406	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE OF GOOD PERIODONTAL HEALTH (AMERICAN ACADEMY OF PERIODONTOLOGY PERIODONTAL CLASSIFICATION OF TYPE I OR II).
P407	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE VISIBLE ON RADIOGRAPHS THAT AT LEAST 50 PERCENT OF THE CLINICAL CROWN IS INTACT.
P409	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING SIX OR MORE TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED, INCLUDING THIRD MOLARS.
P410	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING ONE OR MORE ANTERIOR TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED.
P411	DOCUMENTATION DOES NOT SUPPORT THE NEED FOR PERIODONTIC SERVICES. POCKETS ARE LESS THAN 4MM AND/OR GREATER THAN 6MM FOR CLIENT AND/OR THE CLIENT IS UNDER THE AGE OF 13.
P412	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA.

Denial Code	Long Description
P413	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA. THIS PA HAS BEEN GRANTED AS APPROVED NOT APPROVED WITH REVISIONS. THE DURATION REQUESTED MAY HAVE BEEN REDUCED TO REFLECT COVERAGE LIMITATIONS, PRESCRIBER ORDERS, CONFLICTI
P417	THE SERVICE(S) REQUESTED COULD BE ADEQUATELY PERFORMED WITH LOCAL ANESTHESIA.
P437	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO POOR ORAL HYGIENE.
P444	THIS LINE ITEM IS A DUPLICATE OF ANOTHER LINE ITEM ON THIS PRIOR AUTHORIZATION (PA) REQUEST. PLEASE CORRECT.
P446	THIS IS A DUPLICATE OF AN EXISTING PRIOR AUTHORIZATION (PA) REQUEST. YOU MAY CONTACT PROVIDER SERVICES IF YOU REQUIRE ASSISTANCE. DUPLICATE PA REQUEST
P448	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO DECAY HISTORY.
P449	QUESTIONABLE LONG TERM PROGNOSIS DUE TO GUM AND BONE DISEASE.
P456	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO APPARENT ROOT INFECTION.
P457	OUR RECORDS INDICATE THIS CLIENT HAS EXCEEDED ESTABLISHED PROGRAM LIMITATIONS. COLORADO MEDICAID WILL NOT AUTHORIZE NEW DENTURES.
P458	DOCUMENTATION PROVIDED INDICATES A LESS ELABORATE PROCEDURE SHOULD BE CONSIDERED.
P502	RENTAL ONLY ALLOWED; MEDICAL NEED FOR PURCHASE HAS NOT BEEN DOCUMENTED.
P503	PURCHASE ONLY ALLOWED; MEDICAL NEED FOR RENTAL HAS NOT BEEN DOCUMENTED.
P504	OCCUPATIONAL THERAPY GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P505	THE SERVICE REQUESTED IS INCLUDED IN THE NURSING HOME RATE STRUCTURE.
P511	THIS NATIONAL DRUG CODE IS ONLY BILLABLE AS PART OF A COMPOUND DRUG.
P515	THE PRESENCE OF A HANDICAPPING MALOCCLUSION OR HANDICAPPING DENTOFACIAL DEFORMITY IS NOT SUPPORTED BY THE DOCUMENTATION SUBMITTED.
P521	THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVERED BY COLORADO MEDICAID.
P522	GASTRO-INTESTINAL SURGERY FOR THE PURPOSE OF WEIGHT CONTROL IS COVERED ONLY AS A LIFE THREATENING PROCEDURE.
P523	THE TREATMENT REQUEST IS NOT CONSISTENT WITH THE CLIENT'S DIAGNOSIS.
P524	PSYCHOTHERAPY PROVIDED IN THE CLIENTS HOME IS NOT A COVERED BENEFIT OF COLORADO MEDICAID.
P525	THE INFORMATION PROVIDED IS NOT CONSISTENT WITH THE INTENSITY OF SERVICES REQUESTED.
P526	INTENSIVE MULTIPLE MODALITY TREATMENT IS NOT CONSISTENT WITH THE INFORMATION PROVIDED.
P527	MULTIPLE PROVIDERS OF TREATMENT ARE NOT INDICATED FOR THIS CLIENT.
P528	THE DURATION OF TREATMENT SESSIONS EXCEED CURRENT COLORADO MEDICAID GUIDELINES.
P534	DOCUMENTATION OF POOR PHYSICAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P535	OTHER PHYSICAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P536	THE PHYSICAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P537	USE OF PHYSICAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P538	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF A PHYSICAL THERAPIST.
P539	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS AND LIVING ARRANGEMENT.
P540	GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P541	THE PROCEDURE(S) REQUESTED ARE NOT MEDICAL IN NATURE.
P542	DOCUMENTATION OF POOR OCCUPATIONAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P543	DOCUMENTATION OF POOR SPEECH THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P544	OTHER OCCUPATIONAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P546	THE OCCUPATIONAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.

Denial Code	Long Description
P547	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF PHYSICAL THERAPY.
P548	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P549	ACTIVITIES TO PROMOTE DIVERSION OR GENERAL MOTIVATION ARE NONCOVERED COLORADO MEDICAID SERVICES.
P550	REVISIONS OF THE REQUEST IS NECESSITATED BY THE CLIENTS MINIMAL PROGRESS.
P551	RESTORATIVE NURSING INVOLVEMENT COULD BE INCREASED.
P552	CLIENTS DEMONSTRATED RESPONSE TO CURRENT THERAPY DOES NOT WARRANT THE INTENSE FREQUENCY REQUESTED.
P553	MAINTENANCE IS TWO TIMES PER WEEK OR LESS.
P554	THE SPEECH THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P555	USE OF OCCUPATIONAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P556	USE OF SPEECH THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P557	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF AN OCCUPATIONAL THERAPIST.
P558	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
P559	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P560	THE MATERIALS/ SERVICES REQUESTED ARE PRINCIPALLY COSMETIC IN NATURE.
P561	THE LENS FORMULA DOES NOT JUSTIFY REPLACEMENT.
P562	THE CHANGE IN THE LENS FORMULA DOES NOT WARRANT MULTIPLE REPLACEMENTS.
P563	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P564	LENSES ONLY ARE APPROVED; PLEASE DISPENSE A CONTRACTED FRAME. THE NON-CONTRACTED FRAME IS NOT MEDICALLY JUSTIFIED.
P565	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P566	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P567	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF OCCUPATIONAL THERAPY.
P568	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF SPEECH THERAPY.
P569	LEVEL, INTENSITY, OR EXTENT OF SERVICE(S) REQUESTED HAS BEEN MODIFIED CONSISTENT WITH MEDICAL NEED AS DEFINED IN THE PLAN OF CARE.
P570	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P571	THE SERVICE ASKED FOR IS NOT COVERED BY COLORADO MEDICAID AS THESE TASKS CAN BE DONE BY NURSES OR ACTIVITY STAFF.
P572	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P573	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.
P574	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P575	MEDICAL NEED FOR EQUIPMENT/ SUPPLY REQUESTED IS NOT SUPPORTED BY DOCUMENTATION SUBMITTED.
P576	OTHER SPEECH THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P577	DOCUMENTATION SUBMITTED IDENTIFIES THAT THE CLIENT HAS FEWER THAN TWO POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P582	LESS EXPENSIVE ALTERNATIVE SERVICES ARE AVAILABLE FOR THIS CLIENT.
P634	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P711	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING PERIODONTAL SCALING AND ROOT PLANNING.
P712	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING GINGIVECTOMY.
P754	AN APPROVED SUBSTANCE ABUSE DAY TREATMENT PROGRAM CANNOT EXCEED A SIX WEEK PERIOD.

Denial Code	Long Description
P761	THE CLIENT DOES NOT APPEAR TO BE ABLE OR WILLING TO ABSTAIN FROM ALCOHOL/DRUG USAGE WHILE IN TREATMENT. THEREFORE, SUBSTANCE ABUSE DAY TREATMENT SERVICES ARE NOT APPROVED.
P764	THIS CLIENT HAS COMPLETED INTENSIVE SUBSTANCE ABUSE TREATMENT WITHIN THE PAST 12 MONTHS. THE DOCUMENTATION PROVIDED IS NOT ADEQUATE TO JUSTIFY ADDITIONAL INTENSIVE TREATMENT AT THIS TIME.
P785	A LESS THAN SIX-WEEK HEALING PERIOD HAS BEEN SPECIFIED FOR THIS PRIOR AUTHORIZATION. THEREFORE IT IS NOT NECESSARY TO WAIT THE FULL SIX WEEKS AFTER EXTRACTIONS BEFORE TAKING DENTURE IMPRESSIONS.
P818	SIX-WEEK HEALING TIME IS REQUIRED BETWEEN EDENTULATION AND FINAL IMPRESSIONS. PAYMENT FOR DENTURES WILL BE DENIED OR RECOUPED IF HEALING PERIOD IS NOT OBSERVED.
P849	COLORADO MEDICAID HAS DETERMINED THERE WERE (ARE) SEVERAL HOME HEALTH AGENCIES WILLING TO PROVIDE MEDICALLY NECESSARY SKILLED NURSING SERVICES TO THIS CLIENT.
P864	THE DOCUMENTATION YOU HAVE SUBMITTED DOES NOT MEET THE REQUIREMENTS OF COLORADO MEDICAID.
P873	THE MEDICAL NECESSITY FOR THE HOURS REQUESTED IS NOT SUPPORTED BY THE INFORMATION SUBMITTED.
P874	THE DOCUMENTATION SUBMITTED INDICATES THE TASKS SPECIFIED CAN BE COMPLETED DURING THE VISITS APPROVED.
P878	THE DOCUMENTATION SUBMITTED DOES NOT INDICATE THAT MEDICALLY ORIENTED TASKS ARE MEDICALLY NECESSARY; THEREFORE PERSONAL CARE SERVICES HAVE BEEN APPROVED.
P880	THE QUANTITY OF SERVICES AUTHORIZED FOR THIS CLIENTS PERSONAL CARE HAS BEEN AMENDED BASED ON INFORMATION RECEIVED FROM ONE OR MORE OF THESE SOURCES: THE CLIENT, THEIR PHYSICIAN, AND/OR THE IN-HOME VISIT BY STAFF OF THE OIG (OFFICE OF INSPECTOR GENERAL).
P885	THE USE OF THIS DRUG FOR THE INTENDED PURPOSE IS NOT COVERED BY COLORADO MEDICAID, CONSISTENT WITH COLORADO ADMINISTRATIVE CODE AND FEDERAL LAW.
P924	THE MEDICAL RECORDS SUBMITTED WITH THE CURRENT REQUEST CONFLICT OR DISAGREE WITH OUR MEDICAL RECORDS ON THIS CLIENT.
P950	INDEPENDENT NURSES, PLEASE NOTE PAYABLE SERVICES MAY NOT EXCEED 12 HOURS/DAY OR 60 HOURS/WEEK.
P951	SERVICES CAN ONLY BE AUTHORIZED THROUGH ONE YEAR FROM THE PRESCRIPTION DATE.
P952	LEAD INSPECTION IS A COVERED COLORADO MEDICAID SERVICE WHEN THE CHILD HAS BEEN SHOWN TO HAVE LEAD POISONING (E.G., CHILD HAS A BLOOD LEAD LEVEL > 19 UG/DL OR TWO CONSECUTIVE BLOOD LEAD LEVELS OF 15-19 UG/DL DONE AT LEAST 90 DAYS APART). THE INSPECTION MUS
P953	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P954	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P956	THE REQUEST CAN ONLY BE BACKDATED A MAXIMUM OF 14 DAYS FROM FIRST DATE RECEIVED BY COLORADO MEDICAID.
P957	COMPLETE PERIODONTAL CHARTING AT TIME OF SERVICE, AND SUBMIT CHARTING, COPY OF OPERATIVE REPORT, TOGETHER WITH A COPY OF THE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF), F-11035, TO PA UNIT ATTENTION DENTAL CONTSULTANT.
P958	NOTE THAT CODE D4341 HAS BEEN CHANGED. REFER TO THE DECISION NOTICE FOR AUTHORIZED QUANTITY.
P960	YOUR PA HAS BEEN APPROVED FOR 90 DAYS. THE 90 DAY APPROVAL DOES NOT IMPLY THE PA REQUEST MEETS PRIOR AUTHORIZATION CRITERIA. AFTER ADDITIONAL INFORMATION IS AVAILABLE IN INTERCHANGE, COLORADO MEDICAID WILL CREATE AN AMENDMENT REQUEST TO EXTEND THE PA FOR
P961	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P962	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
PA10	THE REQUESTED END DATE IS INVALID.
PA12	PLEASE FURNISH A WRITTEN DESCRIPTION OF THE CLIENTS DIAGNOSIS.

Denial Code	Long Description
PA13	PROVIDE DIAGNOSES WITH DATES OF ONSET.
PA14	IDENTIFY PROBLEMS TO BE TREATED.
PA15	THE AUDIOLOGISTS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1), F-11020, AND PRIOR AUTHORIZATION REQUEST/HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2), F-11021.
PA16	THE PHYSICIANS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION/PHYSICIAN OTOLOGICAL REPORT (PA/POR), F-11019.
PA17	SUBMIT BRIEF HISTORY WITH REFERRAL INFORMATION, LIVING SITUATION, FUNCTIONAL STATUS, AND OTHER PERTINENT INFORMATION. WHAT CHANGE OF STATUS RESULTED IN REFERRAL AT THIS TIME?
PA18	PLEASE FURNISH THE CLIENTS HEIGHT AND WEIGHT.
PA19	PLEASE SUBMIT CLINICAL INFORMATION SUFFICIENT TO VERIFY THE NEED FOR THE REQUESTED SERVICE(S).
PA20	PLEASE RESUBMIT WITH COMPLETE PERIODONTAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PA21	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL EDUCATIONAL PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA22	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL PROGRAM PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA23	REFER TO THE DURABLE MEDICAL EQUIPMENT INDEX FOR APPROPRIATE CODE AND DESCRIPTION. DO NOT USE AN "UNLISTED" CODE.
PA24	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUALIZED FAMILY SERVICE PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA25	INFORMATION ON THE REQUEST FORM IS ILLEGIBLE, AND THE REQUEST CANNOT BE PROCESSED.
PA26	RE-EVALUATE YOUR GOALS. EMPHASIS SHOULD BE ON FUNCTIONAL SELF-CARE. GOALS MUST BE RELATED TO FUNCTIONAL OUTCOME.
PA27	PLEASE CLARIFY THE NUMBER OF HOURS PER WEEK REQUESTED.
PA28	PLEASE CLARIFY THE NUMBER OF HOURS PER DAY REQUESTED.
PA29	PLEASE CLARIFY THE NUMBER OF VISITS PER DAY REQUESTED.
PA30	ATTACH SUPPORTIVE DOCUMENTATION; HOME EXERCISE PROGRAM AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA31	THE DIAGNOSIS CODE INDICATED ON THE REQUEST DOES NOT CORRESPOND TO THE DIAGNOSIS CODE DESCRIPTION.
PA32	PLEASE SUBMIT ADDITIONAL INFORMATION SUFFICIENT TO VERIFY APPROPRIATENESS AND NEED FOR TRANSPLANT.
PA33	PLEASE SUBMIT THE INITIAL AND PROGRESSIVE OBJECTIVE FINDINGS.
PA34	ATTACH SUPPORTIVE DOCUMENTATION, FACILITY PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA35	PLEASE SUBMIT THE CLIENTS ORIGINAL COMPLAINTS AND EXAMINATION FINDINGS.
PA36	ATTACH SUPPORTIVE DOCUMENTATION, IN-HOME AUTISM PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA37	PLEASE SUBMIT YOUR TREATMENT PLAN FOR THIS CLIENT.
PA38	ATTACH SUPPORTIVE DOCUMENTATION AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA39	INITIAL EVALUATIONS MUST BE PERFORMED BY AN OCCUPATIONAL THERAPIST REGISTERED (OTR), PER AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA) STANDARDS.
PA41	IDENTIFY THE PLACE OF SERVICE AND ITS EFFECT ON SUPPORTING THE DESIRED TREATMENT OUTCOME.
PA42	PLEASE INDICATE THE HOURS OF USE OF OXYGEN PER 24-HOUR PERIOD.
PA43	PROVIDE BASELINE DOCUMENTATION FOR THIS CLIENTS LIMITATIONS USING UNITS OF MEASUREMENT THAT ARE APPLIED CONSISTENTLY WHEN REPORTING STATUS.
PA44	IDENTIFY FUNCTIONAL LIMITATIONS AS THEY ARE RELATED TO IDENTIFIED CONDITIONS.
PA46	CORRELATE PLAN OF CARE TO REQUESTED PROCEDURE CODES.
PA47	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE FREQUENCY/DURATION REQUESTED.

Denial Code	Long Description
PA48	PLEASE PROVIDE THE NAME AND CREDENTIALS OF THE RENDERING PROVIDER.
PA50	COLORADO MEDICAID RECORDS INDICATE THE CLIENT OWNS A WHEELCHAIR. DOCUMENT THE REASON AND NEED FOR REPLACEMENT AND COST TO REPAIR CURRENT WHEELCHAIR.
PA51	PLEASE DISTINGUISH PRIMARY AND SUPPORTIVE MODALITIES.
PA52	PLEASE SUBMIT A PROGRESS REPORT.
PA53	MULTIPLE FAMILY CLIENTS TREATMENT BY THE SAME PROVIDER REQUIRES FURTHER INFORMATION DOCUMENTING COORDINATION OF TREATMENT PLAN.
PA54	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE MINUTES REQUESTED.
PA55	MEDICAL NECESSITY OF TREATMENT REQUIRES ADDITIONAL DOCUMENTATION.
PA56	GIVEN AGE, DIAGNOSES, CURRENT LEVEL OF FUNCTION, PAST RESPONSE TO TREATMENT, AND LIVING SITUATION, EXPAND ON POTENTIAL FOR SIGNIFICANT FUNCTIONAL PROGRESS WITHIN THE NEXT SIX MONTHS. EMPHASIZE WHY PROGRESS IS EXPECTED WITH SERVICES AT THIS TIME.
PA57	SUBMIT THE INITIAL FINDINGS. INCLUDE A COMPREHENSIVE EVALUATION.
PA58	SUBMIT PROGRESSIVE, OBJECTIVE FINDINGS. INCLUDE A PERTINENT RE-EVALUATION.
PA59	PLEASE SUPPLY INFORMATION REGARDING THE CLIENTS MEDICATION REQUIREMENTS, IF ANY.
PA60	PLEASE SPECIFY IF THE CLIENT IS IN AN EDUCATIONAL SETTING.
PA61	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA62	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
PA63	THE SKILLS OF A THERAPIST ARE PURPOSEFUL AND SKILLED INTERVENTIONS REQUIRED TO CONTINUALLY DESIGN, IMPLEMENT, REASSESS, MODIFY/GRADE, AND/OR DISCONTINUE A PLAN OF CARE IN A TIMELY MANNER, BASED ON THE COMPLEXITY OF THE CLIENTS MEDICAL CONDITION AND/OR CO
PA64	PLEASE SUBMIT A THERAPY PLAN OF CARE, INCLUDING A CURRENT, DATED EVALUATION.
PA65	A PLAN OF CARE SIGNED AND DATED BY THE PHYSICIAN IS REQUIRED.
PA66	THE SKILLS OF A THERAPIST ARE REQUIRED WHEN ONLY THE THERAPIST CAN SAFELY AND EFFECTIVELY DELIVER THE THERAPEUTIC PROCEDURES BECAUSE OF THEIR UNIQUE KNOWLEDGE, TRAINING, AND EXPERTISE. DESCRIBE THE REASON THAT SOMEONE OTHER THAN A THERAPIST CANNOT SAFELY
PA67	PLEASE SPECIFY IF THE CLIENTS WORK SITE DEMANDS GOOD BINAURAL HEARING.
PA68	DESCRIBE THE REASON, BASED ON THE CLIENTS COGNITIVE, PHYSICAL, COMMUNICATION, OR RESOURCE STATUS, THAT A HOME PROGRAM, EQUIPMENT, OR ENVIRONMENTAL ADAPTATIONS ALONE CANNOT MEET CLIENTS NEEDS.
PA69	PLEASE SPECIFY IF THE CLIENT HAS AN ACCOMPANYING DISABILITY THAT ADDS TO THE HEARING PROBLEM.
PA70	DISTINGUISH REQUESTED PROCEDURES AND GOALS FROM OTHER SERVICES THIS CLIENT RECEIVES. THEY MAY NOT BE DUPLICATIVE.
PA71	PLEASE INDICATE THE NUMBER OF DAYS REQUESTED.
PA73	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA74	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA75	PLEASE DOCUMENT CARRYOVER OF THE THERAPY PROGRAM TO NURSING.
PA76	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA79	PROVIDE EVIDENCE OF SIGNIFICANT FUNCTIONAL PROGRESS IN LAST SIX MONTHS.
PA84	THE GRANT DATE OF THIS REQUEST CANNOT BE PRIOR TO THE SIGNATURE DATE OF THE PRESCRIBING PHYSICIAN.
PA86	PROVIDE EVIDENCE OF SKILLS GAINED IN THERAPY CARRYING OVER TO OTHER SETTINGS WITHIN SIX MONTHS.
PA87	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE NUMBER OF SESSIONS REQUESTED.
PA88	THE REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL SCOPE OF PRACTICE.
PA89	PRIOR AUTHORIZATION IS NOT REQUIRED UNTIL LIMITATION OF SERVICE HAS BEEN REACHED.
PA91	PLEASE SUBMIT REQUIRED X-RAYS.

Denial Code	Long Description
PA92	PLEASE PROVIDE AN EXPLANATION FOR THE MATERIAL SUBMITTED WITH THE REQUEST.
PA95	PLEASE DESCRIBE HOW THE PROVISION OF THIS SERVICE WOULD PREVENT INSTITUTIONALIZATION OF THE CLIENT.
PA96	COULD THE EXISTING DENTURE(S) BE RELINED OR REBASED? IF NOT, PLEASE EXPLAIN WHY NOT.
PA97	REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL STANDARDS OF PRACTICE.
PA98	PLEASE INDICATE IF THE CLIENT IS CURRENTLY BEING TUBE FED.
PB02	PLEASE PROVIDE THE REQUIRED DATED SIGNATURES ON THE ATTACHMENTS.
PB03	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING THE LOSS/DESTRUCTION/THEFT OF THE HEARING AID.
PB04	DESCRIBE THE CLIENTS ABILITY TO STAND OR AMBULATE SUFFICIENTLY TO ACCOMPLISH SELF-CARE ACTIVITIES.
PB07	PLEASE SUBMIT AN ORTHODONTIC STUDY MODEL OR DIAGNOSTIC CASTS.
PB09	PLEASE PROVIDE A PHOTOGRAPH OF THE INVOLVED AREA(S).
PB10	PLEASE PROVIDE AN ESTIMATION (IN GRAMS) OF THE TOTAL AMOUNT OF TISSUE TO BE RESECTED.
PB11	PLEASE SUBMIT THE PLAN OF CARE FOR CO-TREATMENT.
PB12	FURNISH A DETAILED DESCRIPTION FOR THE PROCEDURE CODE REQUESTED.
PB13	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB15	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB18	PLEASE COMPLETE THE ATTACHED OUT-OF-STATE PROVIDER DATA SHEET, F-11001, AND RESUBMIT.
PB20	A SIGNED AND DATED PRESCRIPTION IS REQUIRED WITHIN THREE MONTHS OF RECEIPT BY COLORADO MEDICAID FOR INITIAL REQUESTS AND WITHIN 12 MONTHS OF RECEIPT BY COLORADO MEDICAID FOR SUBSEQUENT REQUESTS.
PB21	PLEASE COMPLETE THE APPROPRIATE PRIOR AUTHORIZATION ATTACHMENT. CONTACT PROVIDER SERVICES OR THE PRIOR AUTHORIZATION UNIT FOR ASSISTANCE.
PB23	PHYSICAL THERAPY ASSISTANT NOTES AND ALL FORMS SUBMITTED MUST BE COSIGNED BY A REGISTERED PHYSICAL THERAPIST.
PB31	ARE YOU REQUESTING A COMPLETE APPLIANCE, OR REPLACEMENT PARTS?
PB32	THE PROCEDURE CODE INDICATED ON THE REQUEST DOES NOT MATCH THE DESCRIPTION OF SERVICE; PLEASE CORRECT AND RESUBMIT.
PB35	THE SERVICE REQUESTED DOES NOT REQUIRE PRIOR AUTHORIZATION.
PB41	PLEASE FURNISH A CURRENT MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT, F-11090 (DATED WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID).
PB45	THE CERTIFICATION PERIOD ON THE PLAN OF CARE (POC) DOES NOT COVER THE REQUESTED GRANT/START DATE. PLEASE RESUBMIT YOUR REQUEST WITH A NEW POC.
PB49	A CERTIFIED OCCUPATIONAL THERAPY ASSISTANTS NOTES MUST BE COSIGNED BY AN OCCUPATIONAL THERAPIST REGISTERED.
PB51	ADDITIONAL INFORMATION IS REQUIRED ON PRIOR AUTHORIZATION TO ENABLE PRICING.
PB54	REQUESTED SERVICES DO NOT MATCH SERVICES ON THE PHYSICIANS ORDERS.
PB59	PLEASE PROVIDE AN INDIVIDUAL EDUCATIONAL PLAN (IEP), WHICH HAS BEEN SIGNED BY THE PROVIDER NO EARLIER THAN NINE MONTHS PRIOR TO RECEIPT AT COLORADO MEDICAID; OTHERWISE, DOCUMENT WHY NO IEP EXISTS.
PB65	PLEASE FURNISH THE ANTICIPATED TOTAL CHARGES FOR THIS REQUEST.
PB66	A PHOTOCOPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED; THE DATE MUST BE WITHIN SIX MONTHS OF RECEIPT BY COLORADO MEDICAID.
PB67	THE PRESCRIPTION DATE MUST INCLUDE MONTH, DAY, AND YEAR.
PB68	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID.
PB73	THE SERVICES IDENTIFIED ON THE PLAN OF CARE DO NOT APPEAR APPROPRIATE FOR THE PROCEDURE CODE(S) REQUESTED ON THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018.
PB74	THE CLIENT/PROVIDER DOES NOT HAVE RETROACTIVE ENROLLMENT.
PB75	THE REQUESTED START DATE IS MORE THAN 14 DAYS BEFORE OR 62 DAYS AFTER RECEIPT.
PB82	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
PB83	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A HOME HEALTH AIDE. PLEASE RESUBMIT AS A PERSONAL CARE WORKER OR PROVIDE ADDITIONAL DOCUMENTATION.

Denial Code	Long Description
PB86	THE SERVICES REQUESTED ARE NOT BEING PROVIDED IN THE CLIENTS RESIDENCE. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL.
PB87	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A NURSE. PLEASE RESUBMIT AS A HOME HEALTH AIDE OR PROVIDE ADDITIONAL DOCUMENTATION.
PB92	PLEASE FURNISH THE CLIENTS COMPLETE ADDRESS.
PB94	IF THE CLIENT IS A RESIDENT OF A NURSING HOME, SUPPLY THE COMPLETE NAME AND ADDRESS OF THE NURSING HOME.
PB99	THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018, MUST BE SIGNED AND DATED.
PC01	PLEASE SUPPLY THE RENDERING PROVIDERS PROVIDER NUMBER.
PC03	THE DRUG ENFORCEMENT ADMINISTRATION NUMBER IS MISSING OR INVALID.
PC06	PLEASE DESCRIBE YOUR PROGRAM; INCLUDE ENTRY DATE, TERMINATION DATE, HOURS PER WEEK, AND NUMBER OF WEEKS OF PRIMARY INTENSIVE SERVICE REQUESTED.
PC07	PLEASE DESCRIBE YOUR "AFTERCARE/FOLLOW-UP" PLANS FOR THIS CLIENT.
PC08	PLEASE SUPPLY DOCUMENTATION OF PREVIOUS SUBSTANCE ABUSE SERVICES WITH DATE(S) AND OUTCOME.
PC09	PLEASE DESCRIBE IN DETAIL THE TREATMENT OBJECTIVES/GOALS FOR THIS CLIENT.
PC10	PLEASE DESCRIBE THE FAMILY SITUATION/DYNAMICS. EXPLAIN HOW THE FAMILY WILL BE INCORPORATED INTO THE CLIENTS PLAN OF CARE.
PC12	PLEASE EXPLAIN IF YOUR SERVICE ENCOURAGES THE CLIENT TO ATTEND SELF-HELP GROUPS.
PC13	PLEASE SUPPLY A SPECIFIC SCHEDULE OF ACTIVITIES, INCLUDING DAY, TIME OF DAY, LENGTH OF SESSION, AND SERVICE TO BE RENDERED DURING THAT TIME.
PC15	PLEASE FURNISH DIAGNOSTIC RATIONALE.
PC17	PLEASE DOCUMENT IF THE CLIENT EVER RECEIVED SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT.
PC19	PLEASE FURNISH MORE EXTENSIVE AND IN-DEPTH HISTORICAL AND PSYCHOSOCIAL DATA.
PC20	PLEASE SUPPLY THE DATE THE CLIENT BECAME TOTALLY ENDENTULOUS.
PC23	PLEASE SUBMIT A PHYSICIANS STATEMENT REGARDING THE MEDICAL NECESSITY OF DENTURES FOR THIS CLIENT. THE PHYSICIANS STATEMENT MUST DOCUMENT THE MEDICAL NEED FOR DENTURES.
PC24	THE SERVICE REQUESTED WAS PREVIOUSLY AUTHORIZED. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT INDICATING THIS FACT IS REQUIRED.
PC25	PLEASE SUPPLY SUFFICIENT MITIGATING CIRCUMSTANCES TO WARRANT THE CONSTRUCTION OF NEW DENTURES(S).
PC26	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
PC28	PLEASE SUBMIT A PHYSICIANS STATEMENT INDICATING DENTURES ARE NECESSARY FOR THIS NURSING HOME CLIENT.
PC29	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING LOSS OR DESTRUCTION OF DENTURE(S). INCLUDE SIGNED STATEMENT FROM CLIENT OR FACILITY DIRECTOR REGARDING HOW, WHEN AND WHERE LOST.
PC30	PLEASE PROVIDE COMPLETE INTRAORAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PC31	PLEASE DESCRIBE ANY RELATED DEFORMITIES OF THE FEET.
PC34	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD WITH REQUESTED DME ITEM(S) AND DOCUMENT IF THE CLIENT CAN USE SAFELY AND INDEPENDENTLY.
PC35	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD AND DESCRIBE THE RESULTS AND EFFECTIVENESS OF THE SERVICE REQUESTED.
PC39	PLEASE INDICATE LITER FLOW PER MINUTE, HOURS OF USE PER 24 HOUR PERIOD, AND THE EXPECTED DURATION OF NEED.
PC40	THE ITEM DOES NOT REQUIRE PRIOR AUTHORIZATION UNTIL THE LIFE EXPECTANCY HAS BEEN REACHED.
PC41	PLEASE SUPPLY INFORMATION INDICATING THE NECESSITY OF POSITIONING THE CLIENT'S BODY IN MULTIPLE POSITIONS.
PC42	PLEASE INDICATE IF THE BED HEIGHT MUST BE CHANGED TO ALLOW FOR SAFE TRANSFER OR ADEQUATE BED CARE.
PC43	SUPPLY A PHYSICIANS STATEMENT INDICATING TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR UNIT HAS REDUCED PAIN, IMPROVED/INCREASED THE CLIENTS ACTIVITY LEVEL, AND/OR REDUCED CLIENTS USE OF PAIN MEDICATION.

Denial Code	Long Description
PC44	A CURRENT AUTHORIZATION FOR THIS SERVICE IS ON FILE FOR ANOTHER PROVIDER. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT OF THAT FACT IS REQUIRED BY THE CLIENT OF FIRST PROVIDER.
PC59	DOCUMENT DECLINE OR PROGRESS IN SPECIFIC, MEASURABLE, OBJECTIVE TERMS.
PC60	DOCUMENT IF CLIENT HAS DEMONSTRATED A GOOD APPOINTMENT COMPLIANCE RECORD.
PC61	THE PHYSICIANS SIGNATURE DATE MUST NOT EXCEED 90 DAYS FROM THE DATE OF RECEIPT BY COLORADO MEDICAID.
PC62	REQUESTS FOR A CONTINUATION OF THERAPY SHOULD NOT BE SUBMITTED MORE THAN FOUR WEEKS PRIOR TO THE EXPIRATION DATE OF THE CURRENT AUTHORIZATION.
PC63	PLEASE FURNISH THE STYLE AND MANUFACTURER OF THE FRAME.
PC64	PLEASE FURNISH THE CLIENTS LENS FORMULA.
PC66	ALL REQUESTS FOR TINTS REQUIRE DOCUMENTATION OF THE VISUAL OR MEDICAL CONDITION RELATED TO PHOTOPHOBIA.
PC67	PLEASE DOCUMENT THE REASON AND JUSTIFICATION FOR REPLACEMENT BEYOND THE FIRST LENS/FRAME.
PC68	DOCUMENT IF ALL REMAINING MAXILLARY AND/OR MANDIBULAR TEETH ARE DECAY-FREE, PROPERLY RESTORED, AND PERIODONTICALLY SOUND.
PC72	SUPPLY MORE DETAIL REGARDING PROGRESS (ATTACHMENT OF GOALS, ETC.). CORRELATE PROGRESS TO PREVIOUS GOALS AND IDENTIFIED LIMITATIONS.
PC77	PLEASE SUBMIT A PLAN OF CARE DESCRIBING THE SERVICES THAT WOULD BE PROVIDED.
PC78	PLEASE DOCUMENT SPECIFIC, MEASURABLE GOALS.
PC82	THE PRIOR AUTHORIZATION (PA) SYSTEM CAN PROCESS ONLY 26 DETAILS PER PA REQUEST. PLEASE RESUBMIT YOUR REQUEST WITH NO MORE THAN 26 DETAILS.
PC83	PLEASE SUPPLY A PHYSICIANS PRESCRIPTION DATED WITHIN ONE MONTH OF REQUESTED SUBSTANCE ABUSE DAY TREATMENT.
PC84	PLEASE PROVIDE INFORMATION INDICATING THIS CLIENT IS APPROPRIATELY DETOXIFIED FROM ALCOHOL AND/OR OTHER DRUGS.
PC85	PLEASE PROVIDE INFORMATION TO INDICATE THE CLIENTS ABILITY TO ABSTAIN FROM ALCOHOL OR DRUGS WHILE IN THE SUBSTANCE ABUSE DAY TREATMENT PROGRAM.
PC86	PLEASE INDICATE IF THIS CLIENT IS WILLING TO PARTICIPATE IN AFTERCARE OR CONTINUING CARE SERVICES.
PC87	PROVIDE MORE INFORMATION ON TREATMENT HISTORY; INCLUDE SERVICE PROVIDED, DATES, AND OUTCOME. PROVIDE DETAIL OF PREVIOUS TREATMENT.
PC88	PLEASE PROVIDE MORE RATIONALE FOR THE APPROPRIATENESS AND MEDICAL NECESSITY OF SUBSTANCE ABUSE DAY TREATMENT.
PC89	PROVIDE A TREATMENT PLAN THAT CONTAINS MEASURABLE GOALS AND OBJECTIVES CORRESPONDING TO THE IDENTIFIED DEFICIT.
PC91	PLEASE PROVIDE MORE INFORMATION ON FAMILY INVOLVEMENT TREATMENT.
PC92	PLEASE PROVIDE MORE HISTORY AND EXPLANATION ABOUT THE ISSUE OF ABSTINENCE FOR THIS CLIENT.
PC94	PLEASE PROVIDE THE ANTICIPATED BEGINNING DATE AND/OR THE ESTIMATED SUBSTANCE ABUSE DAY TREATMENT DISCHARGE DATE.
PC95	PLEASE SUPPLY JUSTIFICATION FOR BEGINNING CLIENT IN SERVICE PRIOR TO AUTHORIZATION BEING OBTAINED.
PC96	THE INITIAL THREE HOURS OF SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IN A CALENDAR YEAR DO NOT REQUIRE PRIOR AUTHORIZATION.
PC97	REIMBURSEMENT FOR INITIAL SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IS LIMITED TO THREE HOURS IN A CALENDAR YEAR AND DOES NOT REQUIRE PRIOR AUTHORIZATION.
PC98	THIS DRUG IS CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE BILL USING THE APPROPRIATE NATIONAL DRUG CODE (NDC) OR SUBMIT A COMPLETED DRUG ADDITION REQUEST FORM IF THE NDC IS NOT LISTED IN THE DRUG INDEX.
PC99	THIS DRUG IS NOT CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL, CURRENT ADMINISTRATIVE RULE, OR COLORADO DRUG INDEX FOR COVERAGE LIMITATIONS.
PD01	DOCUMENT THAT CLIENT HAS ACHIEVED GOOD ORAL HYGIENE, PERIODONTAL CASE TYPE 1 OR 2, AND IS MOTIVATED TO MAINTAIN SAME.

Denial Code	Long Description
PD03	PLEASE PROVIDE AN ARTERIAL BLOOD GAS READING OR PULSE OXIMETRY RESULTS DONE ON ROOM AIR SIGNED AND DATED BY A MEDICAL DOCTOR. THIS SHOULD BE DONE WITHIN 60 DAYS OF REQUESTED SERVICE.
PD04	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 30 DAYS OF RECEIPT BY COLORADO MEDICAID.
PD07	SUBMIT A PHOTOCOPY OF A VALID PRESCRIPTION, ISSUED WITHIN THE PAST YEAR, OR COMPLETE SECTION B OF THE PRIOR AUTHORIZATION/DRUG ATTACHMENT (PA/DGA), F-11049.
PD10	BRAND MEDICALLY NECESSARY MUST BE IN THE PRESCRIBERS OWN HANDWRITING AND WRITTEN DIRECTLY ON THE PRESCRIPTION OR A SEPARATE ORDER ATTACHED TO THE ORIGINAL PRESCRIPTION.
PD12	COMPLETE DENTURES, PARTIAL DENTURES, DENTURE RELINES, AND FIXED PROSTHODONTIC SERVICES ARE NOT COVERED SERVICES FOR ADULTS FOR DATES OF SERVICE ON AND AFTER OCTOBER 1, 1995.
PD22	PLEASE COMPLETE ALL REQUIRED ELEMENTS ON THE PERSONAL CARE SCREENING TOOL (PCST), F-11133.
PD24	THIS PRIOR AUTHORIZATION REQUEST IS UNABLE TO BE PROCESSED. PLEASE RESUBMIT WITH ADDITIONAL REQUIRED FORMS, INCLUDING THE ENTIRE PERSONAL CARE SCREENING TOOL (PCST), F-11133; PERSONAL CARE ADDENDUM, F-11136; AND SUPPORTING DOCUMENTATION, AS DIRECTED.
PD25	THERE IS A PERSONAL CARE SCREENING TOOL (PCST), F-11133, COMPLETED BY ANOTHER AGENCY. CONTACT THE AGENCY TO TRANSFER SCREEN.
PD26	THERE IS A LIMITED TERM CARE FUNCTIONAL SCREEN (LTC-FS) COMPLETED BY ANOTHER AGENCY. THE PERSONAL CARE SCREENING TOOL (PCST), F-11133, INFORMATION IS IN CONFLICT WITH LTC-FS.
PD27	ONLY ONE LEVEL OF FUNCTION MAY BE SELECTED FOR ALL ELEMENTS EXCEPT TOILETING. COLORADO MEDICAID IS UNABLE TO PROCESS THE PRIOR AUTHORIZATION REQUEST.
PD28	NO UNITS MAY BE REQUESTED USING THIS PRIOR AUTHORIZATION PROCESS. PLEASE SUBMIT WITH THE APPROPRIATE ATTACHMENTS FOR REQUESTING SPECIFIC PERSONAL CARE WORKER UNITS.
PD29	CLIENT IS NOT ELIGIBLE FOR THE REQUESTED SERVICE(S) AS OF THE REQUESTED START DATE.
PD30	NO TRAVEL TIME MAY BE AUTHORIZED WHEN NO PERSONAL CARE WORKER SERVICE IS AUTHORIZED.
PD32	PROVIDER NOT CERTIFIED TO RENDER THE SERVICE(S) REQUESTED.
PD34	BASED ON THE DOCUMENTATION SUBMITTED, THIS REQUEST CAN NOT BE PRIOR AUTHORIZED. REFER TO THE PA MESSAGES FROM THE CONSULTANT FOR COMPLETE EXPLANATION.
PD98	PLEASE DOCUMENT HOW AND WHEN EACH PREVIOUSLY AUTHORIZED PRO RE NATA VISIT WAS USED.

Substance Abuse Rehab

Denial Code	Long Description
0201	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
0233	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0235	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0237	CLIENT IDENTIFICATION NUMBER DOES NOT MATCH CLIENTS FIRST NAME.
0238	THE CLIENT IDENTIFICATION NUMBER DOES NOT MATCH THE CLIENTS LAST NAME.
0242	SECONDARY DIAGNOSIS CODE IS INVALID.
0248	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0249	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0251	PROCEDURE CODE MODIFIER IN FIRST POSITION IS INVALID.
0252	THE PROCEDURE CODE MODIFIER IN SECOND POSITION IS INVALID FOR REQUESTED START DATE OR DATE OF RECEIPT.
0253	THE PROCEDURE CODE MODIFIER IN THIRD POSITION IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
0258	THE PRIMARY DIAGNOSIS CODE IS REQUIRED.
0272	THE PRIMARY DIAGNSOSIS CODE IS INVALID.

Denial Code	Long Description
0339	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0340	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0400	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0853	HCPCS - ANNUAL UPDATE
0885	NEVER EVENTS MODIFIERS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
0886	NEVER EVENTS DIAGNOSIS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
1000	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
1002	RENDERING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1003	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1007	RENDERING PROVIDER ID IS NOT ON FILE.
1047	THE RENDERING PROVIDERS CERTIFICATION HAS BEEN CANCELLED.
1048	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1801	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
1804	A CERTIFIED SUBSTANCE ABUSE DAY TREATMENT PROVIDER MUST SUBMIT A SUBSTANCE ABUSE DAY TREATMENT PROCEDURE CODE.
1806	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
1808	THE BILLING PROVIDER DOES NOT HAVE THE REQUIRED CERTIFICATION ADDENDUM ON FILE.
1900	THE BILLING PROVIDERS TAXONOMY CODE IS INVALID.
1901	THE RENDERING PROVIDERS TAXONOMY CODE IS INVALID.
1927	A NATIONAL PROVIDER IDENTIFIER IS REQUIRED FOR THE BILLING PROVIDER.
1934	A NATIONAL PROVIDER INDENTIFIER IS REQUIRED FOR THE RENDERING PROVIDER.
1936	THE BILLING PROVIDER NUMBER IS INVALID.
1937	THE RENDERING PROVIDER NUMBER IS INVALID.
1960	INTERNAL PROCESSING IS REQUIRED.
1963	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.
1964	THE BILLING PROVIDER INDICATED IS NOT ALLOWABLE AS A BILLING PROVIDER.
1965	RENDERING PROVIDER NUMBER IS MISSING/INVALID FOR THIS PROCEDURE PROVIDER.
1974	PRESCRIBING/REFERRING/ORDERING PROVIDER INDICATED IS NOT CERTIFIED AS A PRESCRIBING/REFERRING/ORDERING PROVIDER.
1975	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
1976	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
2001	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2003	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2017	THE CLIENT IS ENROLLED IN A MEDICAID OR OTHER MANAGED CARE PROGRAM.
2037	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2603	CLIENT LOCKED-IN TO A PROVIDER OR ENROLLED IN A HOSPICE. CONTACT CLIENTS HOSPICE FOR PAYMENT OF SERVICES OR RESUBMIT WITH DOCUMENTATION OF UNRELATED NATURE OF CARE.
3324	THE MODIFIER HAS BEEN DISCONTINUED BY THE CENTERS OF MEDICARE AND MEDICAID SERVICES OR THE AMERICAN MEDICAL ASSOCIATION FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
3337	THE PROCEDURE CODE HAS BEEN TERMINATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AMERICAN MEDICAL ASSOCIATION, OR AMERICAN DENTAL ASSOCIATION FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT. RESUBMIT WITH VALID A PROCEDURE CODE.
3339	THE PROCEDURE BILLED IS NOT PAYABLE ACCORDING TO DEFICIT REDUCTION ACT (DEFRA) GUIDELINES.
3351	THE PROCEDURE IS NOT COVERED FOR CLIENTS WITH A NURSING HOME AUTHORIZATION ON THE REQUESTED START DATE OR DATE OF RECEIPT.
3353	THE PROCEDURE IS NOT A COVERED SERVICE FOR HOME AND COMMUNITY-BASED WAIVER CLIENTS.
4021	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4027	THE DIAGNOSIS CODE IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
4031	THE PROCEDURE SUBMITTED IS NOT APPROPRIATE FOR CLIENTS GENDER.
4032	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4036	THE PLACE OF SERVICE CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4040	THE PRIMARY DIAGNOSIS CODE IS NOT ON FILE.

Denial Code	Long Description
4041	THE SECONDARY DIAGNOSIS IS NOT ON FILE.
4046	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4059	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4127	INTERNAL PROCESSING IS REQUIRED.
4131	INTERNAL PROCESSING IS REQUIRED.
4141	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4149	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4150	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4151	THE PROVIDER IS NOT AUTHORIZED TO PERFORM THE PROCEDURE.
4227	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4236	ETIOLOGY DIAGNOSIS CODE(S) (E-CODES) ARE INVALID AS THE PRIMARY DIAGNOSIS.
4244	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4245	THE FOURTH POSITION MODIFIER IS INVALID FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT.
4256	THE PROCEDURE CODE AND MODIFIER COMBINATION IS NOT PAYABLE FOR THE CLIENTS BENEFIT PLAN.
4257	THE MODIFIERS SUBMITTED ARE EITHER INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT OR THE MODIFIERS ARE MISSING.
4311	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4315	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4316	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4321	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4322	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4371	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4372	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4374	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4711	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR CLIENTS AGE.
4714	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS AGE.
4731	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS DIAGNOSIS.
4733	DIAGNOSIS AND/OR PROCEDURE AND/OR PLACE OF SERVICE (POS) CODE IS NOT COVERED FOR EXPRESS ENROLLMENT CLIENTS.
4742	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4743	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4744	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4745	DIAGNOSIS AND/OR PROCEDURE AND/OR PLACE OF SERVICE (POS) CODE IS NOT COVERED FOR EXPRESS ENROLLMENT CLIENTS.
4746	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4801	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4802	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
4804	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4821	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
4871	PLEASE REFER TO PA MESSAGES FOR RETURN INFORMATION.
4874	PLEASE REFER TO PA MESSAGES FOR RETURN INFORMATION.
4963	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS GENDER.
4975	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4990	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
7500	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
7509	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
P001	THE BILLING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THE SERVICES.

Denial Code	Long Description
P002	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P003	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P005	THE PRIOR AUTHORIZATION CAN NOT BE END DATED. THE PRIOR AUTHORIZATION STATUS IS NOT APPROVED OR APPROVED WITH REVISIONS.
P006	PLEASE FURNISH THE PROCEDURE CODE AND CORRESPONDING DESCRIPTION.
P008	THE BILLING PROVIDER NUMBER IS INVALID.
P009	THE BILLING PROVIDER NUMBER IS INVALID.
P010	THE REQUESTED END DATE IS INVALID.
P011	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P012	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P013	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P014	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P015	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P016	THE REQUESTED START DATE IS MISSING OR INVALID.
P019	THE REQUESTED START DATE IS MISSING OR INVALID.
P020	THE RENDERING PROVIDER NUMBER IS INVALID.
P021	THE RENDERING PROVIDER NUMBER IS INVALID.
P022	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P023	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P024	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P026	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P027	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P030	FIRST MODIFIER IS INVALID.
P031	FIRST MODIFIER IS INVALID.
P032	SECOND MODIFIER IS INVALID.
P033	SECOND MODIFIER IS INVALID.
P034	THIRD MODIFIER IS INVALID.
P035	THIRD MODIFIER IS INVALID.
P036	FOURTH MODIFIER IS INVALID.
P037	FOURTH MODIFIER IS INVALID.
P038	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P039	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P040	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P041	CLIENTS FIRST NAME IS MISSING.
P042	CLIENTS LAST NAME IS MISSING.
P043	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P044	BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES REQUESTED.
P045	FIRST MODIFIER IS INVALID.
P046	SECOND MODIFIER IS INVALID.
P047	THIRD MODIFIER IS INVALID.
P048	FOURTH MODIFIER IS INVALID.
P052	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P053	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P054	RENDERING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES FOR THE BENEFIT PLAN.
P055	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.

Denial Code	Long Description
P061	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P062	THE CLIENT ID AND/OR NAME INDICATED ON THE PA REQUEST IS INCORRECT. THE CLIENT ID AND/OR NAME HAS BEEN UPDATED. PLEASE VERIFY THE ID AND/OR NAME IS CORRECT.
P064	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
P067	THE FREQUENCY OF HOURS REQUESTED ARE NOT APPROPRIATE FOR THIS CLIENT AND HAVE BEEN MODIFIED ACCORDINGLY.
P079	BILLING PROVIDER IS ON PAYMENT SUSPENSION DUE TO CREDIBLE ALLEGATION OF FRAUD.
P120	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAS BEEN REDUCED.
P121	THE SERVICE/ PROCEDURE REQUESTED IS NOT SUPPORTED BY SUBMITTED DOCUMENTATION.
P126	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
P128	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.
P138	SERVICE(S) DO NOT MEET COLORADO MEDICAID GUIDELINES.
P167	REQUESTED DOCUMENTATION HAS NOT BEEN SUBMITTED.
P178	THE SERVICE REQUESTED IS NOT MEDICALLY NECESSARY.
P179	THE MEDICAL NECESSITY FOR THIS SERVICE IS NOT SUPPORTED BY THE SUBMITTED DOCUMENTATION.
P233	THE DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE ADDITIONAL CARE.
P257	THIS CLIENTS FUNCTIONAL ASSESSMENT SCORES PLACE THIS CLIENT OUTSIDE ELIGIBILITY FOR DAY TREATMENT.
P274	OUR RECORDS INDICATE THIS CLIENT IS INVOLVED IN EFFECTIVE AND APPROPRIATE SERVICE ELSEWHERE.
P292	INTENSIVE REHABILITATION HOURS ARE NO LONGER APPROPRIATE AS INDICATED BY HISTORY, DIAGNOSIS, AND/ OR FUNCTIONAL ASSESSMENT SCORES.
P328	THE SERVICES REQUESTED INCLUDE NON-COVERED SERVICES, AND HOURS ARE REDUCED ACCORDINGLY.
P339	THE CLIENTS PAST HISTORY INDICATES REDUCED TREATMENT HOURS ARE WARRANTED.
P342	THE REQUEST DOES NOT MEET GENERALLY ACCEPTED CONDITIONS REQUIRING FLUORIDE TREATMENTS.
P346	SERVICES EXCEED COLORADO MEDICAID LIMITATION AND DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE MEDICAL NECESSITY OF THE SERVICE.
P349	THE SERVICE REQUESTED WAS PERFORMED LESS THAN FIVE YEARS AGO.
P353	THE EXISTING APPLIANCE HAS NOT BEEN WORN FOR THREE YEARS.
P367	THE CLIENT HAS BEEN TOTALLY WITHOUT TEETH AND AN APPLIANCE FOR FIVE YEARS.
P392	THE CLIENT IS MISSING AN ANTERIOR TOOTH AND/OR HAS TWO OR MORE POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P405	THE SERVICE(S) REQUESTED COULD ADEQUATELY BE PERFORMED IN THE DENTAL OFFICE.
P406	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE OF GOOD PERIODONTAL HEALTH (AMERICAN ACADEMY OF PERIODONTOLOGY PERIODONTAL CLASSIFICATION OF TYPE I OR II).
P407	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE VISIBLE ON RADIOGRAPHS THAT AT LEAST 50 PERCENT OF THE CLINICAL CROWN IS INTACT.
P409	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING SIX OR MORE TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED, INCLUDING THIRD MOLARS.
P410	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING ONE OR MORE ANTERIOR TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED.
P411	DOCUMENTATION DOES NOT SUPPORT THE NEED FOR PERIODONTIC SERVICES. POCKETS ARE LESS THAN 4MM AND/OR GREATER THAN 6MM FOR CLIENT AND/OR THE CLIENT IS UNDER THE AGE OF 13.
P412	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA.
P413	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA. THIS PA HAS BEEN GRANTED AS APPROVED NOT APPROVED WITH REVISIONS. THE DURATION REQUESTED MAY HAVE BEEN REDUCED TO REFLECT COVERAGE LIMITATIONS, PRESCRIBER ORDERS, CONFLICTI
P417	THE SERVICE(S) REQUESTED COULD BE ADEQUATELY PERFORMED WITH LOCAL ANESTHESIA.
P437	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO POOR ORAL HYGIENE.
P444	THIS LINE ITEM IS A DUPLICATE OF ANOTHER LINE ITEM ON THIS PRIOR AUTHORIZATION (PA) REQUEST. PLEASE CORRECT.

Denial Code	Long Description
P446	THIS IS A DUPLICATE OF AN EXISTING PRIOR AUTHORIZATION (PA) REQUEST. YOU MAY CONTACT PROVIDER SERVICES IF YOU REQUIRE ASSISTANCE. DUPLICATE PA REQUEST
P448	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO DECAY HISTORY.
P449	QUESTIONABLE LONG TERM PROGNOSIS DUE TO GUM AND BONE DISEASE.
P456	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO APPARENT ROOT INFECTION.
P457	OUR RECORDS INDICATE THIS CLIENT HAS EXCEEDED ESTABLISHED PROGRAM LIMITATIONS. COLORADO MEDICAID WILL NOT AUTHORIZE NEW DENTURES.
P458	DOCUMENTATION PROVIDED INDICATES A LESS ELABORATE PROCEDURE SHOULD BE CONSIDERED.
P502	RENTAL ONLY ALLOWED; MEDICAL NEED FOR PURCHASE HAS NOT BEEN DOCUMENTED.
P503	PURCHASE ONLY ALLOWED; MEDICAL NEED FOR RENTAL HAS NOT BEEN DOCUMENTED.
P504	OCCUPATIONAL THERAPY GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P505	THE SERVICE REQUESTED IS INCLUDED IN THE NURSING HOME RATE STRUCTURE.
P511	THIS NATIONAL DRUG CODE IS ONLY BILLABLE AS PART OF A COMPOUND DRUG.
P515	THE PRESENCE OF A HANDICAPPING MALOCCLUSION OR HANDICAPPING DENTOFACIAL DEFORMITY IS NOT SUPPORTED BY THE DOCUMENTATION SUBMITTED.
P521	THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVERED BY COLORADO MEDICAID.
P522	GASTRO-INTESTINAL SURGERY FOR THE PURPOSE OF WEIGHT CONTROL IS COVERED ONLY AS A LIFE THREATENING PROCEDURE.
P523	THE TREATMENT REQUEST IS NOT CONSISTENT WITH THE CLIENT'S DIAGNOSIS.
P524	PSYCHOTHERAPY PROVIDED IN THE CLIENTS HOME IS NOT A COVERED BENEFIT OF COLORADO MEDICAID.
P525	THE INFORMATION PROVIDED IS NOT CONSISTENT WITH THE INTENSITY OF SERVICES REQUESTED.
P526	INTENSIVE MULTIPLE MODALITY TREATMENT IS NOT CONSISTENT WITH THE INFORMATION PROVIDED.
P527	MULTIPLE PROVIDERS OF TREATMENT ARE NOT INDICATED FOR THIS CLIENT.
P528	THE DURATION OF TREATMENT SESSIONS EXCEED CURRENT COLORADO MEDICAID GUIDELINES.
P534	DOCUMENTATION OF POOR PHYSICAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P535	OTHER PHYSICAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P536	THE PHYSICAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P537	USE OF PHYSICAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P538	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF A PHYSICAL THERAPIST.
P539	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS AND LIVING ARRANGEMENT.
P540	GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P541	THE PROCEDURE(S) REQUESTED ARE NOT MEDICAL IN NATURE.
P542	DOCUMENTATION OF POOR OCCUPATIONAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P543	DOCUMENTATION OF POOR SPEECH THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P544	OTHER OCCUPATIONAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P546	THE OCCUPATIONAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P547	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF PHYSICAL THERAPY.
P548	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P549	ACTIVITIES TO PROMOTE DIVERSION OR GENERAL MOTIVATION ARE NONCOVERED COLORADO MEDICAID SERVICES.
P550	REVISIONS OF THE REQUEST IS NECESSITATED BY THE CLIENTS MINIMAL PROGRESS.

Denial Code	Long Description
P551	RESTORATIVE NURSING INVOLVEMENT COULD BE INCREASED.
P552	CLIENTS DEMONSTRATED RESPONSE TO CURRENT THERAPY DOES NOT WARRANT THE INTENSE FREQUENCY REQUESTED.
P553	MAINTENANCE IS TWO TIMES PER WEEK OR LESS.
P554	THE SPEECH THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P555	USE OF OCCUPATIONAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P556	USE OF SPEECH THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P557	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF AN OCCUPATIONAL THERAPIST.
P558	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
P559	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P560	THE MATERIALS/ SERVICES REQUESTED ARE PRINCIPALLY COSMETIC IN NATURE.
P561	THE LENS FORMULA DOES NOT JUSTIFY REPLACEMENT.
P562	THE CHANGE IN THE LENS FORMULA DOES NOT WARRANT MULTIPLE REPLACEMENTS.
P563	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P564	LENSES ONLY ARE APPROVED; PLEASE DISPENSE A CONTRACTED FRAME. THE NON-CONTRACTED FRAME IS NOT MEDICALLY JUSTIFIED.
P565	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P566	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P567	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF OCCUPATIONAL THERAPY.
P568	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF SPEECH THERAPY.
P569	LEVEL, INTENSITY, OR EXTENT OF SERVICE(S) REQUESTED HAS BEEN MODIFIED CONSISTENT WITH MEDICAL NEED AS DEFINED IN THE PLAN OF CARE.
P570	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P571	THE SERVICE ASKED FOR IS NOT COVERED BY COLORADO MEDICAID AS THESE TASKS CAN BE DONE BY NURSES OR ACTIVITY STAFF.
P572	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P573	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.
P574	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P575	MEDICAL NEED FOR EQUIPMENT/ SUPPLY REQUESTED IS NOT SUPPORTED BY DOCUMENTATION SUBMITTED.
P576	OTHER SPEECH THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P577	DOCUMENTATION SUBMITTED IDENTIFIES THAT THE CLIENT HAS FEWER THAN TWO POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P582	LESS EXPENSIVE ALTERNATIVE SERVICES ARE AVAILABLE FOR THIS CLIENT.
P634	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P711	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING PERIODONTAL SCALING AND ROOT PLANNING.
P712	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING GINGIVECTOMY.
P754	AN APPROVED SUBSTANCE ABUSE DAY TREATMENT PROGRAM CANNOT EXCEED A SIX WEEK PERIOD.
P761	THE CLIENT DOES NOT APPEAR TO BE ABLE OR WILLING TO ABSTAIN FROM ALCOHOL/DRUG USAGE WHILE IN TREATMENT. THEREFORE, SUBSTANCE ABUSE DAY TREATMENT SERVICES ARE NOT APPROVED.
P764	THIS CLIENT HAS COMPLETED INTENSIVE SUBSTANCE ABUSE TREATMENT WITHIN THE PAST 12 MONTHS. THE DOCUMENTATION PROVIDED IS NOT ADEQUATE TO JUSTIFY ADDITIONAL INTENSIVE TREATMENT AT THIS TIME.
P785	A LESS THAN SIX-WEEK HEALING PERIOD HAS BEEN SPECIFIED FOR THIS PRIOR AUTHORIZATION. THEREFORE IT IS NOT NECESSARY TO WAIT THE FULL SIX WEEKS AFTER EXTRACTIONS BEFORE TAKING DENTURE IMPRESSIONS.

Denial Code	Long Description
P818	SIX-WEEK HEALING TIME IS REQUIRED BETWEEN EDENTULATION AND FINAL IMPRESSIONS. PAYMENT FOR DENTURES WILL BE DENIED OR RECOUPED IF HEALING PERIOD IS NOT OBSERVED.
P849	COLORADO MEDICAID HAS DETERMINED THERE WERE (ARE) SEVERAL HOME HEALTH AGENCIES WILLING TO PROVIDE MEDICALLY NECESSARY SKILLED NURSING SERVICES TO THIS CLIENT.
P864	THE DOCUMENTATION YOU HAVE SUBMITTED DOES NOT MEET THE REQUIREMENTS OF COLORADO MEDICAID.
P873	THE MEDICAL NECESSITY FOR THE HOURS REQUESTED IS NOT SUPPORTED BY THE INFORMATION SUBMITTED.
P874	THE DOCUMENTATION SUBMITTED INDICATES THE TASKS SPECIFIED CAN BE COMPLETED DURING THE VISITS APPROVED.
P878	THE DOCUMENTATION SUBMITTED DOES NOT INDICATE THAT MEDICALLY ORIENTED TASKS ARE MEDICALLY NECESSARY; THEREFORE PERSONAL CARE SERVICES HAVE BEEN APPROVED.
P880	THE QUANTITY OF SERVICES AUTHORIZED FOR THIS CLIENTS PERSONAL CARE HAS BEEN AMENDED BASED ON INFORMATION RECEIVED FROM ONE OR MORE OF THESE SOURCES: THE CLIENT, THEIR PHYSICIAN, AND/OR THE IN-HOME VISIT BY STAFF OF THE OIG (OFFICE OF INSPECTOR GENERAL).
P885	THE USE OF THIS DRUG FOR THE INTENDED PURPOSE IS NOT COVERED BY COLORADO MEDICAID, CONSISTENT WITH COLORADO ADMINISTRATIVE CODE AND FEDERAL LAW.
P924	THE MEDICAL RECORDS SUBMITTED WITH THE CURRENT REQUEST CONFLICT OR DISAGREE WITH OUR MEDICAL RECORDS ON THIS CLIENT.
P950	INDEPENDENT NURSES, PLEASE NOTE PAYABLE SERVICES MAY NOT EXCEED 12 HOURS/DAY OR 60 HOURS/WEEK.
P951	SERVICES CAN ONLY BE AUTHORIZED THROUGH ONE YEAR FROM THE PRESCRIPTION DATE.
P952	LEAD INSPECTION IS A COVERED COLORADO MEDICAID SERVICE WHEN THE CHILD HAS BEEN SHOWN TO HAVE LEAD POISONING (E.G., CHILD HAS A BLOOD LEAD LEVEL > 19 UG/DL OR TWO CONSECUTIVE BLOOD LEAD LEVELS OF 15-19 UG/DL DONE AT LEAST 90 DAYS APART). THE INSPECTION MUS
P953	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P954	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P956	THE REQUEST CAN ONLY BE BACKDATED A MAXIMUM OF 14 DAYS FROM FIRST DATE RECEIVED BY COLORADO MEDICAID.
P957	COMPLETE PERIODONTAL CHARTING AT TIME OF SERVICE, AND SUBMIT CHARTING, COPY OF OPERATIVE REPORT, TOGETHER WITH A COPY OF THE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF), F-11035, TO PA UNIT ATTENTION DENTAL CONTSULTANT.
P958	NOTE THAT CODE D4341 HAS BEEN CHANGED. REFER TO THE DECISION NOTICE FOR AUTHORIZED QUANTITY.
P960	YOUR PA HAS BEEN APPROVED FOR 90 DAYS. THE 90 DAY APPROVAL DOES NOT IMPLY THE PA REQUEST MEETS PRIOR AUTHORIZATION CRITERIA. AFTER ADDITIONAL INFORMATION IS AVAILABLE IN INTERCHANGE, COLORADO MEDICAID WILL CREATE AN AMENDMENT REQUEST TO EXTEND THE PA FOR
P961	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P962	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
PA10	THE REQUESTED END DATE IS INVALID.
PA12	PLEASE FURNISH A WRITTEN DESCRIPTION OF THE CLIENTS DIAGNOSIS.
PA13	PROVIDE DIAGNOSES WITH DATES OF ONSET.
PA14	IDENTIFY PROBLEMS TO BE TREATED.
PA15	THE AUDIOLOGISTS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1), F-11020, AND PRIOR AUTHORIZATION REQUEST/HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2), F-11021.
PA16	THE PHYSICIANS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION/PHYSICIAN OTOLOGICAL REPORT (PA/POR), F-11019.

Denial Code	Long Description
PA17	SUBMIT BRIEF HISTORY WITH REFERRAL INFORMATION, LIVING SITUATION, FUNCTIONAL STATUS, AND OTHER PERTINENT INFORMATION. WHAT CHANGE OF STATUS RESULTED IN REFERRAL AT THIS TIME?
PA18	PLEASE FURNISH THE CLIENTS HEIGHT AND WEIGHT.
PA19	PLEASE SUBMIT CLINICAL INFORMATION SUFFICIENT TO VERIFY THE NEED FOR THE REQUESTED SERVICE(S).
PA20	PLEASE RESUBMIT WITH COMPLETE PERIODONTAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PA21	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL EDUCATIONAL PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA22	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL PROGRAM PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA23	REFER TO THE DURABLE MEDICAL EQUIPMENT INDEX FOR APPROPRIATE CODE AND DESCRIPTION. DO NOT USE AN "UNLISTED" CODE.
PA24	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUALIZED FAMILY SERVICE PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA25	INFORMATION ON THE REQUEST FORM IS ILLEGIBLE, AND THE REQUEST CANNOT BE PROCESSED.
PA26	RE-EVALUATE YOUR GOALS. EMPHASIS SHOULD BE ON FUNCTIONAL SELF-CARE. GOALS MUST BE RELATED TO FUNCTIONAL OUTCOME.
PA27	PLEASE CLARIFY THE NUMBER OF HOURS PER WEEK REQUESTED.
PA28	PLEASE CLARIFY THE NUMBER OF HOURS PER DAY REQUESTED.
PA29	PLEASE CLARIFY THE NUMBER OF VISITS PER DAY REQUESTED.
PA30	ATTACH SUPPORTIVE DOCUMENTATION; HOME EXERCISE PROGRAM AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA31	THE DIAGNOSIS CODE INDICATED ON THE REQUEST DOES NOT CORRESPOND TO THE DIAGNOSIS CODE DESCRIPTION.
PA32	PLEASE SUBMIT ADDITIONAL INFORMATION SUFFICIENT TO VERIFY APPROPRIATENESS AND NEED FOR TRANSPLANT.
PA33	PLEASE SUBMIT THE INITIAL AND PROGRESSIVE OBJECTIVE FINDINGS.
PA34	ATTACH SUPPORTIVE DOCUMENTATION, FACILITY PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA35	PLEASE SUBMIT THE CLIENTS ORIGINAL COMPLAINTS AND EXAMINATION FINDINGS.
PA36	ATTACH SUPPORTIVE DOCUMENTATION, IN-HOME AUTISM PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA37	PLEASE SUBMIT YOUR TREATMENT PLAN FOR THIS CLIENT.
PA38	ATTACH SUPPORTIVE DOCUMENTATION AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA39	INITIAL EVALUATIONS MUST BE PERFORMED BY AN OCCUPATIONAL THERAPIST REGISTERED (OTR), PER AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA) STANDARDS.
PA41	IDENTIFY THE PLACE OF SERVICE AND ITS EFFECT ON SUPPORTING THE DESIRED TREATMENT OUTCOME.
PA42	PLEASE INDICATE THE HOURS OF USE OF OXYGEN PER 24-HOUR PERIOD.
PA43	PROVIDE BASELINE DOCUMENTATION FOR THIS CLIENTS LIMITATIONS USING UNITS OF MEASUREMENT THAT ARE APPLIED CONSISTENTLY WHEN REPORTING STATUS.
PA44	IDENTIFY FUNCTIONAL LIMITATIONS AS THEY ARE RELATED TO IDENTIFIED CONDITIONS.
PA46	CORRELATE PLAN OF CARE TO REQUESTED PROCEDURE CODES.
PA47	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE FREQUENCY/DURATION REQUESTED.
PA48	PLEASE PROVIDE THE NAME AND CREDENTIALS OF THE RENDERING PROVIDER.
PA50	COLORADO MEDICAID RECORDS INDICATE THE CLIENT OWNS A WHEELCHAIR. DOCUMENT THE REASON AND NEED FOR REPLACEMENT AND COST TO REPAIR CURRENT WHEELCHAIR.
PA51	PLEASE DISTINGUISH PRIMARY AND SUPPORTIVE MODALITIES.
PA52	PLEASE SUBMIT A PROGRESS REPORT.
PA53	MULTIPLE FAMILY CLIENTS TREATMENT BY THE SAME PROVIDER REQUIRES FURTHER INFORMATION DOCUMENTING COORDINATION OF TREATMENT PLAN.

Denial Code	Long Description
PA54	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE MINUTES REQUESTED.
PA55	MEDICAL NECESSITY OF TREATMENT REQUIRES ADDITIONAL DOCUMENTATION.
PA56	GIVEN AGE, DIAGNOSES, CURRENT LEVEL OF FUNCTION, PAST RESPONSE TO TREATMENT, AND LIVING SITUATION, EXPAND ON POTENTIAL FOR SIGNIFICANT FUNCTIONAL PROGRESS WITHIN THE NEXT SIX MONTHS. EMPHASIZE WHY PROGRESS IS EXPECTED WITH SERVICES AT THIS TIME.
PA57	SUBMIT THE INITIAL FINDINGS. INCLUDE A COMPREHENSIVE EVALUATION.
PA58	SUBMIT PROGRESSIVE, OBJECTIVE FINDINGS. INCLUDE A PERTINENT RE-EVALUATION.
PA59	PLEASE SUPPLY INFORMATION REGARDING THE CLIENTS MEDICATION REQUIREMENTS, IF ANY.
PA60	PLEASE SPECIFY IF THE CLIENT IS IN AN EDUCATIONAL SETTING.
PA61	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA62	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
PA63	THE SKILLS OF A THERAPIST ARE PURPOSEFUL AND SKILLED INTERVENTIONS REQUIRED TO CONTINUALLY DESIGN, IMPLEMENT, REASSESS, MODIFY/GRADE, AND/OR DISCONTINUE A PLAN OF CARE IN A TIMELY MANNER, BASED ON THE COMPLEXITY OF THE CLIENTS MEDICAL CONDITION AND/OR CO
PA64	PLEASE SUBMIT A THERAPY PLAN OF CARE, INCLUDING A CURRENT, DATED EVALUATION.
PA65	A PLAN OF CARE SIGNED AND DATED BY THE PHYSICIAN IS REQUIRED.
PA66	THE SKILLS OF A THERAPIST ARE REQUIRED WHEN ONLY THE THERAPIST CAN SAFELY AND EFFECTIVELY DELIVER THE THERAPEUTIC PROCEDURES BECAUSE OF THEIR UNIQUE KNOWLEDGE, TRAINING, AND EXPERTISE. DESCRIBE THE REASON THAT SOMEONE OTHER THAN A THERAPIST CANNOT SAFELY
PA67	PLEASE SPECIFY IF THE CLIENTS WORK SITE DEMANDS GOOD BINAURAL HEARING.
PA68	DESCRIBE THE REASON, BASED ON THE CLIENTS COGNITIVE, PHYSICAL, COMMUNICATION, OR RESOURCE STATUS, THAT A HOME PROGRAM, EQUIPMENT, OR ENVIRONMENTAL ADAPTATIONS ALONE CANNOT MEET CLIENTS NEEDS.
PA69	PLEASE SPECIFY IF THE CLIENT HAS AN ACCOMPANYING DISABILITY THAT ADDS TO THE HEARING PROBLEM.
PA70	DISTINGUISH REQUESTED PROCEDURES AND GOALS FROM OTHER SERVICES THIS CLIENT RECEIVES. THEY MAY NOT BE DUPLICATIVE.
PA71	PLEASE INDICATE THE NUMBER OF DAYS REQUESTED.
PA73	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA74	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA75	PLEASE DOCUMENT CARRYOVER OF THE THERAPY PROGRAM TO NURSING.
PA76	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA79	PROVIDE EVIDENCE OF SIGNIFICANT FUNCTIONAL PROGRESS IN LAST SIX MONTHS.
PA84	THE GRANT DATE OF THIS REQUEST CANNOT BE PRIOR TO THE SIGNATURE DATE OF THE PRESCRIBING PHYSICIAN.
PA86	PROVIDE EVIDENCE OF SKILLS GAINED IN THERAPY CARRYING OVER TO OTHER SETTINGS WITHIN SIX MONTHS.
PA87	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE NUMBER OF SESSIONS REQUESTED.
PA88	THE REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL SCOPE OF PRACTICE.
PA89	PRIOR AUTHORIZATION IS NOT REQUIRED UNTIL LIMITATION OF SERVICE HAS BEEN REACHED.
PA91	PLEASE SUBMIT REQUIRED X-RAYS.
PA92	PLEASE PROVIDE AN EXPLANATION FOR THE MATERIAL SUBMITTED WITH THE REQUEST.
PA95	PLEASE DESCRIBE HOW THE PROVISION OF THIS SERVICE WOULD PREVENT INSTITUTIONALIZATION OF THE CLIENT.
PA96	COULD THE EXISTING DENTURE(S) BE RELINED OR REBASED? IF NOT, PLEASE EXPLAIN WHY NOT.
PA97	REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL STANDARDS OF PRACTICE.
PA98	PLEASE INDICATE IF THE CLIENT IS CURRENTLY BEING TUBE FED.
PB02	PLEASE PROVIDE THE REQUIRED DATED SIGNATURES ON THE ATTACHMENTS.

Denial Code	Long Description
PB03	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING THE LOSS/DESTRUCTION/THEFT OF THE HEARING AID.
PB04	DESCRIBE THE CLIENTS ABILITY TO STAND OR AMBULATE SUFFICIENTLY TO ACCOMPLISH SELF-CARE ACTIVITIES.
PB07	PLEASE SUBMIT AN ORTHODONTIC STUDY MODEL OR DIAGNOSTIC CASTS.
PB09	PLEASE PROVIDE A PHOTOGRAPH OF THE INVOLVED AREA(S).
PB10	PLEASE PROVIDE AN ESTIMATION (IN GRAMS) OF THE TOTAL AMOUNT OF TISSUE TO BE RESECTED.
PB11	PLEASE SUBMIT THE PLAN OF CARE FOR CO-TREATMENT.
PB12	FURNISH A DETAILED DESCRIPTION FOR THE PROCEDURE CODE REQUESTED.
PB13	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB15	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB18	PLEASE COMPLETE THE ATTACHED OUT-OF-STATE PROVIDER DATA SHEET, F-11001, AND RESUBMIT.
PB20	A SIGNED AND DATED PRESCRIPTION IS REQUIRED WITHIN THREE MONTHS OF RECEIPT BY COLORADO MEDICAID FOR INITIAL REQUESTS AND WITHIN 12 MONTHS OF RECEIPT BY COLORADO MEDICAID FOR SUBSEQUENT REQUESTS.
PB21	PLEASE COMPLETE THE APPROPRIATE PRIOR AUTHORIZATION ATTACHMENT. CONTACT PROVIDER SERVICES OR THE PRIOR AUTHORIZATION UNIT FOR ASSISTANCE.
PB23	PHYSICAL THERAPY ASSISTANT NOTES AND ALL FORMS SUBMITTED MUST BE COSIGNED BY A REGISTERED PHYSICAL THERAPIST.
PB31	ARE YOU REQUESTING A COMPLETE APPLIANCE, OR REPLACEMENT PARTS?
PB32	THE PROCEDURE CODE INDICATED ON THE REQUEST DOES NOT MATCH THE DESCRIPTION OF SERVICE; PLEASE CORRECT AND RESUBMIT.
PB35	THE SERVICE REQUESTED DOES NOT REQUIRE PRIOR AUTHORIZATION.
PB41	PLEASE FURNISH A CURRENT MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT, F-11090 (DATED WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID).
PB45	THE CERTIFICATION PERIOD ON THE PLAN OF CARE (POC) DOES NOT COVER THE REQUESTED GRANT/START DATE. PLEASE RESUBMIT YOUR REQUEST WITH A NEW POC.
PB49	A CERTIFIED OCCUPATIONAL THERAPY ASSISTANTS NOTES MUST BE COSIGNED BY AN OCCUPATIONAL THERAPIST REGISTERED.
PB51	ADDITIONAL INFORMATION IS REQUIRED ON PRIOR AUTHORIZATION TO ENABLE PRICING.
PB54	REQUESTED SERVICES DO NOT MATCH SERVICES ON THE PHYSICIANS ORDERS.
PB59	PLEASE PROVIDE AN INDIVIDUAL EDUCATIONAL PLAN (IEP), WHICH HAS BEEN SIGNED BY THE PROVIDER NO EARLIER THAN NINE MONTHS PRIOR TO RECEIPT AT COLORADO MEDICAID; OTHERWISE, DOCUMENT WHY NO IEP EXISTS.
PB65	PLEASE FURNISH THE ANTICIPATED TOTAL CHARGES FOR THIS REQUEST.
PB66	A PHOTOCOPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED; THE DATE MUST BE WITHIN SIX MONTHS OF RECEIPT BY COLORADO MEDICAID.
PB67	THE PRESCRIPTION DATE MUST INCLUDE MONTH, DAY, AND YEAR.
PB68	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID.
PB73	THE SERVICES IDENTIFIED ON THE PLAN OF CARE DO NOT APPEAR APPROPRIATE FOR THE PROCEDURE CODE(S) REQUESTED ON THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018.
PB74	THE CLIENT/PROVIDER DOES NOT HAVE RETROACTIVE ENROLLMENT.
PB75	THE REQUESTED START DATE IS MORE THAN 14 DAYS BEFORE OR 62 DAYS AFTER RECEIPT.
PB82	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
PB83	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A HOME HEALTH AIDE. PLEASE RESUBMIT AS A PERSONAL CARE WORKER OR PROVIDE ADDITIONAL DOCUMENTATION.
PB86	THE SERVICES REQUESTED ARE NOT BEING PROVIDED IN THE CLIENTS RESIDENCE. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL.
PB87	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A NURSE. PLEASE RESUBMIT AS A HOME HEALTH AIDE OR PROVIDE ADDITIONAL DOCUMENTATION.
PB92	PLEASE FURNISH THE CLIENTS COMPLETE ADDRESS.
PB94	IF THE CLIENT IS A RESIDENT OF A NURSING HOME, SUPPLY THE COMPLETE NAME AND ADDRESS OF THE NURSING HOME.

Denial Code	Long Description
PB99	THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018, MUST BE SIGNED AND DATED.
PC01	PLEASE SUPPLY THE RENDERING PROVIDERS PROVIDER NUMBER.
PC03	THE DRUG ENFORCEMENT ADMINISTRATION NUMBER IS MISSING OR INVALID.
PC06	PLEASE DESCRIBE YOUR PROGRAM; INCLUDE ENTRY DATE, TERMINATION DATE, HOURS PER WEEK, AND NUMBER OF WEEKS OF PRIMARY INTENSIVE SERVICE REQUESTED.
PC07	PLEASE DESCRIBE YOUR "AFTERCARE/FOLLOW-UP" PLANS FOR THIS CLIENT.
PC08	PLEASE SUPPLY DOCUMENTATION OF PREVIOUS SUBSTANCE ABUSE SERVICES WITH DATE(S) AND OUTCOME.
PC09	PLEASE DESCRIBE IN DETAIL THE TREATMENT OBJECTIVES/GOALS FOR THIS CLIENT.
PC10	PLEASE DESCRIBE THE FAMILY SITUATION/DYNAMICS. EXPLAIN HOW THE FAMILY WILL BE INCORPORATED INTO THE CLIENTS PLAN OF CARE.
PC12	PLEASE EXPLAIN IF YOUR SERVICE ENCOURAGES THE CLIENT TO ATTEND SELF-HELP GROUPS.
PC13	PLEASE SUPPLY A SPECIFIC SCHEDULE OF ACTIVITIES, INCLUDING DAY, TIME OF DAY, LENGTH OF SESSION, AND SERVICE TO BE RENDERED DURING THAT TIME.
PC15	PLEASE FURNISH DIAGNOSTIC RATIONALE.
PC17	PLEASE DOCUMENT IF THE CLIENT EVER RECEIVED SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT.
PC19	PLEASE FURNISH MORE EXTENSIVE AND IN-DEPTH HISTORICAL AND PSYCHOSOCIAL DATA.
PC20	PLEASE SUPPLY THE DATE THE CLIENT BECAME TOTALLY ENDENTULOUS.
PC23	PLEASE SUBMIT A PHYSICIANS STATEMENT REGARDING THE MEDICAL NECESSITY OF DENTURES FOR THIS CLIENT. THE PHYSICIANS STATEMENT MUST DOCUMENT THE MEDICAL NEED FOR DENTURES.
PC24	THE SERVICE REQUESTED WAS PREVIOUSLY AUTHORIZED. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT INDICATING THIS FACT IS REQUIRED.
PC25	PLEASE SUPPLY SUFFICIENT MITIGATING CIRCUMSTANCES TO WARRANT THE CONSTRUCTION OF NEW DENTURES(S).
PC26	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
PC28	PLEASE SUBMIT A PHYSICIANS STATEMENT INDICATING DENTURES ARE NECESSARY FOR THIS NURSING HOME CLIENT.
PC29	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING LOSS OR DESTRUCTION OF DENTURE(S). INCLUDE SIGNED STATEMENT FROM CLIENT OR FACILITY DIRECTOR REGARDING HOW, WHEN AND WHERE LOST.
PC30	PLEASE PROVIDE COMPLETE INTRAORAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PC31	PLEASE DESCRIBE ANY RELATED DEFORMITIES OF THE FEET.
PC34	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD WITH REQUESTED DME ITEM(S) AND DOCUMENT IF THE CLIENT CAN USE SAFELY AND INDEPENDENTLY.
PC35	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD AND DESCRIBE THE RESULTS AND EFFECTIVENESS OF THE SERVICE REQUESTED.
PC39	PLEASE INDICATE LITER FLOW PER MINUTE, HOURS OF USE PER 24 HOUR PERIOD, AND THE EXPECTED DURATION OF NEED.
PC40	THE ITEM DOES NOT REQUIRE PRIOR AUTHORIZATION UNTIL THE LIFE EXPECTANCY HAS BEEN REACHED.
PC41	PLEASE SUPPLY INFORMATION INDICATING THE NECESSITY OF POSITIONING THE CLIENT'S BODY IN MULTIPLE POSITIONS.
PC42	PLEASE INDICATE IF THE BED HEIGHT MUST BE CHANGED TO ALLOW FOR SAFE TRANSFER OR ADEQUATE BED CARE.
PC43	SUPPLY A PHYSICIANS STATEMENT INDICATING TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR UNIT HAS REDUCED PAIN, IMPROVED/INCREASED THE CLIENTS ACTIVITY LEVEL, AND/OR REDUCED CLIENTS USE OF PAIN MEDICATION.
PC44	A CURRENT AUTHORIZATION FOR THIS SERVICE IS ON FILE FOR ANOTHER PROVIDER. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT OF THAT FACT IS REQUIRED BY THE CLIENT OF FIRST PROVIDER.
PC59	DOCUMENT DECLINE OR PROGRESS IN SPECIFIC, MEASURABLE, OBJECTIVE TERMS.
PC60	DOCUMENT IF CLIENT HAS DEMONSTRATED A GOOD APPOINTMENT COMPLIANCE RECORD.
PC61	THE PHYSICIANS SIGNATURE DATE MUST NOT EXCEED 90 DAYS FROM THE DATE OF RECEIPT BY COLORADO MEDICAID.

Denial Code	Long Description
PC62	REQUESTS FOR A CONTINUATION OF THERAPY SHOULD NOT BE SUBMITTED MORE THAN FOUR WEEKS PRIOR TO THE EXPIRATION DATE OF THE CURRENT AUTHORIZATION.
PC63	PLEASE FURNISH THE STYLE AND MANUFACTURER OF THE FRAME.
PC64	PLEASE FURNISH THE CLIENTS LENS FORMULA.
PC66	ALL REQUESTS FOR TINTS REQUIRE DOCUMENTATION OF THE VISUAL OR MEDICAL CONDITION RELATED TO PHOTOPHOBIA.
PC67	PLEASE DOCUMENT THE REASON AND JUSTIFICATION FOR REPLACEMENT BEYOND THE FIRST LENS/FRAME.
PC68	DOCUMENT IF ALL REMAINING MAXILLARY AND/OR MANDIBULAR TEETH ARE DECAY-FREE, PROPERLY RESTORED, AND PERIODONTICALLY SOUND.
PC72	SUPPLY MORE DETAIL REGARDING PROGRESS (ATTACHMENT OF GOALS, ETC.). CORRELATE PROGRESS TO PREVIOUS GOALS AND IDENTIFIED LIMITATIONS.
PC77	PLEASE SUBMIT A PLAN OF CARE DESCRIBING THE SERVICES THAT WOULD BE PROVIDED.
PC78	PLEASE DOCUMENT SPECIFIC, MEASURABLE GOALS.
PC82	THE PRIOR AUTHORIZATION (PA) SYSTEM CAN PROCESS ONLY 26 DETAILS PER PA REQUEST. PLEASE RESUBMIT YOUR REQUEST WITH NO MORE THAN 26 DETAILS.
PC83	PLEASE SUPPLY A PHYSICIANS PRESCRIPTION DATED WITHIN ONE MONTH OF REQUESTED SUBSTANCE ABUSE DAY TREATMENT.
PC84	PLEASE PROVIDE INFORMATION INDICATING THIS CLIENT IS APPROPRIATELY DETOXIFIED FROM ALCOHOL AND/OR OTHER DRUGS.
PC85	PLEASE PROVIDE INFORMATION TO INDICATE THE CLIENTS ABILITY TO ABSTAIN FROM ALCOHOL OR DRUGS WHILE IN THE SUBSTANCE ABUSE DAY TREATMENT PROGRAM.
PC86	PLEASE INDICATE IF THIS CLIENT IS WILLING TO PARTICIPATE IN AFTERCARE OR CONTINUING CARE SERVICES.
PC87	PROVIDE MORE INFORMATION ON TREATMENT HISTORY; INCLUDE SERVICE PROVIDED, DATES, AND OUTCOME. PROVIDE DETAIL OF PREVIOUS TREATMENT.
PC88	PLEASE PROVIDE MORE RATIONALE FOR THE APPROPRIATENESS AND MEDICAL NECESSITY OF SUBSTANCE ABUSE DAY TREATMENT.
PC89	PROVIDE A TREATMENT PLAN THAT CONTAINS MEASURABLE GOALS AND OBJECTIVES CORRESPONDING TO THE IDENTIFIED DEFICIT.
PC91	PLEASE PROVIDE MORE INFORMATION ON FAMILY INVOLVEMENT TREATMENT.
PC92	PLEASE PROVIDE MORE HISTORY AND EXPLANATION ABOUT THE ISSUE OF ABSTINENCE FOR THIS CLIENT.
PC94	PLEASE PROVIDE THE ANTICIPATED BEGINNING DATE AND/OR THE ESTIMATED SUBSTANCE ABUSE DAY TREATMENT DISCHARGE DATE.
PC95	PLEASE SUPPLY JUSTIFICATION FOR BEGINNING CLIENT IN SERVICE PRIOR TO AUTHORIZATION BEING OBTAINED.
PC96	THE INITIAL THREE HOURS OF SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IN A CALENDAR YEAR DO NOT REQUIRE PRIOR AUTHORIZATION.
PC97	REIMBURSEMENT FOR INITIAL SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IS LIMITED TO THREE HOURS IN A CALENDAR YEAR AND DOES NOT REQUIRE PRIOR AUTHORIZATION.
PC98	THIS DRUG IS CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE BILL USING THE APPROPRIATE NATIONAL DRUG CODE (NDC) OR SUBMIT A COMPLETED DRUG ADDITION REQUEST FORM IF THE NDC IS NOT LISTED IN THE DRUG INDEX.
PC99	THIS DRUG IS NOT CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL, CURRENT ADMINISTRATIVE RULE, OR COLORADO DRUG INDEX FOR COVERAGE LIMITATIONS.
PD01	DOCUMENT THAT CLIENT HAS ACHIEVED GOOD ORAL HYGIENE, PERIODONTAL CASE TYPE 1 OR 2, AND IS MOTIVATED TO MAINTAIN SAME.
PD03	PLEASE PROVIDE AN ARTERIAL BLOOD GAS READING OR PULSE OXIMETRY RESULTS DONE ON ROOM AIR SIGNED AND DATED BY A MEDICAL DOCTOR. THIS SHOULD BE DONE WITHIN 60 DAYS OF REQUESTED SERVICE.
PD04	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 30 DAYS OF RECEIPT BY COLORADO MEDICAID.

Denial Code	Long Description
PD07	SUBMIT A PHOTOCOPY OF A VALID PRESCRIPTION, ISSUED WITHIN THE PAST YEAR, OR COMPLETE SECTION B OF THE PRIOR AUTHORIZATION/DRUG ATTACHMENT (PA/DGA), F-11049.
PD10	BRAND MEDICALLY NECESSARY MUST BE IN THE PRESCRIBERS OWN HANDWRITING AND WRITTEN DIRECTLY ON THE PRESCRIPTION OR A SEPARATE ORDER ATTACHED TO THE ORIGINAL PRESCRIPTION.
PD12	COMPLETE DENTURES, PARTIAL DENTURES, DENTURE RELINES, AND FIXED PROSTHODONTIC SERVICES ARE NOT COVERED SERVICES FOR ADULTS FOR DATES OF SERVICE ON AND AFTER OCTOBER 1, 1995.
PD22	PLEASE COMPLETE ALL REQUIRED ELEMENTS ON THE PERSONAL CARE SCREENING TOOL (PCST), F-11133.
PD24	THIS PRIOR AUTHORIZATION REQUEST IS UNABLE TO BE PROCESSED. PLEASE RESUBMIT WITH ADDITIONAL REQUIRED FORMS, INCLUDING THE ENTIRE PERSONAL CARE SCREENING TOOL (PCST), F-11133; PERSONAL CARE ADDENDUM, F-11136; AND SUPPORTING DOCUMENTATION, AS DIRECTED.
PD25	THERE IS A PERSONAL CARE SCREENING TOOL (PCST), F-11133, COMPLETED BY ANOTHER AGENCY. CONTACT THE AGENCY TO TRANSFER SCREEN.
PD26	THERE IS A LIMITED TERM CARE FUNCTIONAL SCREEN (LTC-FS) COMPLETED BY ANOTHER AGENCY. THE PERSONAL CARE SCREENING TOOL (PCST), F-11133, INFORMATION IS IN CONFLICT WITH LTC-FS.
PD27	ONLY ONE LEVEL OF FUNCTION MAY BE SELECTED FOR ALL ELEMENTS EXCEPT TOILETING. COLORADO MEDICAID IS UNABLE TO PROCESS THE PRIOR AUTHORIZATION REQUEST.
PD28	NO UNITS MAY BE REQUESTED USING THIS PRIOR AUTHORIZATION PROCESS. PLEASE SUBMIT WITH THE APPROPRIATE ATTACHMENTS FOR REQUESTING SPECIFIC PERSONAL CARE WORKER UNITS.
PD29	CLIENT IS NOT ELIGIBLE FOR THE REQUESTED SERVICE(S) AS OF THE REQUESTED START DATE.
PD30	NO TRAVEL TIME MAY BE AUTHORIZED WHEN NO PERSONAL CARE WORKER SERVICE IS AUTHORIZED.
PD32	PROVIDER NOT CERTIFIED TO RENDER THE SERVICE(S) REQUESTED.
PD34	BASED ON THE DOCUMENTATION SUBMITTED, THIS REQUEST CAN NOT BE PRIOR AUTHORIZED. REFER TO THE PA MESSAGES FROM THE CONSULTANT FOR COMPLETE EXPLANATION.
PD98	PLEASE DOCUMENT HOW AND WHEN EACH PREVIOUSLY AUTHORIZED PRO RE NATA VISIT WAS USED.

Second Surgical Opinion

Denial Code	Long Description
0201	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
0233	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0235	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0237	CLIENT IDENTIFICATION NUMBER DOES NOT MATCH CLIENTS FIRST NAME.
0238	THE CLIENT IDENTIFICATION NUMBER DOES NOT MATCH THE CLIENTS LAST NAME.
0242	SECONDARY DIAGNOSIS CODE IS INVALID.
0248	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0249	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0251	PROCEDURE CODE MODIFIER IN FIRST POSITION IS INVALID.
0252	THE PROCEDURE CODE MODIFIER IN SECOND POSITION IS INVALID FOR REQUESTED START DATE OR DATE OF RECEIPT.
0253	THE PROCEDURE CODE MODIFIER IN THIRD POSITION IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
0258	THE PRIMARY DIAGNOSIS CODE IS REQUIRED.
0272	THE PRIMARY DIAGNSOSIS CODE IS INVALID.
0400	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0853	HCPCS - ANNUAL UPDATE
0885	NEVER EVENTS MODIFIERS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.

Denial Code	Long Description
0886	NEVER EVENTS DIAGNOSIS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
1000	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
1002	RENDERING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1003	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1007	RENDERING PROVIDER ID IS NOT ON FILE.
1047	THE RENDERING PROVIDERS CERTIFICATION HAS BEEN CANCELLED.
1048	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1801	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
1804	A CERTIFIED SUBSTANCE ABUSE DAY TREATMENT PROVIDER MUST SUBMIT A SUBSTANCE ABUSE DAY TREATMENT PROCEDURE CODE.
1806	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
1808	THE BILLING PROVIDER DOES NOT HAVE THE REQUIRED CERTIFICATION ADDENDUM ON FILE.
1900	THE BILLING PROVIDERS TAXONOMY CODE IS INVALID.
1901	THE RENDERING PROVIDERS TAXONOMY CODE IS INVALID.
1927	A NATIONAL PROVIDER IDENTIFIER IS REQUIRED FOR THE BILLING PROVIDER.
1934	A NATIONAL PROVIDER INDENTIFIER IS REQUIRED FOR THE RENDERING PROVIDER.
1936	THE BILLING PROVIDER NUMBER IS INVALID.
1937	THE RENDERING PROVIDER NUMBER IS INVALID.
1960	INTERNAL PROCESSING IS REQUIRED.
1963	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.
1964	THE BILLING PROVIDER INDICATED IS NOT ALLOWABLE AS A BILLING PROVIDER.
1965	RENDERING PROVIDER NUMBER IS MISSING/INVALID FOR THIS PROCEDURE PROVIDER.
1974	PRESCRIBING/REFERRING/ORDERING PROVIDER INDICATED IS NOT CERTIFIED AS A PRESCRIBING/REFERRING/ORDERING PROVIDER.
1975	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
1976	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
2001	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2003	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2017	THE CLIENT IS ENROLLED IN A MEDICAID OR OTHER MANAGED CARE PROGRAM.
2037	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2603	CLIENT LOCKED-IN TO A PROVIDER OR ENROLLED IN A HOSPICE. CONTACT CLIENTS HOSPICE FOR PAYMENT OF SERVICES OR RESUBMIT WITH DOCUMENTATION OF UNRELATED NATURE OF CARE.
3324	THE MODIFIER HAS BEEN DISCONTINUED BY THE CENTERS OF MEDICARE AND MEDICAID SERVICES OR THE AMERICAN MEDICAL ASSOCIATION FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
3337	THE PROCEDURE CODE HAS BEEN TERMINATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AMERICAN MEDICAL ASSOCIATION, OR AMERICAN DENTAL ASSOCIATION FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT. RESUBMIT WITH VALID A PROCEDURE CODE.
3339	THE PROCEDURE BILLED IS NOT PAYABLE ACCORDING TO DEFICIT REDUCTION ACT (DEFRA) GUIDELINES.
3351	THE PROCEDURE IS NOT COVERED FOR CLIENTS WITH A NURSING HOME AUTHORIZATION ON THE REQUESTED START DATE OR DATE OF RECEIPT.
3353	THE PROCEDURE IS NOT A COVERED SERVICE FOR HOME AND COMMUNITY-BASED WAIVER CLIENTS.
4021	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4027	THE DIAGNOSIS CODE IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
4031	THE PROCEDURE SUBMITTED IS NOT APPROPRIATE FOR CLIENTS GENDER.
4032	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4034	THE PROCEDURE CODE HAS AN AGE RESTRICTION.
4036	THE PLACE OF SERVICE CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4040	THE PRIMARY DIAGNOSIS CODE IS NOT ON FILE.
4041	THE SECONDARY DIAGNOSIS IS NOT ON FILE.
4046	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4127	INTERNAL PROCESSING IS REQUIRED.
4131	INTERNAL PROCESSING IS REQUIRED.

Denial Code	Long Description
4141	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4149	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4150	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4236	ETIOLOGY DIAGNOSIS CODE(S) (E-CODES) ARE INVALID AS THE PRIMARY DIAGNOSIS.
4244	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4245	THE FOURTH POSITION MODIFIER IS INVALID FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT.
4256	THE PROCEDURE CODE AND MODIFIER COMBINATION IS NOT PAYABLE FOR THE CLIENTS BENEFIT PLAN.
4257	THE MODIFIERS SUBMITTED ARE EITHER INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT OR THE MODIFIERS ARE MISSING.
4311	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4315	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4316	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4371	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4372	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4711	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR CLIENTS AGE.
4714	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS AGE.
4731	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS DIAGNOSIS.
4742	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4743	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4744	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4745	DIAGNOSIS AND/OR PROCEDURE AND/OR PLACE OF SERVICE (POS) CODE IS NOT COVERED FOR EXPRESS ENROLLMENT CLIENTS.
4746	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4801	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4802	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
4821	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
4871	PLEASE REFER TO PA MESSAGES FOR RETURN INFORMATION.
4963	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS GENDER.
4990	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
7500	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
7509	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
P001	THE BILLING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THE SERVICES.
P002	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P003	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P005	THE PRIOR AUTHORIZATION CAN NOT BE END DATED. THE PRIOR AUTHORIZATION STATUS IS NOT APPROVED OR APPROVED WITH REVISIONS.
P006	PLEASE FURNISH THE PROCEDURE CODE AND CORRESPONDING DESCRIPTION.
P008	THE BILLING PROVIDER NUMBER IS INVALID.
P009	THE BILLING PROVIDER NUMBER IS INVALID.
P010	THE REQUESTED END DATE IS INVALID.
P011	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P012	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P013	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P014	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P015	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.

Denial Code	Long Description
P016	THE REQUESTED START DATE IS MISSING OR INVALID.
P019	THE REQUESTED START DATE IS MISSING OR INVALID.
P020	THE RENDERING PROVIDER NUMBER IS INVALID.
P021	THE RENDERING PROVIDER NUMBER IS INVALID.
P022	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P023	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P024	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P026	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P027	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P030	FIRST MODIFIER IS INVALID.
P031	FIRST MODIFIER IS INVALID.
P032	SECOND MODIFIER IS INVALID.
P033	SECOND MODIFIER IS INVALID.
P034	THIRD MODIFIER IS INVALID.
P035	THIRD MODIFIER IS INVALID.
P036	FOURTH MODIFIER IS INVALID.
P037	FOURTH MODIFIER IS INVALID.
P038	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P039	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P040	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P041	CLIENTS FIRST NAME IS MISSING.
P042	CLIENTS LAST NAME IS MISSING.
P043	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P044	BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES REQUESTED.
P045	FIRST MODIFIER IS INVALID.
P046	SECOND MODIFIER IS INVALID.
P047	THIRD MODIFIER IS INVALID.
P048	FOURTH MODIFIER IS INVALID.
P052	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P053	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P054	RENDERING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES FOR THE BENEFIT PLAN.
P055	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P061	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P062	THE CLIENT ID AND/OR NAME INDICATED ON THE PA REQUEST IS INCORRECT. THE CLIENT ID AND/OR NAME HAS BEEN UPDATED. PLEASE VERIFY THE ID AND/OR NAME IS CORRECT.
P064	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
P067	THE FREQUENCY OF HOURS REQUESTED ARE NOT APPROPRIATE FOR THIS CLIENT AND HAVE BEEN MODIFIED ACCORDINGLY.
P079	BILLING PROVIDER IS ON PAYMENT SUSPENSION DUE TO CREDIBLE ALLEGATION OF FRAUD.
P120	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAS BEEN REDUCED.
P121	THE SERVICE/ PROCEDURE REQUESTED IS NOT SUPPORTED BY SUBMITTED DOCUMENTATION.
P126	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
P128	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.
P138	SERVICE(S) DO NOT MEET COLORADO MEDICAID GUIDELINES.
P167	REQUESTED DOCUMENTATION HAS NOT BEEN SUBMITTED.
P178	THE SERVICE REQUESTED IS NOT MEDICALLY NECESSARY.
P179	THE MEDICAL NECESSITY FOR THIS SERVICE IS NOT SUPPORTED BY THE SUBMITTED DOCUMENTATION.

Denial Code	Long Description
P233	THE DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE ADDITIONAL CARE.
P257	THIS CLIENTS FUNCTIONAL ASSESSMENT SCORES PLACE THIS CLIENT OUTSIDE ELIGIBILITY FOR DAY TREATMENT.
P274	OUR RECORDS INDICATE THIS CLIENT IS INVOLVED IN EFFECTIVE AND APPROPRIATE SERVICE ELSEWHERE.
P292	INTENSIVE REHABILITATION HOURS ARE NO LONGER APPROPRIATE AS INDICATED BY HISTORY, DIAGNOSIS, AND/ OR FUNCTIONAL ASSESSMENT SCORES.
P328	THE SERVICES REQUESTED INCLUDE NON-COVERED SERVICES, AND HOURS ARE REDUCED ACCORDINGLY.
P339	THE CLIENTS PAST HISTORY INDICATES REDUCED TREATMENT HOURS ARE WARRANTED.
P342	THE REQUEST DOES NOT MEET GENERALLY ACCEPTED CONDITIONS REQUIRING FLUORIDE TREATMENTS.
P346	SERVICES EXCEED COLORADO MEDICAID LIMITATION AND DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE MEDICAL NECESSITY OF THE SERVICE.
P349	THE SERVICE REQUESTED WAS PERFORMED LESS THAN FIVE YEARS AGO.
P353	THE EXISTING APPLIANCE HAS NOT BEEN WORN FOR THREE YEARS.
P367	THE CLIENT HAS BEEN TOTALLY WITHOUT TEETH AND AN APPLIANCE FOR FIVE YEARS.
P392	THE CLIENT IS MISSING AN ANTERIOR TOOTH AND/OR HAS TWO OR MORE POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P405	THE SERVICE(S) REQUESTED COULD ADEQUATELY BE PERFORMED IN THE DENTAL OFFICE.
P406	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE OF GOOD PERIODONTAL HEALTH (AMERICAN ACADEMY OF PERIODONTOLOGY PERIODONTAL CLASSIFICATION OF TYPE I OR II).
P407	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE VISIBLE ON RADIOGRAPHS THAT AT LEAST 50 PERCENT OF THE CLINICAL CROWN IS INTACT.
P409	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING SIX OR MORE TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED, INCLUDING THIRD MOLARS.
P410	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING ONE OR MORE ANTERIOR TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED.
P411	DOCUMENTATION DOES NOT SUPPORT THE NEED FOR PERIODONTIC SERVICES. POCKETS ARE LESS THAN 4MM AND/OR GREATER THAN 6MM FOR CLIENT AND/OR THE CLIENT IS UNDER THE AGE OF 13.
P412	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA.
P413	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA. THIS PA HAS BEEN GRANTED AS APPROVED NOT APPROVED WITH REVISIONS. THE DURATION REQUESTED MAY HAVE BEEN REDUCED TO REFLECT COVERAGE LIMITATIONS, PRESCRIBER ORDERS, CONFLICTI
P417	THE SERVICE(S) REQUESTED COULD BE ADEQUATELY PERFORMED WITH LOCAL ANESTHESIA.
P437	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO POOR ORAL HYGIENE.
P444	THIS LINE ITEM IS A DUPLICATE OF ANOTHER LINE ITEM ON THIS PRIOR AUTHORIZATION (PA) REQUEST. PLEASE CORRECT.
P446	THIS IS A DUPLICATE OF AN EXISTING PRIOR AUTHORIZATION (PA) REQUEST. YOU MAY CONTACT PROVIDER SERVICES IF YOU REQUIRE ASSISTANCE. DUPLICATE PA REQUEST
P448	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO DECAY HISTORY.
P449	QUESTIONABLE LONG TERM PROGNOSIS DUE TO GUM AND BONE DISEASE.
P456	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO APPARENT ROOT INFECTION.
P457	OUR RECORDS INDICATE THIS CLIENT HAS EXCEEDED ESTABLISHED PROGRAM LIMITATIONS. COLORADO MEDICAID WILL NOT AUTHORIZE NEW DENTURES.
P458	DOCUMENTATION PROVIDED INDICATES A LESS ELABORATE PROCEDURE SHOULD BE CONSIDERED.
P502	RENTAL ONLY ALLOWED; MEDICAL NEED FOR PURCHASE HAS NOT BEEN DOCUMENTED.
P503	PURCHASE ONLY ALLOWED; MEDICAL NEED FOR RENTAL HAS NOT BEEN DOCUMENTED.
P504	OCCUPATIONAL THERAPY GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P505	THE SERVICE REQUESTED IS INCLUDED IN THE NURSING HOME RATE STRUCTURE.
P511	THIS NATIONAL DRUG CODE IS ONLY BILLABLE AS PART OF A COMPOUND DRUG.
P515	THE PRESENCE OF A HANDICAPPING MALOCCLUSION OR HANDICAPPING DENTOFACIAL DEFORMITY IS NOT SUPPORTED BY THE DOCUMENTATION SUBMITTED.
P521	THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVERED BY COLORADO MEDICAID.

Denial Code	Long Description
P522	GASTRO-INTESTINAL SURGERY FOR THE PURPOSE OF WEIGHT CONTROL IS COVERED ONLY AS A LIFE THREATENING PROCEDURE.
P523	THE TREATMENT REQUEST IS NOT CONSISTENT WITH THE CLIENT'S DIAGNOSIS.
P524	PSYCHOTHERAPY PROVIDED IN THE CLIENTS HOME IS NOT A COVERED BENEFIT OF COLORADO MEDICAID.
P525	THE INFORMATION PROVIDED IS NOT CONSISTENT WITH THE INTENSITY OF SERVICES REQUESTED.
P526	INTENSIVE MULTIPLE MODALITY TREATMENT IS NOT CONSISTENT WITH THE INFORMATION PROVIDED.
P527	MULTIPLE PROVIDERS OF TREATMENT ARE NOT INDICATED FOR THIS CLIENT.
P528	THE DURATION OF TREATMENT SESSIONS EXCEED CURRENT COLORADO MEDICAID GUIDELINES.
P534	DOCUMENTATION OF POOR PHYSICAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P535	OTHER PHYSICAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P536	THE PHYSICAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P537	USE OF PHYSICAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P538	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF A PHYSICAL THERAPIST.
P539	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS AND LIVING ARRANGEMENT.
P540	GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P541	THE PROCEDURE(S) REQUESTED ARE NOT MEDICAL IN NATURE.
P542	DOCUMENTATION OF POOR OCCUPATIONAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P543	DOCUMENTATION OF POOR SPEECH THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P544	OTHER OCCUPATIONAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P546	THE OCCUPATIONAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P547	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF PHYSICAL THERAPY.
P548	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P549	ACTIVITIES TO PROMOTE DIVERSION OR GENERAL MOTIVATION ARE NONCOVERED COLORADO MEDICAID SERVICES.
P550	REVISIONS OF THE REQUEST IS NECESSITATED BY THE CLIENTS MINIMAL PROGRESS.
P551	RESTORATIVE NURSING INVOLVEMENT COULD BE INCREASED.
P552	CLIENTS DEMONSTRATED RESPONSE TO CURRENT THERAPY DOES NOT WARRANT THE INTENSE FREQUENCY REQUESTED.
P553	MAINTENANCE IS TWO TIMES PER WEEK OR LESS.
P554	THE SPEECH THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P555	USE OF OCCUPATIONAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P556	USE OF SPEECH THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P557	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF AN OCCUPATIONAL THERAPIST.
P558	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
P559	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P560	THE MATERIALS/ SERVICES REQUESTED ARE PRINCIPALLY COSMETIC IN NATURE.
P561	THE LENS FORMULA DOES NOT JUSTIFY REPLACEMENT.
P562	THE CHANGE IN THE LENS FORMULA DOES NOT WARRANT MULTIPLE REPLACEMENTS.
P563	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P564	LENSES ONLY ARE APPROVED; PLEASE DISPENSE A CONTRACTED FRAME. THE NON-CONTRACTED FRAME IS NOT MEDICALLY JUSTIFIED.
P565	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.

Denial Code	Long Description
P566	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P567	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF OCCUPATIONAL THERAPY.
P568	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF SPEECH THERAPY.
P569	LEVEL, INTENSITY, OR EXTENT OF SERVICE(S) REQUESTED HAS BEEN MODIFIED CONSISTENT WITH MEDICAL NEED AS DEFINED IN THE PLAN OF CARE.
P570	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P571	THE SERVICE ASKED FOR IS NOT COVERED BY COLORADO MEDICAID AS THESE TASKS CAN BE DONE BY NURSES OR ACTIVITY STAFF.
P572	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P573	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.
P574	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P575	MEDICAL NEED FOR EQUIPMENT/ SUPPLY REQUESTED IS NOT SUPPORTED BY DOCUMENTATION SUBMITTED.
P576	OTHER SPEECH THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P577	DOCUMENTATION SUBMITTED IDENTIFIES THAT THE CLIENT HAS FEWER THAN TWO POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P582	LESS EXPENSIVE ALTERNATIVE SERVICES ARE AVAILABLE FOR THIS CLIENT.
P634	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P711	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING PERIODONTAL SCALING AND ROOT PLANNING.
P712	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING GINGIVECTOMY.
P754	AN APPROVED SUBSTANCE ABUSE DAY TREATMENT PROGRAM CANNOT EXCEED A SIX WEEK PERIOD.
P761	THE CLIENT DOES NOT APPEAR TO BE ABLE OR WILLING TO ABSTAIN FROM ALCOHOL/DRUG USAGE WHILE IN TREATMENT. THEREFORE, SUBSTANCE ABUSE DAY TREATMENT SERVICES ARE NOT APPROVED.
P764	THIS CLIENT HAS COMPLETED INTENSIVE SUBSTANCE ABUSE TREATMENT WITHIN THE PAST 12 MONTHS. THE DOCUMENTATION PROVIDED IS NOT ADEQUATE TO JUSTIFY ADDITIONAL INTENSIVE TREATMENT AT THIS TIME.
P785	A LESS THAN SIX-WEEK HEALING PERIOD HAS BEEN SPECIFIED FOR THIS PRIOR AUTHORIZATION. THEREFORE IT IS NOT NECESSARY TO WAIT THE FULL SIX WEEKS AFTER EXTRACTIONS BEFORE TAKING DENTURE IMPRESSIONS.
P818	SIX-WEEK HEALING TIME IS REQUIRED BETWEEN EDENTULATION AND FINAL IMPRESSIONS. PAYMENT FOR DENTURES WILL BE DENIED OR RECOUPED IF HEALING PERIOD IS NOT OBSERVED.
P849	COLORADO MEDICAID HAS DETERMINED THERE WERE (ARE) SEVERAL HOME HEALTH AGENCIES WILLING TO PROVIDE MEDICALLY NECESSARY SKILLED NURSING SERVICES TO THIS CLIENT.
P864	THE DOCUMENTATION YOU HAVE SUBMITTED DOES NOT MEET THE REQUIREMENTS OF COLORADO MEDICAID.
P873	THE MEDICAL NECESSITY FOR THE HOURS REQUESTED IS NOT SUPPORTED BY THE INFORMATION SUBMITTED.
P874	THE DOCUMENTATION SUBMITTED INDICATES THE TASKS SPECIFIED CAN BE COMPLETED DURING THE VISITS APPROVED.
P878	THE DOCUMENTATION SUBMITTED DOES NOT INDICATE THAT MEDICALLY ORIENTED TASKS ARE MEDICALLY NECESSARY; THEREFORE PERSONAL CARE SERVICES HAVE BEEN APPROVED.
P880	THE QUANTITY OF SERVICES AUTHORIZED FOR THIS CLIENTS PERSONAL CARE HAS BEEN AMENDED BASED ON INFORMATION RECEIVED FROM ONE OR MORE OF THESE SOURCES: THE CLIENT, THEIR PHYSICIAN, AND/OR THE IN-HOME VISIT BY STAFF OF THE OIG (OFFICE OF INSPECTOR GENERAL).
P885	THE USE OF THIS DRUG FOR THE INTENDED PURPOSE IS NOT COVERED BY COLORADO MEDICAID, CONSISTENT WITH COLORADO ADMINISTRATIVE CODE AND FEDERAL LAW.

Denial Code	Long Description
P924	THE MEDICAL RECORDS SUBMITTED WITH THE CURRENT REQUEST CONFLICT OR DISAGREE WITH OUR MEDICAL RECORDS ON THIS CLIENT.
P950	INDEPENDENT NURSES, PLEASE NOTE PAYABLE SERVICES MAY NOT EXCEED 12 HOURS/DAY OR 60 HOURS/WEEK.
P951	SERVICES CAN ONLY BE AUTHORIZED THROUGH ONE YEAR FROM THE PRESCRIPTION DATE.
P952	LEAD INSPECTION IS A COVERED COLORADO MEDICAID SERVICE WHEN THE CHILD HAS BEEN SHOWN TO HAVE LEAD POISONING (E.G., CHILD HAS A BLOOD LEAD LEVEL > 19 UG/DL OR TWO CONSECUTIVE BLOOD LEAD LEVELS OF 15-19 UG/DL DONE AT LEAST 90 DAYS APART). THE INSPECTION MUS
P953	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P954	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P956	THE REQUEST CAN ONLY BE BACKDATED A MAXIMUM OF 14 DAYS FROM FIRST DATE RECEIVED BY COLORADO MEDICAID.
P957	COMPLETE PERIODONTAL CHARTING AT TIME OF SERVICE, AND SUBMIT CHARTING, COPY OF OPERATIVE REPORT, TOGETHER WITH A COPY OF THE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF), F-11035, TO PA UNIT ATTENTION DENTAL CONTSULTANT.
P958	NOTE THAT CODE D4341 HAS BEEN CHANGED. REFER TO THE DECISION NOTICE FOR AUTHORIZED QUANTITY.
P960	YOUR PA HAS BEEN APPROVED FOR 90 DAYS. THE 90 DAY APPROVAL DOES NOT IMPLY THE PA REQUEST MEETS PRIOR AUTHORIZATION CRITERIA. AFTER ADDITIONAL INFORMATION IS AVAILABLE IN INTERCHANGE, COLORADO MEDICAID WILL CREATE AN AMENDMENT REQUEST TO EXTEND THE PA FOR
P961	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P962	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
PA10	THE REQUESTED END DATE IS INVALID.
PA12	PLEASE FURNISH A WRITTEN DESCRIPTION OF THE CLIENTS DIAGNOSIS.
PA13	PROVIDE DIAGNOSES WITH DATES OF ONSET.
PA14	IDENTIFY PROBLEMS TO BE TREATED.
PA15	THE AUDIOLOGISTS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1), F-11020, AND PRIOR AUTHORIZATION REQUEST/HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2), F-11021.
PA16	THE PHYSICIANS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION/PHYSICIAN OTOLOGICAL REPORT (PA/POR), F-11019.
PA17	SUBMIT BRIEF HISTORY WITH REFERRAL INFORMATION, LIVING SITUATION, FUNCTIONAL STATUS, AND OTHER PERTINENT INFORMATION. WHAT CHANGE OF STATUS RESULTED IN REFERRAL AT THIS TIME?
PA18	PLEASE FURNISH THE CLIENTS HEIGHT AND WEIGHT.
PA19	PLEASE SUBMIT CLINICAL INFORMATION SUFFICIENT TO VERIFY THE NEED FOR THE REQUESTED SERVICE(S).
PA20	PLEASE RESUBMIT WITH COMPLETE PERIODONTAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PA21	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL EDUCATIONAL PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA22	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL PROGRAM PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA23	REFER TO THE DURABLE MEDICAL EQUIPMENT INDEX FOR APPROPRIATE CODE AND DESCRIPTION. DO NOT USE AN "UNLISTED" CODE.
PA24	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUALIZED FAMILY SERVICE PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA25	INFORMATION ON THE REQUEST FORM IS ILLEGIBLE, AND THE REQUEST CANNOT BE PROCESSED.
PA26	RE-EVALUATE YOUR GOALS. EMPHASIS SHOULD BE ON FUNCTIONAL SELF-CARE. GOALS MUST BE RELATED TO FUNCTIONAL OUTCOME.

Denial Code	Long Description
PA27	PLEASE CLARIFY THE NUMBER OF HOURS PER WEEK REQUESTED.
PA28	PLEASE CLARIFY THE NUMBER OF HOURS PER DAY REQUESTED.
PA29	PLEASE CLARIFY THE NUMBER OF VISITS PER DAY REQUESTED.
PA30	ATTACH SUPPORTIVE DOCUMENTATION; HOME EXERCISE PROGRAM AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA31	THE DIAGNOSIS CODE INDICATED ON THE REQUEST DOES NOT CORRESPOND TO THE DIAGNOSIS CODE DESCRIPTION.
PA32	PLEASE SUBMIT ADDITIONAL INFORMATION SUFFICIENT TO VERIFY APPROPRIATENESS AND NEED FOR TRANSPLANT.
PA33	PLEASE SUBMIT THE INITIAL AND PROGRESSIVE OBJECTIVE FINDINGS.
PA34	ATTACH SUPPORTIVE DOCUMENTATION, FACILITY PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA35	PLEASE SUBMIT THE CLIENTS ORIGINAL COMPLAINTS AND EXAMINATION FINDINGS.
PA36	ATTACH SUPPORTIVE DOCUMENTATION, IN-HOME AUTISM PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA37	PLEASE SUBMIT YOUR TREATMENT PLAN FOR THIS CLIENT.
PA38	ATTACH SUPPORTIVE DOCUMENTATION AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA39	INITIAL EVALUATIONS MUST BE PERFORMED BY AN OCCUPATIONAL THERAPIST REGISTERED (OTR), PER AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA) STANDARDS.
PA41	IDENTIFY THE PLACE OF SERVICE AND ITS EFFECT ON SUPPORTING THE DESIRED TREATMENT OUTCOME.
PA42	PLEASE INDICATE THE HOURS OF USE OF OXYGEN PER 24-HOUR PERIOD.
PA43	PROVIDE BASELINE DOCUMENTATION FOR THIS CLIENTS LIMITATIONS USING UNITS OF MEASUREMENT THAT ARE APPLIED CONSISTENTLY WHEN REPORTING STATUS.
PA44	IDENTIFY FUNCTIONAL LIMITATIONS AS THEY ARE RELATED TO IDENTIFIED CONDITIONS.
PA46	CORRELATE PLAN OF CARE TO REQUESTED PROCEDURE CODES.
PA47	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE FREQUENCY/DURATION REQUESTED.
PA48	PLEASE PROVIDE THE NAME AND CREDENTIALS OF THE RENDERING PROVIDER.
PA50	COLORADO MEDICAID RECORDS INDICATE THE CLIENT OWNS A WHEELCHAIR. DOCUMENT THE REASON AND NEED FOR REPLACEMENT AND COST TO REPAIR CURRENT WHEELCHAIR.
PA51	PLEASE DISTINGUISH PRIMARY AND SUPPORTIVE MODALITIES.
PA52	PLEASE SUBMIT A PROGRESS REPORT.
PA53	MULTIPLE FAMILY CLIENTS TREATMENT BY THE SAME PROVIDER REQUIRES FURTHER INFORMATION DOCUMENTING COORDINATION OF TREATMENT PLAN.
PA54	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE MINUTES REQUESTED.
PA55	MEDICAL NECESSITY OF TREATMENT REQUIRES ADDITIONAL DOCUMENTATION.
PA56	GIVEN AGE, DIAGNOSES, CURRENT LEVEL OF FUNCTION, PAST RESPONSE TO TREATMENT, AND LIVING SITUATION, EXPAND ON POTENTIAL FOR SIGNIFICANT FUNCTIONAL PROGRESS WITHIN THE NEXT SIX MONTHS. EMPHASIZE WHY PROGRESS IS EXPECTED WITH SERVICES AT THIS TIME.
PA57	SUBMIT THE INITIAL FINDINGS. INCLUDE A COMPREHENSIVE EVALUATION.
PA58	SUBMIT PROGRESSIVE, OBJECTIVE FINDINGS. INCLUDE A PERTINENT RE-EVALUATION.
PA59	PLEASE SUPPLY INFORMATION REGARDING THE CLIENTS MEDICATION REQUIREMENTS, IF ANY.
PA60	PLEASE SPECIFY IF THE CLIENT IS IN AN EDUCATIONAL SETTING.
PA61	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA62	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
PA63	THE SKILLS OF A THERAPIST ARE PURPOSEFUL AND SKILLED INTERVENTIONS REQUIRED TO CONTINUALLY DESIGN, IMPLEMENT, REASSESS, MODIFY/GRADE, AND/OR DISCONTINUE A PLAN OF CARE IN A TIMELY MANNER, BASED ON THE COMPLEXITY OF THE CLIENTS MEDICAL CONDITION AND/OR CO
PA64	PLEASE SUBMIT A THERAPY PLAN OF CARE, INCLUDING A CURRENT, DATED EVALUATION.
PA65	A PLAN OF CARE SIGNED AND DATED BY THE PHYSICIAN IS REQUIRED.

Denial Code	Long Description
PA66	THE SKILLS OF A THERAPIST ARE REQUIRED WHEN ONLY THE THERAPIST CAN SAFELY AND EFFECTIVELY DELIVER THE THERAPEUTIC PROCEDURES BECAUSE OF THEIR UNIQUE KNOWLEDGE, TRAINING, AND EXPERTISE. DESCRIBE THE REASON THAT SOMEONE OTHER THAN A THERAPIST CANNOT SAFELY
PA67	PLEASE SPECIFY IF THE CLIENTS WORK SITE DEMANDS GOOD BINAURAL HEARING.
PA68	DESCRIBE THE REASON, BASED ON THE CLIENTS COGNITIVE, PHYSICAL, COMMUNICATION, OR RESOURCE STATUS, THAT A HOME PROGRAM, EQUIPMENT, OR ENVIRONMENTAL ADAPTATIONS ALONE CANNOT MEET CLIENTS NEEDS.
PA69	PLEASE SPECIFY IF THE CLIENT HAS AN ACCOMPANYING DISABILITY THAT ADDS TO THE HEARING PROBLEM.
PA70	DISTINGUISH REQUESTED PROCEDURES AND GOALS FROM OTHER SERVICES THIS CLIENT RECEIVES. THEY MAY NOT BE DUPLICATIVE.
PA71	PLEASE INDICATE THE NUMBER OF DAYS REQUESTED.
PA73	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA74	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA75	PLEASE DOCUMENT CARRYOVER OF THE THERAPY PROGRAM TO NURSING.
PA76	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA79	PROVIDE EVIDENCE OF SIGNIFICANT FUNCTIONAL PROGRESS IN LAST SIX MONTHS.
PA84	THE GRANT DATE OF THIS REQUEST CANNOT BE PRIOR TO THE SIGNATURE DATE OF THE PRESCRIBING PHYSICIAN.
PA86	PROVIDE EVIDENCE OF SKILLS GAINED IN THERAPY CARRYING OVER TO OTHER SETTINGS WITHIN SIX MONTHS.
PA87	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE NUMBER OF SESSIONS REQUESTED.
PA88	THE REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL SCOPE OF PRACTICE.
PA89	PRIOR AUTHORIZATION IS NOT REQUIRED UNTIL LIMITATION OF SERVICE HAS BEEN REACHED.
PA91	PLEASE SUBMIT REQUIRED X-RAYS.
PA92	PLEASE PROVIDE AN EXPLANATION FOR THE MATERIAL SUBMITTED WITH THE REQUEST.
PA95	PLEASE DESCRIBE HOW THE PROVISION OF THIS SERVICE WOULD PREVENT INSTITUTIONALIZATION OF THE CLIENT.
PA96	COULD THE EXISTING DENTURE(S) BE RELINED OR REBASED? IF NOT, PLEASE EXPLAIN WHY NOT.
PA97	REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL STANDARDS OF PRACTICE.
PA98	PLEASE INDICATE IF THE CLIENT IS CURRENTLY BEING TUBE FED.
PB02	PLEASE PROVIDE THE REQUIRED DATED SIGNATURES ON THE ATTACHMENTS.
PB03	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING THE LOSS/DESTRUCTION/THEFT OF THE HEARING AID.
PB04	DESCRIBE THE CLIENTS ABILITY TO STAND OR AMBULATE SUFFICIENTLY TO ACCOMPLISH SELF-CARE ACTIVITIES.
PB07	PLEASE SUBMIT AN ORTHODONTIC STUDY MODEL OR DIAGNOSTIC CASTS.
PB09	PLEASE PROVIDE A PHOTOGRAPH OF THE INVOLVED AREA(S).
PB10	PLEASE PROVIDE AN ESTIMATION (IN GRAMS) OF THE TOTAL AMOUNT OF TISSUE TO BE RESECTED.
PB11	PLEASE SUBMIT THE PLAN OF CARE FOR CO-TREATMENT.
PB12	FURNISH A DETAILED DESCRIPTION FOR THE PROCEDURE CODE REQUESTED.
PB13	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB15	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB18	PLEASE COMPLETE THE ATTACHED OUT-OF-STATE PROVIDER DATA SHEET, F-11001, AND RESUBMIT.
PB20	A SIGNED AND DATED PRESCRIPTION IS REQUIRED WITHIN THREE MONTHS OF RECEIPT BY COLORADO MEDICAID FOR INITIAL REQUESTS AND WITHIN 12 MONTHS OF RECEIPT BY COLORADO MEDICAID FOR SUBSEQUENT REQUESTS.
PB21	PLEASE COMPLETE THE APPROPRIATE PRIOR AUTHORIZATION ATTACHMENT. CONTACT PROVIDER SERVICES OR THE PRIOR AUTHORIZATION UNIT FOR ASSISTANCE.
PB23	PHYSICAL THERAPY ASSISTANT NOTES AND ALL FORMS SUBMITTED MUST BE COSIGNED BY A REGISTERED PHYSICAL THERAPIST.

Denial Code	Long Description
PB31	ARE YOU REQUESTING A COMPLETE APPLIANCE, OR REPLACEMENT PARTS?
PB32	THE PROCEDURE CODE INDICATED ON THE REQUEST DOES NOT MATCH THE DESCRIPTION OF SERVICE; PLEASE CORRECT AND RESUBMIT.
PB35	THE SERVICE REQUESTED DOES NOT REQUIRE PRIOR AUTHORIZATION.
PB41	PLEASE FURNISH A CURRENT MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT, F-11090 (DATED WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID).
PB45	THE CERTIFICATION PERIOD ON THE PLAN OF CARE (POC) DOES NOT COVER THE REQUESTED GRANT/START DATE. PLEASE RESUBMIT YOUR REQUEST WITH A NEW POC.
PB49	A CERTIFIED OCCUPATIONAL THERAPY ASSISTANTS NOTES MUST BE COSIGNED BY AN OCCUPATIONAL THERAPIST REGISTERED.
PB51	ADDITIONAL INFORMATION IS REQUIRED ON PRIOR AUTHORIZATION TO ENABLE PRICING.
PB54	REQUESTED SERVICES DO NOT MATCH SERVICES ON THE PHYSICIANS ORDERS.
PB59	PLEASE PROVIDE AN INDIVIDUAL EDUCATIONAL PLAN (IEP), WHICH HAS BEEN SIGNED BY THE PROVIDER NO EARLIER THAN NINE MONTHS PRIOR TO RECEIPT AT COLORADO MEDICAID; OTHERWISE, DOCUMENT WHY NO IEP EXISTS.
PB65	PLEASE FURNISH THE ANTICIPATED TOTAL CHARGES FOR THIS REQUEST.
PB66	A PHOTOCOPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED; THE DATE MUST BE WITHIN SIX MONTHS OF RECEIPT BY COLORADO MEDICAID.
PB67	THE PRESCRIPTION DATE MUST INCLUDE MONTH, DAY, AND YEAR.
PB68	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID.
PB73	THE SERVICES IDENTIFIED ON THE PLAN OF CARE DO NOT APPEAR APPROPRIATE FOR THE PROCEDURE CODE(S) REQUESTED ON THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018.
PB74	THE CLIENT/PROVIDER DOES NOT HAVE RETROACTIVE ENROLLMENT.
PB75	THE REQUESTED START DATE IS MORE THAN 14 DAYS BEFORE OR 62 DAYS AFTER RECEIPT.
PB82	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
PB83	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A HOME HEALTH AIDE. PLEASE RESUBMIT AS A PERSONAL CARE WORKER OR PROVIDE ADDITIONAL DOCUMENTATION.
PB86	THE SERVICES REQUESTED ARE NOT BEING PROVIDED IN THE CLIENTS RESIDENCE. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL.
PB87	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A NURSE. PLEASE RESUBMIT AS A HOME HEALTH AIDE OR PROVIDE ADDITIONAL DOCUMENTATION.
PB92	PLEASE FURNISH THE CLIENTS COMPLETE ADDRESS.
PB94	IF THE CLIENT IS A RESIDENT OF A NURSING HOME, SUPPLY THE COMPLETE NAME AND ADDRESS OF THE NURSING HOME.
PB99	THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018, MUST BE SIGNED AND DATED.
PC01	PLEASE SUPPLY THE RENDERING PROVIDERS PROVIDER NUMBER.
PC03	THE DRUG ENFORCEMENT ADMINISTRATION NUMBER IS MISSING OR INVALID.
PC06	PLEASE DESCRIBE YOUR PROGRAM; INCLUDE ENTRY DATE, TERMINATION DATE, HOURS PER WEEK, AND NUMBER OF WEEKS OF PRIMARY INTENSIVE SERVICE REQUESTED.
PC07	PLEASE DESCRIBE YOUR "AFTERCARE/FOLLOW-UP" PLANS FOR THIS CLIENT.
PC08	PLEASE SUPPLY DOCUMENTATION OF PREVIOUS SUBSTANCE ABUSE SERVICES WITH DATE(S) AND OUTCOME.
PC09	PLEASE DESCRIBE IN DETAIL THE TREATMENT OBJECTIVES/GOALS FOR THIS CLIENT.
PC10	PLEASE DESCRIBE THE FAMILY SITUATION/DYNAMICS. EXPLAIN HOW THE FAMILY WILL BE INCORPORATED INTO THE CLIENTS PLAN OF CARE.
PC12	PLEASE EXPLAIN IF YOUR SERVICE ENCOURAGES THE CLIENT TO ATTEND SELF-HELP GROUPS.
PC13	PLEASE SUPPLY A SPECIFIC SCHEDULE OF ACTIVITIES, INCLUDING DAY, TIME OF DAY, LENGTH OF SESSION, AND SERVICE TO BE RENDERED DURING THAT TIME.
PC15	PLEASE FURNISH DIAGNOSTIC RATIONALE.
PC17	PLEASE DOCUMENT IF THE CLIENT EVER RECEIVED SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT.
PC19	PLEASE FURNISH MORE EXTENSIVE AND IN-DEPTH HISTORICAL AND PSYCHOSOCIAL DATA.
PC20	PLEASE SUPPLY THE DATE THE CLIENT BECAME TOTALLY ENDENTULOUS.

Denial Code	Long Description
PC23	PLEASE SUBMIT A PHYSICIANS STATEMENT REGARDING THE MEDICAL NECESSITY OF DENTURES FOR THIS CLIENT. THE PHYSICIANS STATEMENT MUST DOCUMENT THE MEDICAL NEED FOR DENTURES.
PC24	THE SERVICE REQUESTED WAS PREVIOUSLY AUTHORIZED. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT INDICATING THIS FACT IS REQUIRED.
PC25	PLEASE SUPPLY SUFFICIENT MITIGATING CIRCUMSTANCES TO WARRANT THE CONSTRUCTION OF NEW DENTURES(S).
PC26	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
PC28	PLEASE SUBMIT A PHYSICIANS STATEMENT INDICATING DENTURES ARE NECESSARY FOR THIS NURSING HOME CLIENT.
PC29	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING LOSS OR DESTRUCTION OF DENTURE(S). INCLUDE SIGNED STATEMENT FROM CLIENT OR FACILITY DIRECTOR REGARDING HOW, WHEN AND WHERE LOST.
PC30	PLEASE PROVIDE COMPLETE INTRAORAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PC31	PLEASE DESCRIBE ANY RELATED DEFORMITIES OF THE FEET.
PC34	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD WITH REQUESTED DME ITEM(S) AND DOCUMENT IF THE CLIENT CAN USE SAFELY AND INDEPENDENTLY.
PC35	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD AND DESCRIBE THE RESULTS AND EFFECTIVENESS OF THE SERVICE REQUESTED.
PC39	PLEASE INDICATE LITER FLOW PER MINUTE, HOURS OF USE PER 24 HOUR PERIOD, AND THE EXPECTED DURATION OF NEED.
PC40	THE ITEM DOES NOT REQUIRE PRIOR AUTHORIZATION UNTIL THE LIFE EXPECTANCY HAS BEEN REACHED.
PC41	PLEASE SUPPLY INFORMATION INDICATING THE NECESSITY OF POSITIONING THE CLIENT'S BODY IN MULTIPLE POSITIONS.
PC42	PLEASE INDICATE IF THE BED HEIGHT MUST BE CHANGED TO ALLOW FOR SAFE TRANSFER OR ADEQUATE BED CARE.
PC43	SUPPLY A PHYSICIANS STATEMENT INDICATING TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR UNIT HAS REDUCED PAIN, IMPROVED/INCREASED THE CLIENTS ACTIVITY LEVEL, AND/OR REDUCED CLIENTS USE OF PAIN MEDICATION.
PC44	A CURRENT AUTHORIZATION FOR THIS SERVICE IS ON FILE FOR ANOTHER PROVIDER. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT OF THAT FACT IS REQUIRED BY THE CLIENT OF FIRST PROVIDER.
PC59	DOCUMENT DECLINE OR PROGRESS IN SPECIFIC, MEASURABLE, OBJECTIVE TERMS.
PC60	DOCUMENT IF CLIENT HAS DEMONSTRATED A GOOD APPOINTMENT COMPLIANCE RECORD.
PC61	THE PHYSICIANS SIGNATURE DATE MUST NOT EXCEED 90 DAYS FROM THE DATE OF RECEIPT BY COLORADO MEDICAID.
PC62	REQUESTS FOR A CONTINUATION OF THERAPY SHOULD NOT BE SUBMITTED MORE THAN FOUR WEEKS PRIOR TO THE EXPIRATION DATE OF THE CURRENT AUTHORIZATION.
PC63	PLEASE FURNISH THE STYLE AND MANUFACTURER OF THE FRAME.
PC64	PLEASE FURNISH THE CLIENTS LENS FORMULA.
PC66	ALL REQUESTS FOR TINTS REQUIRE DOCUMENTATION OF THE VISUAL OR MEDICAL CONDITION RELATED TO PHOTOPHOBIA.
PC67	PLEASE DOCUMENT THE REASON AND JUSTIFICATION FOR REPLACEMENT BEYOND THE FIRST LENS/FRAME.
PC68	DOCUMENT IF ALL REMAINING MAXILLARY AND/OR MANDIBULAR TEETH ARE DECAY-FREE, PROPERLY RESTORED, AND PERIODONTICALLY SOUND.
PC72	SUPPLY MORE DETAIL REGARDING PROGRESS (ATTACHMENT OF GOALS, ETC.). CORRELATE PROGRESS TO PREVIOUS GOALS AND IDENTIFIED LIMITATIONS.
PC77	PLEASE SUBMIT A PLAN OF CARE DESCRIBING THE SERVICES THAT WOULD BE PROVIDED.
PC78	PLEASE DOCUMENT SPECIFIC, MEASURABLE GOALS.
PC82	THE PRIOR AUTHORIZATION (PA) SYSTEM CAN PROCESS ONLY 26 DETAILS PER PA REQUEST. PLEASE RESUBMIT YOUR REQUEST WITH NO MORE THAN 26 DETAILS.
PC83	PLEASE SUPPLY A PHYSICIANS PRESCRIPTION DATED WITHIN ONE MONTH OF REQUESTED SUBSTANCE ABUSE DAY TREATMENT.

Denial Code	Long Description
PC84	PLEASE PROVIDE INFORMATION INDICATING THIS CLIENT IS APPROPRIATELY DETOXIFIED FROM ALCOHOL AND/OR OTHER DRUGS.
PC85	PLEASE PROVIDE INFORMATION TO INDICATE THE CLIENTS ABILITY TO ABSTAIN FROM ALCOHOL OR DRUGS WHILE IN THE SUBSTANCE ABUSE DAY TREATMENT PROGRAM.
PC86	PLEASE INDICATE IF THIS CLIENT IS WILLING TO PARTICIPATE IN AFTERCARE OR CONTINUING CARE SERVICES.
PC87	PROVIDE MORE INFORMATION ON TREATMENT HISTORY; INCLUDE SERVICE PROVIDED, DATES, AND OUTCOME. PROVIDE DETAIL OF PREVIOUS TREATMENT.
PC88	PLEASE PROVIDE MORE RATIONALE FOR THE APPROPRIATENESS AND MEDICAL NECESSITY OF SUBSTANCE ABUSE DAY TREATMENT.
PC89	PROVIDE A TREATMENT PLAN THAT CONTAINS MEASURABLE GOALS AND OBJECTIVES CORRESPONDING TO THE IDENTIFIED DEFICIT.
PC91	PLEASE PROVIDE MORE INFORMATION ON FAMILY INVOLVEMENT TREATMENT.
PC92	PLEASE PROVIDE MORE HISTORY AND EXPLANATION ABOUT THE ISSUE OF ABSTINENCE FOR THIS CLIENT.
PC94	PLEASE PROVIDE THE ANTICIPATED BEGINNING DATE AND/OR THE ESTIMATED SUBSTANCE ABUSE DAY TREATMENT DISCHARGE DATE.
PC95	PLEASE SUPPLY JUSTIFICATION FOR BEGINNING CLIENT IN SERVICE PRIOR TO AUTHORIZATION BEING OBTAINED.
PC96	THE INITIAL THREE HOURS OF SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IN A CALENDAR YEAR DO NOT REQUIRE PRIOR AUTHORIZATION.
PC97	REIMBURSEMENT FOR INITIAL SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IS LIMITED TO THREE HOURS IN A CALENDAR YEAR AND DOES NOT REQUIRE PRIOR AUTHORIZATION.
PC98	THIS DRUG IS CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE BILL USING THE APPROPRIATE NATIONAL DRUG CODE (NDC) OR SUBMIT A COMPLETED DRUG ADDITION REQUEST FORM IF THE NDC IS NOT LISTED IN THE DRUG INDEX.
PC99	THIS DRUG IS NOT CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL, CURRENT ADMINISTRATIVE RULE, OR COLORADO DRUG INDEX FOR COVERAGE LIMITATIONS.
PD01	DOCUMENT THAT CLIENT HAS ACHIEVED GOOD ORAL HYGIENE, PERIODONTAL CASE TYPE 1 OR 2, AND IS MOTIVATED TO MAINTAIN SAME.
PD03	PLEASE PROVIDE AN ARTERIAL BLOOD GAS READING OR PULSE OXIMETRY RESULTS DONE ON ROOM AIR SIGNED AND DATED BY A MEDICAL DOCTOR. THIS SHOULD BE DONE WITHIN 60 DAYS OF REQUESTED SERVICE.
PD04	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 30 DAYS OF RECEIPT BY COLORADO MEDICAID.
PD07	SUBMIT A PHOTOCOPY OF A VALID PRESCRIPTION, ISSUED WITHIN THE PAST YEAR, OR COMPLETE SECTION B OF THE PRIOR AUTHORIZATION/DRUG ATTACHMENT (PA/DGA), F-11049.
PD10	BRAND MEDICALLY NECESSARY MUST BE IN THE PRESCRIBERS OWN HANDWRITING AND WRITTEN DIRECTLY ON THE PRESCRIPTION OR A SEPARATE ORDER ATTACHED TO THE ORIGINAL PRESCRIPTION.
PD12	COMPLETE DENTURES, PARTIAL DENTURES, DENTURE RELINES, AND FIXED PROSTHODONTIC SERVICES ARE NOT COVERED SERVICES FOR ADULTS FOR DATES OF SERVICE ON AND AFTER OCTOBER 1, 1995.
PD22	PLEASE COMPLETE ALL REQUIRED ELEMENTS ON THE PERSONAL CARE SCREENING TOOL (PCST), F-11133.
PD24	THIS PRIOR AUTHORIZATION REQUEST IS UNABLE TO BE PROCESSED. PLEASE RESUBMIT WITH ADDITIONAL REQUIRED FORMS, INCLUDING THE ENTIRE PERSONAL CARE SCREENING TOOL (PCST), F-11133; PERSONAL CARE ADDENDUM, F-11136; AND SUPPORTING DOCUMENTATION, AS DIRECTED.
PD25	THERE IS A PERSONAL CARE SCREENING TOOL (PCST), F-11133, COMPLETED BY ANOTHER AGENCY. CONTACT THE AGENCY TO TRANSFER SCREEN.
PD26	THERE IS A LIMITED TERM CARE FUNCTIONAL SCREEN (LTC-FS) COMPLETED BY ANOTHER AGENCY. THE PERSONAL CARE SCREENING TOOL (PCST), F-11133, INFORMATION IS IN CONFLICT WITH LTC-FS.
PD27	ONLY ONE LEVEL OF FUNCTION MAY BE SELECTED FOR ALL ELEMENTS EXCEPT TOILETING. COLORADO MEDICAID IS UNABLE TO PROCESS THE PRIOR AUTHORIZATION REQUEST.
PD28	NO UNITS MAY BE REQUESTED USING THIS PRIOR AUTHORIZATION PROCESS. PLEASE SUBMIT WITH THE APPROPRIATE ATTACHMENTS FOR REQUESTING SPECIFIC PERSONAL CARE WORKER UNITS.

Denial Code	Long Description
PD29	CLIENT IS NOT ELIGIBLE FOR THE REQUESTED SERVICE(S) AS OF THE REQUESTED START DATE.
PD30	NO TRAVEL TIME MAY BE AUTHORIZED WHEN NO PERSONAL CARE WORKER SERVICE IS AUTHORIZED.
PD32	PROVIDER NOT CERTIFIED TO RENDER THE SERVICE(S) REQUESTED.
PD34	BASED ON THE DOCUMENTATION SUBMITTED, THIS REQUEST CAN NOT BE PRIOR AUTHORIZED. REFER TO THE PA MESSAGES FROM THE CONSULTANT FOR COMPLETE EXPLANATION.
PD98	PLEASE DOCUMENT HOW AND WHEN EACH PREVIOUSLY AUTHORIZED PRO RE NATA VISIT WAS USED.

Speech and Language Pathology

Denial Code	Long Description
0201	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
0233	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0235	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0237	CLIENT IDENTIFICATION NUMBER DOES NOT MATCH CLIENTS FIRST NAME.
0238	THE CLIENT IDENTIFICATION NUMBER DOES NOT MATCH THE CLIENTS LAST NAME.
0242	SECONDARY DIAGNOSIS CODE IS INVALID.
0248	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0249	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0251	PROCEDURE CODE MODIFIER IN FIRST POSITION IS INVALID.
0252	THE PROCEDURE CODE MODIFIER IN SECOND POSITION IS INVALID FOR REQUESTED START DATE OR DATE OF RECEIPT.
0253	THE PROCEDURE CODE MODIFIER IN THIRD POSITION IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
0258	THE PRIMARY DIAGNOSIS CODE IS REQUIRED.
0272	THE PRIMARY DIAGNSOSIS CODE IS INVALID.
0400	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0853	HCPCS - ANNUAL UPDATE
0885	NEVER EVENTS MODIFIERS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
0886	NEVER EVENTS DIAGNOSIS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
1000	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
1002	RENDERING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1003	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1007	RENDERING PROVIDER ID IS NOT ON FILE.
1047	THE RENDERING PROVIDERS CERTIFICATION HAS BEEN CANCELLED.
1048	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1801	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
1804	A CERTIFIED SUBSTANCE ABUSE DAY TREATMENT PROVIDER MUST SUBMIT A SUBSTANCE ABUSE DAY TREATMENT PROCEDURE CODE.
1806	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
1808	THE BILLING PROVIDER DOES NOT HAVE THE REQUIRED CERTIFICATION ADDENDUM ON FILE.
1900	THE BILLING PROVIDERS TAXONOMY CODE IS INVALID.
1901	THE RENDERING PROVIDERS TAXONOMY CODE IS INVALID.
1927	A NATIONAL PROVIDER IDENTIFIER IS REQUIRED FOR THE BILLING PROVIDER.
1934	A NATIONAL PROVIDER INDENTIFIER IS REQUIRED FOR THE RENDERING PROVIDER.
1936	THE BILLING PROVIDER NUMBER IS INVALID.

Denial Code	Long Description
1937	THE RENDERING PROVIDER NUMBER IS INVALID.
1960	INTERNAL PROCESSING IS REQUIRED.
1963	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.
1964	THE BILLING PROVIDER INDICATED IS NOT ALLOWABLE AS A BILLING PROVIDER.
1965	RENDERING PROVIDER NUMBER IS MISSING/INVALID FOR THIS PROCEDURE PROVIDER.
1974	PRESCRIBING/REFERRING/ORDERING PROVIDER INDICATED IS NOT CERTIFIED AS A PRESCRIBING/REFERRING/ORDERING PROVIDER.
1975	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
1976	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
2001	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2003	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2017	THE CLIENT IS ENROLLED IN A MEDICAID OR OTHER MANAGED CARE PROGRAM.
2037	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2603	CLIENT LOCKED-IN TO A PROVIDER OR ENROLLED IN A HOSPICE. CONTACT CLIENTS HOSPICE FOR PAYMENT OF SERVICES OR RESUBMIT WITH DOCUMENTATION OF UNRELATED NATURE OF CARE.
3324	THE MODIFIER HAS BEEN DISCONTINUED BY THE CENTERS OF MEDICARE AND MEDICAID SERVICES OR THE AMERICAN MEDICAL ASSOCIATION FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
3337	THE PROCEDURE CODE HAS BEEN TERMINATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AMERICAN MEDICAL ASSOCIATION, OR AMERICAN DENTAL ASSOCIATION FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT. RESUBMIT WITH VALID A PROCEDURE CODE.
3339	THE PROCEDURE BILLED IS NOT PAYABLE ACCORDING TO DEFICIT REDUCTION ACT (DEFRA) GUIDELINES.
3351	THE PROCEDURE IS NOT COVERED FOR CLIENTS WITH A NURSING HOME AUTHORIZATION ON THE REQUESTED START DATE OR DATE OF RECEIPT.
3353	THE PROCEDURE IS NOT A COVERED SERVICE FOR HOME AND COMMUNITY-BASED WAIVER CLIENTS.
4021	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4027	THE DIAGNOSIS CODE IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
4031	THE PROCEDURE SUBMITTED IS NOT APPROPRIATE FOR CLIENTS GENDER.
4032	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4034	THE PROCEDURE CODE HAS AN AGE RESTRICTION.
4036	THE PLACE OF SERVICE CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4040	THE PRIMARY DIAGNOSIS CODE IS NOT ON FILE.
4041	THE SECONDARY DIAGNOSIS IS NOT ON FILE.
4046	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4127	INTERNAL PROCESSING IS REQUIRED.
4131	INTERNAL PROCESSING IS REQUIRED.
4141	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4149	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4150	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4236	ETIOLOGY DIAGNOSIS CODE(S) (E-CODES) ARE INVALID AS THE PRIMARY DIAGNOSIS.
4244	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4245	THE FOURTH POSITION MODIFIER IS INVALID FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT.
4256	THE PROCEDURE CODE AND MODIFIER COMBINATION IS NOT PAYABLE FOR THE CLIENTS BENEFIT PLAN.
4257	THE MODIFIERS SUBMITTED ARE EITHER INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT OR THE MODIFIERS ARE MISSING.
4311	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4315	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4316	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4371	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4372	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4711	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR CLIENTS AGE.
4714	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS AGE.
4731	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS DIAGNOSIS.

Denial Code	Long Description
4742	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4743	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4744	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4745	DIAGNOSIS AND/OR PROCEDURE AND/OR PLACE OF SERVICE (POS) CODE IS NOT COVERED FOR EXPRESS ENROLLMENT CLIENTS.
4746	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4801	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4802	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
4821	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
4871	PLEASE REFER TO PA MESSAGES FOR RETURN INFORMATION.
4963	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS GENDER.
4990	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
7500	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
7509	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
P001	THE BILLING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THE SERVICES.
P002	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P003	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P005	THE PRIOR AUTHORIZATION CAN NOT BE END DATED. THE PRIOR AUTHORIZATION STATUS IS NOT APPROVED OR APPROVED WITH REVISIONS.
P006	PLEASE FURNISH THE PROCEDURE CODE AND CORRESPONDING DESCRIPTION.
P008	THE BILLING PROVIDER NUMBER IS INVALID.
P009	THE BILLING PROVIDER NUMBER IS INVALID.
P010	THE REQUESTED END DATE IS INVALID.
P011	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P012	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P013	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P014	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P015	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P016	THE REQUESTED START DATE IS MISSING OR INVALID.
P019	THE REQUESTED START DATE IS MISSING OR INVALID.
P020	THE RENDERING PROVIDER NUMBER IS INVALID.
P021	THE RENDERING PROVIDER NUMBER IS INVALID.
P022	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P023	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P024	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P026	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P027	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P030	FIRST MODIFIER IS INVALID.
P031	FIRST MODIFIER IS INVALID.
P032	SECOND MODIFIER IS INVALID.
P033	SECOND MODIFIER IS INVALID.
P034	THIRD MODIFIER IS INVALID.
P035	THIRD MODIFIER IS INVALID.
P036	FOURTH MODIFIER IS INVALID.
P037	FOURTH MODIFIER IS INVALID.

Denial Code	Long Description
P038	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P039	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P040	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P041	CLIENTS FIRST NAME IS MISSING.
P042	CLIENTS LAST NAME IS MISSING.
P043	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P044	BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES REQUESTED.
P045	FIRST MODIFIER IS INVALID.
P046	SECOND MODIFIER IS INVALID.
P047	THIRD MODIFIER IS INVALID.
P048	FOURTH MODIFIER IS INVALID.
P052	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P053	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P054	RENDERING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES FOR THE BENEFIT PLAN.
P055	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P061	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P062	THE CLIENT ID AND/OR NAME INDICATED ON THE PA REQUEST IS INCORRECT. THE CLIENT ID AND/OR NAME HAS BEEN UPDATED. PLEASE VERIFY THE ID AND/OR NAME IS CORRECT.
P064	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
P067	THE FREQUENCY OF HOURS REQUESTED ARE NOT APPROPRIATE FOR THIS CLIENT AND HAVE BEEN MODIFIED ACCORDINGLY.
P079	BILLING PROVIDER IS ON PAYMENT SUSPENSION DUE TO CREDIBLE ALLEGATION OF FRAUD.
P120	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAS BEEN REDUCED.
P121	THE SERVICE/ PROCEDURE REQUESTED IS NOT SUPPORTED BY SUBMITTED DOCUMENTATION.
P126	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
P128	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.
P138	SERVICE(S) DO NOT MEET COLORADO MEDICAID GUIDELINES.
P167	REQUESTED DOCUMENTATION HAS NOT BEEN SUBMITTED.
P178	THE SERVICE REQUESTED IS NOT MEDICALLY NECESSARY.
P179	THE MEDICAL NECESSITY FOR THIS SERVICE IS NOT SUPPORTED BY THE SUBMITTED DOCUMENTATION.
P233	THE DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE ADDITIONAL CARE.
P257	THIS CLIENTS FUNCTIONAL ASSESSMENT SCORES PLACE THIS CLIENT OUTSIDE ELIGIBILITY FOR DAY TREATMENT.
P274	OUR RECORDS INDICATE THIS CLIENT IS INVOLVED IN EFFECTIVE AND APPROPRIATE SERVICE ELSEWHERE.
P292	INTENSIVE REHABILITATION HOURS ARE NO LONGER APPROPRIATE AS INDICATED BY HISTORY, DIAGNOSIS, AND/ OR FUNCTIONAL ASSESSMENT SCORES.
P328	THE SERVICES REQUESTED INCLUDE NON-COVERED SERVICES, AND HOURS ARE REDUCED ACCORDINGLY.
P339	THE CLIENTS PAST HISTORY INDICATES REDUCED TREATMENT HOURS ARE WARRANTED.
P342	THE REQUEST DOES NOT MEET GENERALLY ACCEPTED CONDITIONS REQUIRING FLUORIDE TREATMENTS.
P346	SERVICES EXCEED COLORADO MEDICAID LIMITATION AND DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE MEDICAL NECESSITY OF THE SERVICE.
P349	THE SERVICE REQUESTED WAS PERFORMED LESS THAN FIVE YEARS AGO.
P353	THE EXISTING APPLIANCE HAS NOT BEEN WORN FOR THREE YEARS.
P367	THE CLIENT HAS BEEN TOTALLY WITHOUT TEETH AND AN APPLIANCE FOR FIVE YEARS.
P392	THE CLIENT IS MISSING AN ANTERIOR TOOTH AND/OR HAS TWO OR MORE POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P405	THE SERVICE(S) REQUESTED COULD ADEQUATELY BE PERFORMED IN THE DENTAL OFFICE.

Denial Code	Long Description
P406	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE OF GOOD PERIODONTAL HEALTH (AMERICAN ACADEMY OF PERIODONTOLOGY PERIODONTAL CLASSIFICATION OF TYPE I OR II).
P407	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE VISIBLE ON RADIOGRAPHS THAT AT LEAST 50 PERCENT OF THE CLINICAL CROWN IS INTACT.
P409	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING SIX OR MORE TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED, INCLUDING THIRD MOLARS.
P410	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING ONE OR MORE ANTERIOR TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED.
P411	DOCUMENTATION DOES NOT SUPPORT THE NEED FOR PERIODONTIC SERVICES. POCKETS ARE LESS THAN 4MM AND/OR GREATER THAN 6MM FOR CLIENT AND/OR THE CLIENT IS UNDER THE AGE OF 13.
P412	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA.
P413	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA. THIS PA HAS BEEN GRANTED AS APPROVED NOT APPROVED WITH REVISIONS. THE DURATION REQUESTED MAY HAVE BEEN REDUCED TO REFLECT COVERAGE LIMITATIONS, PRESCRIBER ORDERS, CONFLICTI
P417	THE SERVICE(S) REQUESTED COULD BE ADEQUATELY PERFORMED WITH LOCAL ANESTHESIA.
P437	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO POOR ORAL HYGIENE.
P444	THIS LINE ITEM IS A DUPLICATE OF ANOTHER LINE ITEM ON THIS PRIOR AUTHORIZATION (PA) REQUEST. PLEASE CORRECT.
P446	THIS IS A DUPLICATE OF AN EXISTING PRIOR AUTHORIZATION (PA) REQUEST. YOU MAY CONTACT PROVIDER SERVICES IF YOU REQUIRE ASSISTANCE. DUPLICATE PA REQUEST
P448	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO DECAY HISTORY.
P449	QUESTIONABLE LONG TERM PROGNOSIS DUE TO GUM AND BONE DISEASE.
P456	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO APPARENT ROOT INFECTION.
P457	OUR RECORDS INDICATE THIS CLIENT HAS EXCEEDED ESTABLISHED PROGRAM LIMITATIONS. COLORADO MEDICAID WILL NOT AUTHORIZE NEW DENTURES.
P458	DOCUMENTATION PROVIDED INDICATES A LESS ELABORATE PROCEDURE SHOULD BE CONSIDERED.
P502	RENTAL ONLY ALLOWED; MEDICAL NEED FOR PURCHASE HAS NOT BEEN DOCUMENTED.
P503	PURCHASE ONLY ALLOWED; MEDICAL NEED FOR RENTAL HAS NOT BEEN DOCUMENTED.
P504	OCCUPATIONAL THERAPY GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P505	THE SERVICE REQUESTED IS INCLUDED IN THE NURSING HOME RATE STRUCTURE.
P511	THIS NATIONAL DRUG CODE IS ONLY BILLABLE AS PART OF A COMPOUND DRUG.
P515	THE PRESENCE OF A HANDICAPPING MALOCCLUSION OR HANDICAPPING DENTOFACIAL DEFORMITY IS NOT SUPPORTED BY THE DOCUMENTATION SUBMITTED.
P521	THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVERED BY COLORADO MEDICAID.
P522	GASTRO-INTESTINAL SURGERY FOR THE PURPOSE OF WEIGHT CONTROL IS COVERED ONLY AS A LIFE THREATENING PROCEDURE.
P523	THE TREATMENT REQUEST IS NOT CONSISTENT WITH THE CLIENT'S DIAGNOSIS.
P524	PSYCHOTHERAPY PROVIDED IN THE CLIENTS HOME IS NOT A COVERED BENEFIT OF COLORADO MEDICAID.
P525	THE INFORMATION PROVIDED IS NOT CONSISTENT WITH THE INTENSITY OF SERVICES REQUESTED.
P526	INTENSIVE MULTIPLE MODALITY TREATMENT IS NOT CONSISTENT WITH THE INFORMATION PROVIDED.
P527	MULTIPLE PROVIDERS OF TREATMENT ARE NOT INDICATED FOR THIS CLIENT.
P528	THE DURATION OF TREATMENT SESSIONS EXCEED CURRENT COLORADO MEDICAID GUIDELINES.
P534	DOCUMENTATION OF POOR PHYSICAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P535	OTHER PHYSICAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P536	THE PHYSICAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P537	USE OF PHYSICAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P538	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF A PHYSICAL THERAPIST.
P539	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS AND LIVING ARRANGEMENT.

Denial Code	Long Description
P540	GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P541	THE PROCEDURE(S) REQUESTED ARE NOT MEDICAL IN NATURE.
P542	DOCUMENTATION OF POOR OCCUPATIONAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P543	DOCUMENTATION OF POOR SPEECH THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P544	OTHER OCCUPATIONAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P546	THE OCCUPATIONAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P547	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF PHYSICAL THERAPY.
P548	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P549	ACTIVITIES TO PROMOTE DIVERSION OR GENERAL MOTIVATION ARE NONCOVERED COLORADO MEDICAID SERVICES.
P550	REVISIONS OF THE REQUEST IS NECESSITATED BY THE CLIENTS MINIMAL PROGRESS.
P551	RESTORATIVE NURSING INVOLVEMENT COULD BE INCREASED.
P552	CLIENTS DEMONSTRATED RESPONSE TO CURRENT THERAPY DOES NOT WARRANT THE INTENSE FREQUENCY REQUESTED.
P553	MAINTENANCE IS TWO TIMES PER WEEK OR LESS.
P554	THE SPEECH THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P555	USE OF OCCUPATIONAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P556	USE OF SPEECH THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P557	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF AN OCCUPATIONAL THERAPIST.
P558	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
P559	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P560	THE MATERIALS/ SERVICES REQUESTED ARE PRINCIPALLY COSMETIC IN NATURE.
P561	THE LENS FORMULA DOES NOT JUSTIFY REPLACEMENT.
P562	THE CHANGE IN THE LENS FORMULA DOES NOT WARRANT MULTIPLE REPLACEMENTS.
P563	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P564	LENSES ONLY ARE APPROVED; PLEASE DISPENSE A CONTRACTED FRAME. THE NON-CONTRACTED FRAME IS NOT MEDICALLY JUSTIFIED.
P565	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P566	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P567	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF OCCUPATIONAL THERAPY.
P568	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF SPEECH THERAPY.
P569	LEVEL, INTENSITY, OR EXTENT OF SERVICE(S) REQUESTED HAS BEEN MODIFIED CONSISTENT WITH MEDICAL NEED AS DEFINED IN THE PLAN OF CARE.
P570	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P571	THE SERVICE ASKED FOR IS NOT COVERED BY COLORADO MEDICAID AS THESE TASKS CAN BE DONE BY NURSES OR ACTIVITY STAFF.
P572	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P573	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.
P574	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.

Denial Code	Long Description
P575	MEDICAL NEED FOR EQUIPMENT/ SUPPLY REQUESTED IS NOT SUPPORTED BY DOCUMENTATION SUBMITTED.
P576	OTHER SPEECH THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P577	DOCUMENTATION SUBMITTED IDENTIFIES THAT THE CLIENT HAS FEWER THAN TWO POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P582	LESS EXPENSIVE ALTERNATIVE SERVICES ARE AVAILABLE FOR THIS CLIENT.
P634	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P711	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING PERIODONTAL SCALING AND ROOT PLANNING.
P712	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING GINGIVECTOMY.
P754	AN APPROVED SUBSTANCE ABUSE DAY TREATMENT PROGRAM CANNOT EXCEED A SIX WEEK PERIOD.
P761	THE CLIENT DOES NOT APPEAR TO BE ABLE OR WILLING TO ABSTAIN FROM ALCOHOL/DRUG USAGE WHILE IN TREATMENT. THEREFORE, SUBSTANCE ABUSE DAY TREATMENT SERVICES ARE NOT APPROVED.
P764	THIS CLIENT HAS COMPLETED INTENSIVE SUBSTANCE ABUSE TREATMENT WITHIN THE PAST 12 MONTHS. THE DOCUMENTATION PROVIDED IS NOT ADEQUATE TO JUSTIFY ADDITIONAL INTENSIVE TREATMENT AT THIS TIME.
P785	A LESS THAN SIX-WEEK HEALING PERIOD HAS BEEN SPECIFIED FOR THIS PRIOR AUTHORIZATION. THEREFORE IT IS NOT NECESSARY TO WAIT THE FULL SIX WEEKS AFTER EXTRACTIONS BEFORE TAKING DENTURE IMPRESSIONS.
P818	SIX-WEEK HEALING TIME IS REQUIRED BETWEEN EDENTULATION AND FINAL IMPRESSIONS. PAYMENT FOR DENTURES WILL BE DENIED OR RECOUPED IF HEALING PERIOD IS NOT OBSERVED.
P849	COLORADO MEDICAID HAS DETERMINED THERE WERE (ARE) SEVERAL HOME HEALTH AGENCIES WILLING TO PROVIDE MEDICALLY NECESSARY SKILLED NURSING SERVICES TO THIS CLIENT.
P864	THE DOCUMENTATION YOU HAVE SUBMITTED DOES NOT MEET THE REQUIREMENTS OF COLORADO MEDICAID.
P873	THE MEDICAL NECESSITY FOR THE HOURS REQUESTED IS NOT SUPPORTED BY THE INFORMATION SUBMITTED.
P874	THE DOCUMENTATION SUBMITTED INDICATES THE TASKS SPECIFIED CAN BE COMPLETED DURING THE VISITS APPROVED.
P878	THE DOCUMENTATION SUBMITTED DOES NOT INDICATE THAT MEDICALLY ORIENTED TASKS ARE MEDICALLY NECESSARY; THEREFORE PERSONAL CARE SERVICES HAVE BEEN APPROVED.
P880	THE QUANTITY OF SERVICES AUTHORIZED FOR THIS CLIENTS PERSONAL CARE HAS BEEN AMENDED BASED ON INFORMATION RECEIVED FROM ONE OR MORE OF THESE SOURCES: THE CLIENT, THEIR PHYSICIAN, AND/OR THE IN-HOME VISIT BY STAFF OF THE OIG (OFFICE OF INSPECTOR GENERAL).
P885	THE USE OF THIS DRUG FOR THE INTENDED PURPOSE IS NOT COVERED BY COLORADO MEDICAID, CONSISTENT WITH COLORADO ADMINISTRATIVE CODE AND FEDERAL LAW.
P924	THE MEDICAL RECORDS SUBMITTED WITH THE CURRENT REQUEST CONFLICT OR DISAGREE WITH OUR MEDICAL RECORDS ON THIS CLIENT.
P950	INDEPENDENT NURSES, PLEASE NOTE PAYABLE SERVICES MAY NOT EXCEED 12 HOURS/DAY OR 60 HOURS/WEEK.
P951	SERVICES CAN ONLY BE AUTHORIZED THROUGH ONE YEAR FROM THE PRESCRIPTION DATE.
P952	LEAD INSPECTION IS A COVERED COLORADO MEDICAID SERVICE WHEN THE CHILD HAS BEEN SHOWN TO HAVE LEAD POISONING (E.G., CHILD HAS A BLOOD LEAD LEVEL > 19 UG/DL OR TWO CONSECUTIVE BLOOD LEAD LEVELS OF 15-19 UG/DL DONE AT LEAST 90 DAYS APART). THE INSPECTION MUS
P953	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P954	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P956	THE REQUEST CAN ONLY BE BACKDATED A MAXIMUM OF 14 DAYS FROM FIRST DATE RECEIVED BY COLORADO MEDICAID.
P957	COMPLETE PERIODONTAL CHARTING AT TIME OF SERVICE, AND SUBMIT CHARTING, COPY OF OPERATIVE REPORT, TOGETHER WITH A COPY OF THE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF), F-11035, TO PA UNIT ATTENTION DENTAL CONTSULTANT.

Denial Code	Long Description
P958	NOTE THAT CODE D4341 HAS BEEN CHANGED. REFER TO THE DECISION NOTICE FOR AUTHORIZED QUANTITY.
P960	YOUR PA HAS BEEN APPROVED FOR 90 DAYS. THE 90 DAY APPROVAL DOES NOT IMPLY THE PA REQUEST MEETS PRIOR AUTHORIZATION CRITERIA. AFTER ADDITIONAL INFORMATION IS AVAILABLE IN INTERCHANGE, COLORADO MEDICAID WILL CREATE AN AMENDMENT REQUEST TO EXTEND THE PA FOR
P961	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P962	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
PA10	THE REQUESTED END DATE IS INVALID.
PA12	PLEASE FURNISH A WRITTEN DESCRIPTION OF THE CLIENTS DIAGNOSIS.
PA13	PROVIDE DIAGNOSES WITH DATES OF ONSET.
PA14	IDENTIFY PROBLEMS TO BE TREATED.
PA15	THE AUDIOLOGISTS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1), F-11020, AND PRIOR AUTHORIZATION REQUEST/HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2), F-11021.
PA16	THE PHYSICIANS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION/PHYSICIAN OTOLOGICAL REPORT (PA/POR), F-11019.
PA17	SUBMIT BRIEF HISTORY WITH REFERRAL INFORMATION, LIVING SITUATION, FUNCTIONAL STATUS, AND OTHER PERTINENT INFORMATION. WHAT CHANGE OF STATUS RESULTED IN REFERRAL AT THIS TIME?
PA18	PLEASE FURNISH THE CLIENTS HEIGHT AND WEIGHT.
PA19	PLEASE SUBMIT CLINICAL INFORMATION SUFFICIENT TO VERIFY THE NEED FOR THE REQUESTED SERVICE(S).
PA20	PLEASE RESUBMIT WITH COMPLETE PERIODONTAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PA21	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL EDUCATIONAL PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA22	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL PROGRAM PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA23	REFER TO THE DURABLE MEDICAL EQUIPMENT INDEX FOR APPROPRIATE CODE AND DESCRIPTION. DO NOT USE AN "UNLISTED" CODE.
PA24	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUALIZED FAMILY SERVICE PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA25	INFORMATION ON THE REQUEST FORM IS ILLEGIBLE, AND THE REQUEST CANNOT BE PROCESSED.
PA26	RE-EVALUATE YOUR GOALS. EMPHASIS SHOULD BE ON FUNCTIONAL SELF-CARE. GOALS MUST BE RELATED TO FUNCTIONAL OUTCOME.
PA27	PLEASE CLARIFY THE NUMBER OF HOURS PER WEEK REQUESTED.
PA28	PLEASE CLARIFY THE NUMBER OF HOURS PER DAY REQUESTED.
PA29	PLEASE CLARIFY THE NUMBER OF VISITS PER DAY REQUESTED.
PA30	ATTACH SUPPORTIVE DOCUMENTATION; HOME EXERCISE PROGRAM AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA31	THE DIAGNOSIS CODE INDICATED ON THE REQUEST DOES NOT CORRESPOND TO THE DIAGNOSIS CODE DESCRIPTION.
PA32	PLEASE SUBMIT ADDITIONAL INFORMATION SUFFICIENT TO VERIFY APPROPRIATENESS AND NEED FOR TRANSPLANT.
PA33	PLEASE SUBMIT THE INITIAL AND PROGRESSIVE OBJECTIVE FINDINGS.
PA34	ATTACH SUPPORTIVE DOCUMENTATION, FACILITY PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA35	PLEASE SUBMIT THE CLIENTS ORIGINAL COMPLAINTS AND EXAMINATION FINDINGS.
PA36	ATTACH SUPPORTIVE DOCUMENTATION, IN-HOME AUTISM PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA37	PLEASE SUBMIT YOUR TREATMENT PLAN FOR THIS CLIENT.

Denial Code	Long Description
PA38	ATTACH SUPPORTIVE DOCUMENTATION AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA39	INITIAL EVALUATIONS MUST BE PERFORMED BY AN OCCUPATIONAL THERAPIST REGISTERED (OTR), PER AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA) STANDARDS.
PA41	IDENTIFY THE PLACE OF SERVICE AND ITS EFFECT ON SUPPORTING THE DESIRED TREATMENT OUTCOME.
PA42	PLEASE INDICATE THE HOURS OF USE OF OXYGEN PER 24-HOUR PERIOD.
PA43	PROVIDE BASELINE DOCUMENTATION FOR THIS CLIENTS LIMITATIONS USING UNITS OF MEASUREMENT THAT ARE APPLIED CONSISTENTLY WHEN REPORTING STATUS.
PA44	IDENTIFY FUNCTIONAL LIMITATIONS AS THEY ARE RELATED TO IDENTIFIED CONDITIONS.
PA46	CORRELATE PLAN OF CARE TO REQUESTED PROCEDURE CODES.
PA47	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE FREQUENCY/DURATION REQUESTED.
PA48	PLEASE PROVIDE THE NAME AND CREDENTIALS OF THE RENDERING PROVIDER.
PA50	COLORADO MEDICAID RECORDS INDICATE THE CLIENT OWNS A WHEELCHAIR. DOCUMENT THE REASON AND NEED FOR REPLACEMENT AND COST TO REPAIR CURRENT WHEELCHAIR.
PA51	PLEASE DISTINGUISH PRIMARY AND SUPPORTIVE MODALITIES.
PA52	PLEASE SUBMIT A PROGRESS REPORT.
PA53	MULTIPLE FAMILY CLIENTS TREATMENT BY THE SAME PROVIDER REQUIRES FURTHER INFORMATION DOCUMENTING COORDINATION OF TREATMENT PLAN.
PA54	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE MINUTES REQUESTED.
PA55	MEDICAL NECESSITY OF TREATMENT REQUIRES ADDITIONAL DOCUMENTATION.
PA56	GIVEN AGE, DIAGNOSES, CURRENT LEVEL OF FUNCTION, PAST RESPONSE TO TREATMENT, AND LIVING SITUATION, EXPAND ON POTENTIAL FOR SIGNIFICANT FUNCTIONAL PROGRESS WITHIN THE NEXT SIX MONTHS. EMPHASIZE WHY PROGRESS IS EXPECTED WITH SERVICES AT THIS TIME.
PA57	SUBMIT THE INITIAL FINDINGS. INCLUDE A COMPREHENSIVE EVALUATION.
PA58	SUBMIT PROGRESSIVE, OBJECTIVE FINDINGS. INCLUDE A PERTINENT RE-EVALUATION.
PA59	PLEASE SUPPLY INFORMATION REGARDING THE CLIENTS MEDICATION REQUIREMENTS, IF ANY.
PA60	PLEASE SPECIFY IF THE CLIENT IS IN AN EDUCATIONAL SETTING.
PA61	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA62	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
PA63	THE SKILLS OF A THERAPIST ARE PURPOSEFUL AND SKILLED INTERVENTIONS REQUIRED TO CONTINUALLY DESIGN, IMPLEMENT, REASSESS, MODIFY/GRADE, AND/OR DISCONTINUE A PLAN OF CARE IN A TIMELY MANNER, BASED ON THE COMPLEXITY OF THE CLIENTS MEDICAL CONDITION AND/OR CO
PA64	PLEASE SUBMIT A THERAPY PLAN OF CARE, INCLUDING A CURRENT, DATED EVALUATION.
PA65	A PLAN OF CARE SIGNED AND DATED BY THE PHYSICIAN IS REQUIRED.
PA66	THE SKILLS OF A THERAPIST ARE REQUIRED WHEN ONLY THE THERAPIST CAN SAFELY AND EFFECTIVELY DELIVER THE THERAPEUTIC PROCEDURES BECAUSE OF THEIR UNIQUE KNOWLEDGE, TRAINING, AND EXPERTISE. DESCRIBE THE REASON THAT SOMEONE OTHER THAN A THERAPIST CANNOT SAFELY
PA67	PLEASE SPECIFY IF THE CLIENTS WORK SITE DEMANDS GOOD BINAURAL HEARING.
PA68	DESCRIBE THE REASON, BASED ON THE CLIENTS COGNITIVE, PHYSICAL, COMMUNICATION, OR RESOURCE STATUS, THAT A HOME PROGRAM, EQUIPMENT, OR ENVIRONMENTAL ADAPTATIONS ALONE CANNOT MEET CLIENTS NEEDS.
PA69	PLEASE SPECIFY IF THE CLIENT HAS AN ACCOMPANYING DISABILITY THAT ADDS TO THE HEARING PROBLEM.
PA70	DISTINGUISH REQUESTED PROCEDURES AND GOALS FROM OTHER SERVICES THIS CLIENT RECEIVES. THEY MAY NOT BE DUPLICATIVE.
PA71	PLEASE INDICATE THE NUMBER OF DAYS REQUESTED.
PA73	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA74	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA75	PLEASE DOCUMENT CARRYOVER OF THE THERAPY PROGRAM TO NURSING.

Denial Code	Long Description
PA76	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA79	PROVIDE EVIDENCE OF SIGNIFICANT FUNCTIONAL PROGRESS IN LAST SIX MONTHS.
PA84	THE GRANT DATE OF THIS REQUEST CANNOT BE PRIOR TO THE SIGNATURE DATE OF THE PRESCRIBING PHYSICIAN.
PA86	PROVIDE EVIDENCE OF SKILLS GAINED IN THERAPY CARRYING OVER TO OTHER SETTINGS WITHIN SIX MONTHS.
PA87	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE NUMBER OF SESSIONS REQUESTED.
PA88	THE REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL SCOPE OF PRACTICE.
PA89	PRIOR AUTHORIZATION IS NOT REQUIRED UNTIL LIMITATION OF SERVICE HAS BEEN REACHED.
PA91	PLEASE SUBMIT REQUIRED X-RAYS.
PA92	PLEASE PROVIDE AN EXPLANATION FOR THE MATERIAL SUBMITTED WITH THE REQUEST.
PA95	PLEASE DESCRIBE HOW THE PROVISION OF THIS SERVICE WOULD PREVENT INSTITUTIONALIZATION OF THE CLIENT.
PA96	COULD THE EXISTING DENTURE(S) BE RELINED OR REBASED? IF NOT, PLEASE EXPLAIN WHY NOT.
PA97	REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL STANDARDS OF PRACTICE.
PA98	PLEASE INDICATE IF THE CLIENT IS CURRENTLY BEING TUBE FED.
PB02	PLEASE PROVIDE THE REQUIRED DATED SIGNATURES ON THE ATTACHMENTS.
PB03	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING THE LOSS/DESTRUCTION/THEFT OF THE HEARING AID.
PB04	DESCRIBE THE CLIENTS ABILITY TO STAND OR AMBULATE SUFFICIENTLY TO ACCOMPLISH SELF-CARE ACTIVITIES.
PB07	PLEASE SUBMIT AN ORTHODONTIC STUDY MODEL OR DIAGNOSTIC CASTS.
PB09	PLEASE PROVIDE A PHOTOGRAPH OF THE INVOLVED AREA(S).
PB10	PLEASE PROVIDE AN ESTIMATION (IN GRAMS) OF THE TOTAL AMOUNT OF TISSUE TO BE RESECTED.
PB11	PLEASE SUBMIT THE PLAN OF CARE FOR CO-TREATMENT.
PB12	FURNISH A DETAILED DESCRIPTION FOR THE PROCEDURE CODE REQUESTED.
PB13	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB15	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB18	PLEASE COMPLETE THE ATTACHED OUT-OF-STATE PROVIDER DATA SHEET, F-11001, AND RESUBMIT.
PB20	A SIGNED AND DATED PRESCRIPTION IS REQUIRED WITHIN THREE MONTHS OF RECEIPT BY COLORADO MEDICAID FOR INITIAL REQUESTS AND WITHIN 12 MONTHS OF RECEIPT BY COLORADO MEDICAID FOR SUBSEQUENT REQUESTS.
PB21	PLEASE COMPLETE THE APPROPRIATE PRIOR AUTHORIZATION ATTACHMENT. CONTACT PROVIDER SERVICES OR THE PRIOR AUTHORIZATION UNIT FOR ASSISTANCE.
PB23	PHYSICAL THERAPY ASSISTANT NOTES AND ALL FORMS SUBMITTED MUST BE COSIGNED BY A REGISTERED PHYSICAL THERAPIST.
PB31	ARE YOU REQUESTING A COMPLETE APPLIANCE, OR REPLACEMENT PARTS?
PB32	THE PROCEDURE CODE INDICATED ON THE REQUEST DOES NOT MATCH THE DESCRIPTION OF SERVICE; PLEASE CORRECT AND RESUBMIT.
PB35	THE SERVICE REQUESTED DOES NOT REQUIRE PRIOR AUTHORIZATION.
PB41	PLEASE FURNISH A CURRENT MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT, F-11090 (DATED WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID).
PB45	THE CERTIFICATION PERIOD ON THE PLAN OF CARE (POC) DOES NOT COVER THE REQUESTED GRANT/START DATE. PLEASE RESUBMIT YOUR REQUEST WITH A NEW POC.
PB49	A CERTIFIED OCCUPATIONAL THERAPY ASSISTANTS NOTES MUST BE COSIGNED BY AN OCCUPATIONAL THERAPIST REGISTERED.
PB51	ADDITIONAL INFORMATION IS REQUIRED ON PRIOR AUTHORIZATION TO ENABLE PRICING.
PB54	REQUESTED SERVICES DO NOT MATCH SERVICES ON THE PHYSICIANS ORDERS.
PB59	PLEASE PROVIDE AN INDIVIDUAL EDUCATIONAL PLAN (IEP), WHICH HAS BEEN SIGNED BY THE PROVIDER NO EARLIER THAN NINE MONTHS PRIOR TO RECEIPT AT COLORADO MEDICAID; OTHERWISE, DOCUMENT WHY NO IEP EXISTS.
PB65	PLEASE FURNISH THE ANTICIPATED TOTAL CHARGES FOR THIS REQUEST.

Denial Code	Long Description
PB66	A PHOTOCOPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED; THE DATE MUST BE WITHIN SIX MONTHS OF RECEIPT BY COLORADO MEDICAID.
PB67	THE PRESCRIPTION DATE MUST INCLUDE MONTH, DAY, AND YEAR.
PB68	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID.
PB73	THE SERVICES IDENTIFIED ON THE PLAN OF CARE DO NOT APPEAR APPROPRIATE FOR THE PROCEDURE CODE(S) REQUESTED ON THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018.
PB74	THE CLIENT/PROVIDER DOES NOT HAVE RETROACTIVE ENROLLMENT.
PB75	THE REQUESTED START DATE IS MORE THAN 14 DAYS BEFORE OR 62 DAYS AFTER RECEIPT.
PB82	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
PB83	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A HOME HEALTH AIDE. PLEASE RESUBMIT AS A PERSONAL CARE WORKER OR PROVIDE ADDITIONAL DOCUMENTATION.
PB86	THE SERVICES REQUESTED ARE NOT BEING PROVIDED IN THE CLIENTS RESIDENCE. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL.
PB87	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A NURSE. PLEASE RESUBMIT AS A HOME HEALTH AIDE OR PROVIDE ADDITIONAL DOCUMENTATION.
PB92	PLEASE FURNISH THE CLIENTS COMPLETE ADDRESS.
PB94	IF THE CLIENT IS A RESIDENT OF A NURSING HOME, SUPPLY THE COMPLETE NAME AND ADDRESS OF THE NURSING HOME.
PB99	THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018, MUST BE SIGNED AND DATED.
PC01	PLEASE SUPPLY THE RENDERING PROVIDERS PROVIDER NUMBER.
PC03	THE DRUG ENFORCEMENT ADMINISTRATION NUMBER IS MISSING OR INVALID.
PC06	PLEASE DESCRIBE YOUR PROGRAM; INCLUDE ENTRY DATE, TERMINATION DATE, HOURS PER WEEK, AND NUMBER OF WEEKS OF PRIMARY INTENSIVE SERVICE REQUESTED.
PC07	PLEASE DESCRIBE YOUR "AFTERCARE/FOLLOW-UP" PLANS FOR THIS CLIENT.
PC08	PLEASE SUPPLY DOCUMENTATION OF PREVIOUS SUBSTANCE ABUSE SERVICES WITH DATE(S) AND OUTCOME.
PC09	PLEASE DESCRIBE IN DETAIL THE TREATMENT OBJECTIVES/GOALS FOR THIS CLIENT.
PC10	PLEASE DESCRIBE THE FAMILY SITUATION/DYNAMICS. EXPLAIN HOW THE FAMILY WILL BE INCORPORATED INTO THE CLIENTS PLAN OF CARE.
PC12	PLEASE EXPLAIN IF YOUR SERVICE ENCOURAGES THE CLIENT TO ATTEND SELF-HELP GROUPS.
PC13	PLEASE SUPPLY A SPECIFIC SCHEDULE OF ACTIVITIES, INCLUDING DAY, TIME OF DAY, LENGTH OF SESSION, AND SERVICE TO BE RENDERED DURING THAT TIME.
PC15	PLEASE FURNISH DIAGNOSTIC RATIONALE.
PC17	PLEASE DOCUMENT IF THE CLIENT EVER RECEIVED SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT.
PC19	PLEASE FURNISH MORE EXTENSIVE AND IN-DEPTH HISTORICAL AND PSYCHOSOCIAL DATA.
PC20	PLEASE SUPPLY THE DATE THE CLIENT BECAME TOTALLY ENDENTULOUS.
PC23	PLEASE SUBMIT A PHYSICIANS STATEMENT REGARDING THE MEDICAL NECESSITY OF DENTURES FOR THIS CLIENT. THE PHYSICIANS STATEMENT MUST DOCUMENT THE MEDICAL NEED FOR DENTURES.
PC24	THE SERVICE REQUESTED WAS PREVIOUSLY AUTHORIZED. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT INDICATING THIS FACT IS REQUIRED.
PC25	PLEASE SUPPLY SUFFICIENT MITIGATING CIRCUMSTANCES TO WARRANT THE CONSTRUCTION OF NEW DENTURES(S).
PC26	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
PC28	PLEASE SUBMIT A PHYSICIANS STATEMENT INDICATING DENTURES ARE NECESSARY FOR THIS NURSING HOME CLIENT.
PC29	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING LOSS OR DESTRUCTION OF DENTURE(S). INCLUDE SIGNED STATEMENT FROM CLIENT OR FACILITY DIRECTOR REGARDING HOW, WHEN AND WHERE LOST.
PC30	PLEASE PROVIDE COMPLETE INTRAORAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PC31	PLEASE DESCRIBE ANY RELATED DEFORMITIES OF THE FEET.
PC34	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD WITH REQUESTED DME ITEM(S) AND DOCUMENT IF THE CLIENT CAN USE SAFELY AND INDEPENDENTLY.

Denial Code	Long Description
PC35	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD AND DESCRIBE THE RESULTS AND EFFECTIVENESS OF THE SERVICE REQUESTED.
PC39	PLEASE INDICATE LITER FLOW PER MINUTE, HOURS OF USE PER 24 HOUR PERIOD, AND THE EXPECTED DURATION OF NEED.
PC40	THE ITEM DOES NOT REQUIRE PRIOR AUTHORIZATION UNTIL THE LIFE EXPECTANCY HAS BEEN REACHED.
PC41	PLEASE SUPPLY INFORMATION INDICATING THE NECESSITY OF POSITIONING THE CLIENT'S BODY IN MULTIPLE POSITIONS.
PC42	PLEASE INDICATE IF THE BED HEIGHT MUST BE CHANGED TO ALLOW FOR SAFE TRANSFER OR ADEQUATE BED CARE.
PC43	SUPPLY A PHYSICIANS STATEMENT INDICATING TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR UNIT HAS REDUCED PAIN, IMPROVED/INCREASED THE CLIENTS ACTIVITY LEVEL, AND/OR REDUCED CLIENTS USE OF PAIN MEDICATION.
PC44	A CURRENT AUTHORIZATION FOR THIS SERVICE IS ON FILE FOR ANOTHER PROVIDER. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT OF THAT FACT IS REQUIRED BY THE CLIENT OF FIRST PROVIDER.
PC59	DOCUMENT DECLINE OR PROGRESS IN SPECIFIC, MEASURABLE, OBJECTIVE TERMS.
PC60	DOCUMENT IF CLIENT HAS DEMONSTRATED A GOOD APPOINTMENT COMPLIANCE RECORD.
PC61	THE PHYSICIANS SIGNATURE DATE MUST NOT EXCEED 90 DAYS FROM THE DATE OF RECEIPT BY COLORADO MEDICAID.
PC62	REQUESTS FOR A CONTINUATION OF THERAPY SHOULD NOT BE SUBMITTED MORE THAN FOUR WEEKS PRIOR TO THE EXPIRATION DATE OF THE CURRENT AUTHORIZATION.
PC63	PLEASE FURNISH THE STYLE AND MANUFACTURER OF THE FRAME.
PC64	PLEASE FURNISH THE CLIENTS LENS FORMULA.
PC66	ALL REQUESTS FOR TINTS REQUIRE DOCUMENTATION OF THE VISUAL OR MEDICAL CONDITION RELATED TO PHOTOPHOBIA.
PC67	PLEASE DOCUMENT THE REASON AND JUSTIFICATION FOR REPLACEMENT BEYOND THE FIRST LENS/FRAME.
PC68	DOCUMENT IF ALL REMAINING MAXILLARY AND/OR MANDIBULAR TEETH ARE DECAY-FREE, PROPERLY RESTORED, AND PERIODONTICALLY SOUND.
PC72	SUPPLY MORE DETAIL REGARDING PROGRESS (ATTACHMENT OF GOALS, ETC.). CORRELATE PROGRESS TO PREVIOUS GOALS AND IDENTIFIED LIMITATIONS.
PC77	PLEASE SUBMIT A PLAN OF CARE DESCRIBING THE SERVICES THAT WOULD BE PROVIDED.
PC78	PLEASE DOCUMENT SPECIFIC, MEASURABLE GOALS.
PC82	THE PRIOR AUTHORIZATION (PA) SYSTEM CAN PROCESS ONLY 26 DETAILS PER PA REQUEST. PLEASE RESUBMIT YOUR REQUEST WITH NO MORE THAN 26 DETAILS.
PC83	PLEASE SUPPLY A PHYSICIANS PRESCRIPTION DATED WITHIN ONE MONTH OF REQUESTED SUBSTANCE ABUSE DAY TREATMENT.
PC84	PLEASE PROVIDE INFORMATION INDICATING THIS CLIENT IS APPROPRIATELY DETOXIFIED FROM ALCOHOL AND/OR OTHER DRUGS.
PC85	PLEASE PROVIDE INFORMATION TO INDICATE THE CLIENTS ABILITY TO ABSTAIN FROM ALCOHOL OR DRUGS WHILE IN THE SUBSTANCE ABUSE DAY TREATMENT PROGRAM.
PC86	PLEASE INDICATE IF THIS CLIENT IS WILLING TO PARTICIPATE IN AFTERCARE OR CONTINUING CARE SERVICES.
PC87	PROVIDE MORE INFORMATION ON TREATMENT HISTORY; INCLUDE SERVICE PROVIDED, DATES, AND OUTCOME. PROVIDE DETAIL OF PREVIOUS TREATMENT.
PC88	PLEASE PROVIDE MORE RATIONALE FOR THE APPROPRIATENESS AND MEDICAL NECESSITY OF SUBSTANCE ABUSE DAY TREATMENT.
PC89	PROVIDE A TREATMENT PLAN THAT CONTAINS MEASURABLE GOALS AND OBJECTIVES CORRESPONDING TO THE IDENTIFIED DEFICIT.
PC91	PLEASE PROVIDE MORE INFORMATION ON FAMILY INVOLVEMENT TREATMENT.
PC92	PLEASE PROVIDE MORE HISTORY AND EXPLANATION ABOUT THE ISSUE OF ABSTINENCE FOR THIS CLIENT.
PC94	PLEASE PROVIDE THE ANTICIPATED BEGINNING DATE AND/OR THE ESTIMATED SUBSTANCE ABUSE DAY TREATMENT DISCHARGE DATE.
PC95	PLEASE SUPPLY JUSTIFICATION FOR BEGINNING CLIENT IN SERVICE PRIOR TO AUTHORIZATION BEING OBTAINED.

Denial Code	Long Description
PC96	THE INITIAL THREE HOURS OF SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IN A CALENDAR YEAR DO NOT REQUIRE PRIOR AUTHORIZATION.
PC97	REIMBURSEMENT FOR INITIAL SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IS LIMITED TO THREE HOURS IN A CALENDAR YEAR AND DOES NOT REQUIRE PRIOR AUTHORIZATION.
PC98	THIS DRUG IS CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE BILL USING THE APPROPRIATE NATIONAL DRUG CODE (NDC) OR SUBMIT A COMPLETED DRUG ADDITION REQUEST FORM IF THE NDC IS NOT LISTED IN THE DRUG INDEX.
PC99	THIS DRUG IS NOT CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL, CURRENT ADMINISTRATIVE RULE, OR COLORADO DRUG INDEX FOR COVERAGE LIMITATIONS.
PD01	DOCUMENT THAT CLIENT HAS ACHIEVED GOOD ORAL HYGIENE, PERIODONTAL CASE TYPE 1 OR 2, AND IS MOTIVATED TO MAINTAIN SAME.
PD03	PLEASE PROVIDE AN ARTERIAL BLOOD GAS READING OR PULSE OXIMETRY RESULTS DONE ON ROOM AIR SIGNED AND DATED BY A MEDICAL DOCTOR. THIS SHOULD BE DONE WITHIN 60 DAYS OF REQUESTED SERVICE.
PD04	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 30 DAYS OF RECEIPT BY COLORADO MEDICAID.
PD07	SUBMIT A PHOTOCOPY OF A VALID PRESCRIPTION, ISSUED WITHIN THE PAST YEAR, OR COMPLETE SECTION B OF THE PRIOR AUTHORIZATION/DRUG ATTACHMENT (PA/DGA), F-11049.
PD10	BRAND MEDICALLY NECESSARY MUST BE IN THE PRESCRIBERS OWN HANDWRITING AND WRITTEN DIRECTLY ON THE PRESCRIPTION OR A SEPARATE ORDER ATTACHED TO THE ORIGINAL PRESCRIPTION.
PD12	COMPLETE DENTURES, PARTIAL DENTURES, DENTURE RELINES, AND FIXED PROSTHODONTIC SERVICES ARE NOT COVERED SERVICES FOR ADULTS FOR DATES OF SERVICE ON AND AFTER OCTOBER 1, 1995.
PD22	PLEASE COMPLETE ALL REQUIRED ELEMENTS ON THE PERSONAL CARE SCREENING TOOL (PCST), F-11133.
PD24	THIS PRIOR AUTHORIZATION REQUEST IS UNABLE TO BE PROCESSED. PLEASE RESUBMIT WITH ADDITIONAL REQUIRED FORMS, INCLUDING THE ENTIRE PERSONAL CARE SCREENING TOOL (PCST), F-11133; PERSONAL CARE ADDENDUM, F-11136; AND SUPPORTING DOCUMENTATION, AS DIRECTED.
PD25	THERE IS A PERSONAL CARE SCREENING TOOL (PCST), F-11133, COMPLETED BY ANOTHER AGENCY. CONTACT THE AGENCY TO TRANSFER SCREEN.
PD26	THERE IS A LIMITED TERM CARE FUNCTIONAL SCREEN (LTC-FS) COMPLETED BY ANOTHER AGENCY. THE PERSONAL CARE SCREENING TOOL (PCST), F-11133, INFORMATION IS IN CONFLICT WITH LTC-FS.
PD27	ONLY ONE LEVEL OF FUNCTION MAY BE SELECTED FOR ALL ELEMENTS EXCEPT TOILETING. COLORADO MEDICAID IS UNABLE TO PROCESS THE PRIOR AUTHORIZATION REQUEST.
PD28	NO UNITS MAY BE REQUESTED USING THIS PRIOR AUTHORIZATION PROCESS. PLEASE SUBMIT WITH THE APPROPRIATE ATTACHMENTS FOR REQUESTING SPECIFIC PERSONAL CARE WORKER UNITS.
PD29	CLIENT IS NOT ELIGIBLE FOR THE REQUESTED SERVICE(S) AS OF THE REQUESTED START DATE.
PD30	NO TRAVEL TIME MAY BE AUTHORIZED WHEN NO PERSONAL CARE WORKER SERVICE IS AUTHORIZED.
PD32	PROVIDER NOT CERTIFIED TO RENDER THE SERVICE(S) REQUESTED.
PD34	BASED ON THE DOCUMENTATION SUBMITTED, THIS REQUEST CAN NOT BE PRIOR AUTHORIZED. REFER TO THE PA MESSAGES FROM THE CONSULTANT FOR COMPLETE EXPLANATION.
PD98	PLEASE DOCUMENT HOW AND WHEN EACH PREVIOUSLY AUTHORIZED PRO RE NATA VISIT WAS USED.

Supported Living Services (SLS)

Denial Code	Long Description
0201	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
0233	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0235	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0237	CLIENT IDENTIFICATION NUMBER DOES NOT MATCH CLIENTS FIRST NAME.
0238	THE CLIENT IDENTIFICATION NUMBER DOES NOT MATCH THE CLIENTS LAST NAME.

Denial Code	Long Description
0242	SECONDARY DIAGNOSIS CODE IS INVALID.
0248	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0249	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0251	PROCEDURE CODE MODIFIER IN FIRST POSITION IS INVALID.
0252	THE PROCEDURE CODE MODIFIER IN SECOND POSITION IS INVALID FOR REQUESTED START DATE OR DATE OF RECEIPT.
0253	THE PROCEDURE CODE MODIFIER IN THIRD POSITION IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
0258	THE PRIMARY DIAGNOSIS CODE IS REQUIRED.
0272	THE PRIMARY DIAGNSOSIS CODE IS INVALID.
0400	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0853	HCPCS - ANNUAL UPDATE
0885	NEVER EVENTS MODIFIERS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
0886	NEVER EVENTS DIAGNOSIS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
1000	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
1002	RENDERING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1003	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1007	RENDERING PROVIDER ID IS NOT ON FILE.
1047	THE RENDERING PROVIDERS CERTIFICATION HAS BEEN CANCELLED.
1048	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1801	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
1804	A CERTIFIED SUBSTANCE ABUSE DAY TREATMENT PROVIDER MUST SUBMIT A SUBSTANCE ABUSE DAY TREATMENT PROCEDURE CODE.
1806	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
1808	THE BILLING PROVIDER DOES NOT HAVE THE REQUIRED CERTIFICATION ADDENDUM ON FILE.
1900	THE BILLING PROVIDERS TAXONOMY CODE IS INVALID.
1901	THE RENDERING PROVIDERS TAXONOMY CODE IS INVALID.
1927	A NATIONAL PROVIDER IDENTIFIER IS REQUIRED FOR THE BILLING PROVIDER.
1934	A NATIONAL PROVIDER INDENTIFIER IS REQUIRED FOR THE RENDERING PROVIDER.
1936	THE BILLING PROVIDER NUMBER IS INVALID.
1937	THE RENDERING PROVIDER NUMBER IS INVALID.
1960	INTERNAL PROCESSING IS REQUIRED.
1963	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.
1964	THE BILLING PROVIDER INDICATED IS NOT ALLOWABLE AS A BILLING PROVIDER.
1965	RENDERING PROVIDER NUMBER IS MISSING/INVALID FOR THIS PROCEDURE PROVIDER.
1974	PRESCRIBING/REFERRING/ORDERING PROVIDER INDICATED IS NOT CERTIFIED AS A PRESCRIBING/REFERRING/ORDERING PROVIDER.
1975	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
1976	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
2001	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2003	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2017	THE CLIENT IS ENROLLED IN A MEDICAID OR OTHER MANAGED CARE PROGRAM.
2037	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2603	CLIENT LOCKED-IN TO A PROVIDER OR ENROLLED IN A HOSPICE. CONTACT CLIENTS HOSPICE FOR PAYMENT OF SERVICES OR RESUBMIT WITH DOCUMENTATION OF UNRELATED NATURE OF CARE.
3324	THE MODIFIER HAS BEEN DISCONTINUED BY THE CENTERS OF MEDICARE AND MEDICAID SERVICES OR THE AMERICAN MEDICAL ASSOCIATION FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
3337	THE PROCEDURE CODE HAS BEEN TERMINATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AMERICAN MEDICAL ASSOCIATION, OR AMERICAN DENTAL ASSOCIATION FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT. RESUBMIT WITH VALID A PROCEDURE CODE.

Denial Code	Long Description
3339	THE PROCEDURE BILLED IS NOT PAYABLE ACCORDING TO DEFICIT REDUCTION ACT (DEFRA) GUIDELINES.
3351	THE PROCEDURE IS NOT COVERED FOR CLIENTS WITH A NURSING HOME AUTHORIZATION ON THE REQUESTED START DATE OR DATE OF RECEIPT.
3353	THE PROCEDURE IS NOT A COVERED SERVICE FOR HOME AND COMMUNITY-BASED WAIVER CLIENTS.
4021	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4027	THE DIAGNOSIS CODE IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
4031	THE PROCEDURE SUBMITTED IS NOT APPROPRIATE FOR CLIENTS GENDER.
4032	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4034	THE PROCEDURE CODE HAS AN AGE RESTRICTION.
4036	THE PLACE OF SERVICE CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4040	THE PRIMARY DIAGNOSIS CODE IS NOT ON FILE.
4041	THE SECONDARY DIAGNOSIS IS NOT ON FILE.
4046	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4127	INTERNAL PROCESSING IS REQUIRED.
4131	INTERNAL PROCESSING IS REQUIRED.
4141	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4149	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4150	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4236	ETIOLOGY DIAGNOSIS CODE(S) (E-CODES) ARE INVALID AS THE PRIMARY DIAGNOSIS.
4244	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4245	THE FOURTH POSITION MODIFIER IS INVALID FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT.
4256	THE PROCEDURE CODE AND MODIFIER COMBINATION IS NOT PAYABLE FOR THE CLIENTS BENEFIT PLAN.
4257	THE MODIFIERS SUBMITTED ARE EITHER INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT OR THE MODIFIERS ARE MISSING.
4311	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4315	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4316	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4371	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4372	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4711	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR CLIENTS AGE.
4714	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS AGE.
4731	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS DIAGNOSIS.
4742	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4743	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4744	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4745	DIAGNOSIS AND/OR PROCEDURE AND/OR PLACE OF SERVICE (POS) CODE IS NOT COVERED FOR EXPRESS ENROLLMENT CLIENTS.
4746	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4801	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4802	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
4821	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
4871	PLEASE REFER TO PA MESSAGES FOR RETURN INFORMATION.
4963	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS GENDER.
4990	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
7500	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
7509	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
P001	THE BILLING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THE SERVICES.
P002	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.

Denial Code	Long Description
P003	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P005	THE PRIOR AUTHORIZATION CAN NOT BE END DATED. THE PRIOR AUTHORIZATION STATUS IS NOT APPROVED OR APPROVED WITH REVISIONS.
P006	PLEASE FURNISH THE PROCEDURE CODE AND CORRESPONDING DESCRIPTION.
P008	THE BILLING PROVIDER NUMBER IS INVALID.
P009	THE BILLING PROVIDER NUMBER IS INVALID.
P010	THE REQUESTED END DATE IS INVALID.
P011	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P012	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P013	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P014	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P015	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P016	THE REQUESTED START DATE IS MISSING OR INVALID.
P019	THE REQUESTED START DATE IS MISSING OR INVALID.
P020	THE RENDERING PROVIDER NUMBER IS INVALID.
P021	THE RENDERING PROVIDER NUMBER IS INVALID.
P022	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P023	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P024	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P026	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P027	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P030	FIRST MODIFIER IS INVALID.
P031	FIRST MODIFIER IS INVALID.
P032	SECOND MODIFIER IS INVALID.
P033	SECOND MODIFIER IS INVALID.
P034	THIRD MODIFIER IS INVALID.
P035	THIRD MODIFIER IS INVALID.
P036	FOURTH MODIFIER IS INVALID.
P037	FOURTH MODIFIER IS INVALID.
P038	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P039	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P040	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P041	CLIENTS FIRST NAME IS MISSING.
P042	CLIENTS LAST NAME IS MISSING.
P043	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P044	BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES REQUESTED.
P045	FIRST MODIFIER IS INVALID.
P046	SECOND MODIFIER IS INVALID.
P047	THIRD MODIFIER IS INVALID.
P048	FOURTH MODIFIER IS INVALID.
P052	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P053	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P054	RENDERING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES FOR THE BENEFIT PLAN.
P055	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P061	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.

Denial Code	Long Description
P062	THE CLIENT ID AND/OR NAME INDICATED ON THE PA REQUEST IS INCORRECT. THE CLIENT ID AND/OR NAME HAS BEEN UPDATED. PLEASE VERIFY THE ID AND/OR NAME IS CORRECT.
P064	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
P067	THE FREQUENCY OF HOURS REQUESTED ARE NOT APPROPRIATE FOR THIS CLIENT AND HAVE BEEN MODIFIED ACCORDINGLY.
P079	BILLING PROVIDER IS ON PAYMENT SUSPENSION DUE TO CREDIBLE ALLEGATION OF FRAUD.
P120	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAS BEEN REDUCED.
P121	THE SERVICE/ PROCEDURE REQUESTED IS NOT SUPPORTED BY SUBMITTED DOCUMENTATION.
P126	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
P128	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.
P138	SERVICE(S) DO NOT MEET COLORADO MEDICAID GUIDELINES.
P167	REQUESTED DOCUMENTATION HAS NOT BEEN SUBMITTED.
P178	THE SERVICE REQUESTED IS NOT MEDICALLY NECESSARY.
P179	THE MEDICAL NECESSITY FOR THIS SERVICE IS NOT SUPPORTED BY THE SUBMITTED DOCUMENTATION.
P233	THE DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE ADDITIONAL CARE.
P257	THIS CLIENTS FUNCTIONAL ASSESSMENT SCORES PLACE THIS CLIENT OUTSIDE ELIGIBILITY FOR DAY TREATMENT.
P274	OUR RECORDS INDICATE THIS CLIENT IS INVOLVED IN EFFECTIVE AND APPROPRIATE SERVICE ELSEWHERE.
P292	INTENSIVE REHABILITATION HOURS ARE NO LONGER APPROPRIATE AS INDICATED BY HISTORY, DIAGNOSIS, AND/ OR FUNCTIONAL ASSESSMENT SCORES.
P328	THE SERVICES REQUESTED INCLUDE NON-COVERED SERVICES, AND HOURS ARE REDUCED ACCORDINGLY.
P339	THE CLIENTS PAST HISTORY INDICATES REDUCED TREATMENT HOURS ARE WARRANTED.
P342	THE REQUEST DOES NOT MEET GENERALLY ACCEPTED CONDITIONS REQUIRING FLUORIDE TREATMENTS.
P346	SERVICES EXCEED COLORADO MEDICAID LIMITATION AND DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE MEDICAL NECESSITY OF THE SERVICE.
P349	THE SERVICE REQUESTED WAS PERFORMED LESS THAN FIVE YEARS AGO.
P353	THE EXISTING APPLIANCE HAS NOT BEEN WORN FOR THREE YEARS.
P367	THE CLIENT HAS BEEN TOTALLY WITHOUT TEETH AND AN APPLIANCE FOR FIVE YEARS.
P392	THE CLIENT IS MISSING AN ANTERIOR TOOTH AND/OR HAS TWO OR MORE POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P405	THE SERVICE(S) REQUESTED COULD ADEQUATELY BE PERFORMED IN THE DENTAL OFFICE.
P406	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE OF GOOD PERIODONTAL HEALTH (AMERICAN ACADEMY OF PERIODONTOLOGY PERIODONTAL CLASSIFICATION OF TYPE I OR II).
P407	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE VISIBLE ON RADIOGRAPHS THAT AT LEAST 50 PERCENT OF THE CLINICAL CROWN IS INTACT.
P409	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING SIX OR MORE TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED, INCLUDING THIRD MOLARS.
P410	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING ONE OR MORE ANTERIOR TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED.
P411	DOCUMENTATION DOES NOT SUPPORT THE NEED FOR PERIODONTIC SERVICES. POCKETS ARE LESS THAN 4MM AND/OR GREATER THAN 6MM FOR CLIENT AND/OR THE CLIENT IS UNDER THE AGE OF 13.
P412	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA.
P413	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA. THIS PA HAS BEEN GRANTED AS APPROVED NOT APPROVED WITH REVISIONS. THE DURATION REQUESTED MAY HAVE BEEN REDUCED TO REFLECT COVERAGE LIMITATIONS, PRESCRIBER ORDERS, CONFLICTI
P417	THE SERVICE(S) REQUESTED COULD BE ADEQUATELY PERFORMED WITH LOCAL ANESTHESIA.
P437	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO POOR ORAL HYGIENE.
P444	THIS LINE ITEM IS A DUPLICATE OF ANOTHER LINE ITEM ON THIS PRIOR AUTHORIZATION (PA) REQUEST. PLEASE CORRECT.
P446	THIS IS A DUPLICATE OF AN EXISTING PRIOR AUTHORIZATION (PA) REQUEST. YOU MAY CONTACT PROVIDER SERVICES IF YOU REQUIRE ASSISTANCE. DUPLICATE PA REQUEST

Denial Code	Long Description
P448	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO DECAY HISTORY.
P449	QUESTIONABLE LONG TERM PROGNOSIS DUE TO GUM AND BONE DISEASE.
P456	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO APPARENT ROOT INFECTION.
P457	OUR RECORDS INDICATE THIS CLIENT HAS EXCEEDED ESTABLISHED PROGRAM LIMITATIONS. COLORADO MEDICAID WILL NOT AUTHORIZE NEW DENTURES.
P458	DOCUMENTATION PROVIDED INDICATES A LESS ELABORATE PROCEDURE SHOULD BE CONSIDERED.
P502	RENTAL ONLY ALLOWED; MEDICAL NEED FOR PURCHASE HAS NOT BEEN DOCUMENTED.
P503	PURCHASE ONLY ALLOWED; MEDICAL NEED FOR RENTAL HAS NOT BEEN DOCUMENTED.
P504	OCCUPATIONAL THERAPY GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P505	THE SERVICE REQUESTED IS INCLUDED IN THE NURSING HOME RATE STRUCTURE.
P511	THIS NATIONAL DRUG CODE IS ONLY BILLABLE AS PART OF A COMPOUND DRUG.
P515	THE PRESENCE OF A HANDICAPPING MALOCCLUSION OR HANDICAPPING DENTOFACIAL DEFORMITY IS NOT SUPPORTED BY THE DOCUMENTATION SUBMITTED.
P521	THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVERED BY COLORADO MEDICAID.
P522	GASTRO-INTESTINAL SURGERY FOR THE PURPOSE OF WEIGHT CONTROL IS COVERED ONLY AS A LIFE THREATENING PROCEDURE.
P523	THE TREATMENT REQUEST IS NOT CONSISTENT WITH THE CLIENT'S DIAGNOSIS.
P524	PSYCHOTHERAPY PROVIDED IN THE CLIENTS HOME IS NOT A COVERED BENEFIT OF COLORADO MEDICAID.
P525	THE INFORMATION PROVIDED IS NOT CONSISTENT WITH THE INTENSITY OF SERVICES REQUESTED.
P526	INTENSIVE MULTIPLE MODALITY TREATMENT IS NOT CONSISTENT WITH THE INFORMATION PROVIDED.
P527	MULTIPLE PROVIDERS OF TREATMENT ARE NOT INDICATED FOR THIS CLIENT.
P528	THE DURATION OF TREATMENT SESSIONS EXCEED CURRENT COLORADO MEDICAID GUIDELINES.
P534	DOCUMENTATION OF POOR PHYSICAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P535	OTHER PHYSICAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P536	THE PHYSICAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P537	USE OF PHYSICAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P538	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF A PHYSICAL THERAPIST.
P539	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS AND LIVING ARRANGEMENT.
P540	GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P541	THE PROCEDURE(S) REQUESTED ARE NOT MEDICAL IN NATURE.
P542	DOCUMENTATION OF POOR OCCUPATIONAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P543	DOCUMENTATION OF POOR SPEECH THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P544	OTHER OCCUPATIONAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P546	THE OCCUPATIONAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P547	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF PHYSICAL THERAPY.
P548	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P549	ACTIVITIES TO PROMOTE DIVERSION OR GENERAL MOTIVATION ARE NONCOVERED COLORADO MEDICAID SERVICES.
P550	REVISIONS OF THE REQUEST IS NECESSITATED BY THE CLIENTS MINIMAL PROGRESS.
P551	RESTORATIVE NURSING INVOLVEMENT COULD BE INCREASED.

Denial Code	Long Description
P552	CLIENTS DEMONSTRATED RESPONSE TO CURRENT THERAPY DOES NOT WARRANT THE INTENSE FREQUENCY REQUESTED.
P553	MAINTENANCE IS TWO TIMES PER WEEK OR LESS.
P554	THE SPEECH THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P555	USE OF OCCUPATIONAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P556	USE OF SPEECH THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P557	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF AN OCCUPATIONAL THERAPIST.
P558	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
P559	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P560	THE MATERIALS/ SERVICES REQUESTED ARE PRINCIPALLY COSMETIC IN NATURE.
P561	THE LENS FORMULA DOES NOT JUSTIFY REPLACEMENT.
P562	THE CHANGE IN THE LENS FORMULA DOES NOT WARRANT MULTIPLE REPLACEMENTS.
P563	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P564	LENSES ONLY ARE APPROVED; PLEASE DISPENSE A CONTRACTED FRAME. THE NON-CONTRACTED FRAME IS NOT MEDICALLY JUSTIFIED.
P565	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P566	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P567	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF OCCUPATIONAL THERAPY.
P568	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF SPEECH THERAPY.
P569	LEVEL, INTENSITY, OR EXTENT OF SERVICE(S) REQUESTED HAS BEEN MODIFIED CONSISTENT WITH MEDICAL NEED AS DEFINED IN THE PLAN OF CARE.
P570	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P571	THE SERVICE ASKED FOR IS NOT COVERED BY COLORADO MEDICAID AS THESE TASKS CAN BE DONE BY NURSES OR ACTIVITY STAFF.
P572	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P573	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.
P574	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P575	MEDICAL NEED FOR EQUIPMENT/ SUPPLY REQUESTED IS NOT SUPPORTED BY DOCUMENTATION SUBMITTED.
P576	OTHER SPEECH THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P577	DOCUMENTATION SUBMITTED IDENTIFIES THAT THE CLIENT HAS FEWER THAN TWO POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P582	LESS EXPENSIVE ALTERNATIVE SERVICES ARE AVAILABLE FOR THIS CLIENT.
P634	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P711	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING PERIODONTAL SCALING AND ROOT PLANNING.
P712	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING GINGIVECTOMY.
P754	AN APPROVED SUBSTANCE ABUSE DAY TREATMENT PROGRAM CANNOT EXCEED A SIX WEEK PERIOD.
P761	THE CLIENT DOES NOT APPEAR TO BE ABLE OR WILLING TO ABSTAIN FROM ALCOHOL/DRUG USAGE WHILE IN TREATMENT. THEREFORE, SUBSTANCE ABUSE DAY TREATMENT SERVICES ARE NOT APPROVED.
P764	THIS CLIENT HAS COMPLETED INTENSIVE SUBSTANCE ABUSE TREATMENT WITHIN THE PAST 12 MONTHS. THE DOCUMENTATION PROVIDED IS NOT ADEQUATE TO JUSTIFY ADDITIONAL INTENSIVE TREATMENT AT THIS TIME.
P785	A LESS THAN SIX-WEEK HEALING PERIOD HAS BEEN SPECIFIED FOR THIS PRIOR AUTHORIZATION. THEREFORE IT IS NOT NECESSARY TO WAIT THE FULL SIX WEEKS AFTER EXTRACTIONS BEFORE TAKING DENTURE IMPRESSIONS.

Denial Code	Long Description
P818	SIX-WEEK HEALING TIME IS REQUIRED BETWEEN EDENTULATION AND FINAL IMPRESSIONS. PAYMENT FOR DENTURES WILL BE DENIED OR RECOUPED IF HEALING PERIOD IS NOT OBSERVED.
P849	COLORADO MEDICAID HAS DETERMINED THERE WERE (ARE) SEVERAL HOME HEALTH AGENCIES WILLING TO PROVIDE MEDICALLY NECESSARY SKILLED NURSING SERVICES TO THIS CLIENT.
P864	THE DOCUMENTATION YOU HAVE SUBMITTED DOES NOT MEET THE REQUIREMENTS OF COLORADO MEDICAID.
P873	THE MEDICAL NECESSITY FOR THE HOURS REQUESTED IS NOT SUPPORTED BY THE INFORMATION SUBMITTED.
P874	THE DOCUMENTATION SUBMITTED INDICATES THE TASKS SPECIFIED CAN BE COMPLETED DURING THE VISITS APPROVED.
P878	THE DOCUMENTATION SUBMITTED DOES NOT INDICATE THAT MEDICALLY ORIENTED TASKS ARE MEDICALLY NECESSARY; THEREFORE PERSONAL CARE SERVICES HAVE BEEN APPROVED.
P880	THE QUANTITY OF SERVICES AUTHORIZED FOR THIS CLIENTS PERSONAL CARE HAS BEEN AMENDED BASED ON INFORMATION RECEIVED FROM ONE OR MORE OF THESE SOURCES: THE CLIENT, THEIR PHYSICIAN, AND/OR THE IN-HOME VISIT BY STAFF OF THE OIG (OFFICE OF INSPECTOR GENERAL).
P885	THE USE OF THIS DRUG FOR THE INTENDED PURPOSE IS NOT COVERED BY COLORADO MEDICAID, CONSISTENT WITH COLORADO ADMINISTRATIVE CODE AND FEDERAL LAW.
P924	THE MEDICAL RECORDS SUBMITTED WITH THE CURRENT REQUEST CONFLICT OR DISAGREE WITH OUR MEDICAL RECORDS ON THIS CLIENT.
P950	INDEPENDENT NURSES, PLEASE NOTE PAYABLE SERVICES MAY NOT EXCEED 12 HOURS/DAY OR 60 HOURS/WEEK.
P951	SERVICES CAN ONLY BE AUTHORIZED THROUGH ONE YEAR FROM THE PRESCRIPTION DATE.
P952	LEAD INSPECTION IS A COVERED COLORADO MEDICAID SERVICE WHEN THE CHILD HAS BEEN SHOWN TO HAVE LEAD POISONING (E.G., CHILD HAS A BLOOD LEAD LEVEL > 19 UG/DL OR TWO CONSECUTIVE BLOOD LEAD LEVELS OF 15-19 UG/DL DONE AT LEAST 90 DAYS APART). THE INSPECTION MUS
P953	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P954	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P956	THE REQUEST CAN ONLY BE BACKDATED A MAXIMUM OF 14 DAYS FROM FIRST DATE RECEIVED BY COLORADO MEDICAID.
P957	COMPLETE PERIODONTAL CHARTING AT TIME OF SERVICE, AND SUBMIT CHARTING, COPY OF OPERATIVE REPORT, TOGETHER WITH A COPY OF THE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF), F-11035, TO PA UNIT ATTENTION DENTAL CONTSULTANT.
P958	NOTE THAT CODE D4341 HAS BEEN CHANGED. REFER TO THE DECISION NOTICE FOR AUTHORIZED QUANTITY.
P960	YOUR PA HAS BEEN APPROVED FOR 90 DAYS. THE 90 DAY APPROVAL DOES NOT IMPLY THE PA REQUEST MEETS PRIOR AUTHORIZATION CRITERIA. AFTER ADDITIONAL INFORMATION IS AVAILABLE IN INTERCHANGE, COLORADO MEDICAID WILL CREATE AN AMENDMENT REQUEST TO EXTEND THE PA FOR
P961	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P962	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
PA10	THE REQUESTED END DATE IS INVALID.
PA12	PLEASE FURNISH A WRITTEN DESCRIPTION OF THE CLIENTS DIAGNOSIS.
PA13	PROVIDE DIAGNOSES WITH DATES OF ONSET.
PA14	IDENTIFY PROBLEMS TO BE TREATED.
PA15	THE AUDIOLOGISTS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1), F-11020, AND PRIOR AUTHORIZATION REQUEST/HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2), F-11021.
PA16	THE PHYSICIANS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION/PHYSICIAN OTOLOGICAL REPORT (PA/POR), F-11019.

Denial Code	Long Description
PA17	SUBMIT BRIEF HISTORY WITH REFERRAL INFORMATION, LIVING SITUATION, FUNCTIONAL STATUS, AND OTHER PERTINENT INFORMATION. WHAT CHANGE OF STATUS RESULTED IN REFERRAL AT THIS TIME?
PA18	PLEASE FURNISH THE CLIENTS HEIGHT AND WEIGHT.
PA19	PLEASE SUBMIT CLINICAL INFORMATION SUFFICIENT TO VERIFY THE NEED FOR THE REQUESTED SERVICE(S).
PA20	PLEASE RESUBMIT WITH COMPLETE PERIODONTAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PA21	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL EDUCATIONAL PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA22	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL PROGRAM PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA23	REFER TO THE DURABLE MEDICAL EQUIPMENT INDEX FOR APPROPRIATE CODE AND DESCRIPTION. DO NOT USE AN "UNLISTED" CODE.
PA24	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUALIZED FAMILY SERVICE PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA25	INFORMATION ON THE REQUEST FORM IS ILLEGIBLE, AND THE REQUEST CANNOT BE PROCESSED.
PA26	RE-EVALUATE YOUR GOALS. EMPHASIS SHOULD BE ON FUNCTIONAL SELF-CARE. GOALS MUST BE RELATED TO FUNCTIONAL OUTCOME.
PA27	PLEASE CLARIFY THE NUMBER OF HOURS PER WEEK REQUESTED.
PA28	PLEASE CLARIFY THE NUMBER OF HOURS PER DAY REQUESTED.
PA29	PLEASE CLARIFY THE NUMBER OF VISITS PER DAY REQUESTED.
PA30	ATTACH SUPPORTIVE DOCUMENTATION; HOME EXERCISE PROGRAM AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA31	THE DIAGNOSIS CODE INDICATED ON THE REQUEST DOES NOT CORRESPOND TO THE DIAGNOSIS CODE DESCRIPTION.
PA32	PLEASE SUBMIT ADDITIONAL INFORMATION SUFFICIENT TO VERIFY APPROPRIATENESS AND NEED FOR TRANSPLANT.
PA33	PLEASE SUBMIT THE INITIAL AND PROGRESSIVE OBJECTIVE FINDINGS.
PA34	ATTACH SUPPORTIVE DOCUMENTATION, FACILITY PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA35	PLEASE SUBMIT THE CLIENTS ORIGINAL COMPLAINTS AND EXAMINATION FINDINGS.
PA36	ATTACH SUPPORTIVE DOCUMENTATION, IN-HOME AUTISM PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA37	PLEASE SUBMIT YOUR TREATMENT PLAN FOR THIS CLIENT.
PA38	ATTACH SUPPORTIVE DOCUMENTATION AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA39	INITIAL EVALUATIONS MUST BE PERFORMED BY AN OCCUPATIONAL THERAPIST REGISTERED (OTR), PER AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA) STANDARDS.
PA41	IDENTIFY THE PLACE OF SERVICE AND ITS EFFECT ON SUPPORTING THE DESIRED TREATMENT OUTCOME.
PA42	PLEASE INDICATE THE HOURS OF USE OF OXYGEN PER 24-HOUR PERIOD.
PA43	PROVIDE BASELINE DOCUMENTATION FOR THIS CLIENTS LIMITATIONS USING UNITS OF MEASUREMENT THAT ARE APPLIED CONSISTENTLY WHEN REPORTING STATUS.
PA44	IDENTIFY FUNCTIONAL LIMITATIONS AS THEY ARE RELATED TO IDENTIFIED CONDITIONS.
PA46	CORRELATE PLAN OF CARE TO REQUESTED PROCEDURE CODES.
PA47	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE FREQUENCY/DURATION REQUESTED.
PA48	PLEASE PROVIDE THE NAME AND CREDENTIALS OF THE RENDERING PROVIDER.
PA50	COLORADO MEDICAID RECORDS INDICATE THE CLIENT OWNS A WHEELCHAIR. DOCUMENT THE REASON AND NEED FOR REPLACEMENT AND COST TO REPAIR CURRENT WHEELCHAIR.
PA51	PLEASE DISTINGUISH PRIMARY AND SUPPORTIVE MODALITIES.
PA52	PLEASE SUBMIT A PROGRESS REPORT.
PA53	MULTIPLE FAMILY CLIENTS TREATMENT BY THE SAME PROVIDER REQUIRES FURTHER INFORMATION DOCUMENTING COORDINATION OF TREATMENT PLAN.

Denial Code	Long Description
PA54	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE MINUTES REQUESTED.
PA55	MEDICAL NECESSITY OF TREATMENT REQUIRES ADDITIONAL DOCUMENTATION.
PA56	GIVEN AGE, DIAGNOSES, CURRENT LEVEL OF FUNCTION, PAST RESPONSE TO TREATMENT, AND LIVING SITUATION, EXPAND ON POTENTIAL FOR SIGNIFICANT FUNCTIONAL PROGRESS WITHIN THE NEXT SIX MONTHS. EMPHASIZE WHY PROGRESS IS EXPECTED WITH SERVICES AT THIS TIME.
PA57	SUBMIT THE INITIAL FINDINGS. INCLUDE A COMPREHENSIVE EVALUATION.
PA58	SUBMIT PROGRESSIVE, OBJECTIVE FINDINGS. INCLUDE A PERTINENT RE-EVALUATION.
PA59	PLEASE SUPPLY INFORMATION REGARDING THE CLIENTS MEDICATION REQUIREMENTS, IF ANY.
PA60	PLEASE SPECIFY IF THE CLIENT IS IN AN EDUCATIONAL SETTING.
PA61	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA62	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
PA63	THE SKILLS OF A THERAPIST ARE PURPOSEFUL AND SKILLED INTERVENTIONS REQUIRED TO CONTINUALLY DESIGN, IMPLEMENT, REASSESS, MODIFY/GRADE, AND/OR DISCONTINUE A PLAN OF CARE IN A TIMELY MANNER, BASED ON THE COMPLEXITY OF THE CLIENTS MEDICAL CONDITION AND/OR CO
PA64	PLEASE SUBMIT A THERAPY PLAN OF CARE, INCLUDING A CURRENT, DATED EVALUATION.
PA65	A PLAN OF CARE SIGNED AND DATED BY THE PHYSICIAN IS REQUIRED.
PA66	THE SKILLS OF A THERAPIST ARE REQUIRED WHEN ONLY THE THERAPIST CAN SAFELY AND EFFECTIVELY DELIVER THE THERAPEUTIC PROCEDURES BECAUSE OF THEIR UNIQUE KNOWLEDGE, TRAINING, AND EXPERTISE. DESCRIBE THE REASON THAT SOMEONE OTHER THAN A THERAPIST CANNOT SAFELY
PA67	PLEASE SPECIFY IF THE CLIENTS WORK SITE DEMANDS GOOD BINAURAL HEARING.
PA68	DESCRIBE THE REASON, BASED ON THE CLIENTS COGNITIVE, PHYSICAL, COMMUNICATION, OR RESOURCE STATUS, THAT A HOME PROGRAM, EQUIPMENT, OR ENVIRONMENTAL ADAPTATIONS ALONE CANNOT MEET CLIENTS NEEDS.
PA69	PLEASE SPECIFY IF THE CLIENT HAS AN ACCOMPANYING DISABILITY THAT ADDS TO THE HEARING PROBLEM.
PA70	DISTINGUISH REQUESTED PROCEDURES AND GOALS FROM OTHER SERVICES THIS CLIENT RECEIVES. THEY MAY NOT BE DUPLICATIVE.
PA71	PLEASE INDICATE THE NUMBER OF DAYS REQUESTED.
PA73	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA74	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA75	PLEASE DOCUMENT CARRYOVER OF THE THERAPY PROGRAM TO NURSING.
PA76	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA79	PROVIDE EVIDENCE OF SIGNIFICANT FUNCTIONAL PROGRESS IN LAST SIX MONTHS.
PA84	THE GRANT DATE OF THIS REQUEST CANNOT BE PRIOR TO THE SIGNATURE DATE OF THE PRESCRIBING PHYSICIAN.
PA86	PROVIDE EVIDENCE OF SKILLS GAINED IN THERAPY CARRYING OVER TO OTHER SETTINGS WITHIN SIX MONTHS.
PA87	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE NUMBER OF SESSIONS REQUESTED.
PA88	THE REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL SCOPE OF PRACTICE.
PA89	PRIOR AUTHORIZATION IS NOT REQUIRED UNTIL LIMITATION OF SERVICE HAS BEEN REACHED.
PA91	PLEASE SUBMIT REQUIRED X-RAYS.
PA92	PLEASE PROVIDE AN EXPLANATION FOR THE MATERIAL SUBMITTED WITH THE REQUEST.
PA95	PLEASE DESCRIBE HOW THE PROVISION OF THIS SERVICE WOULD PREVENT INSTITUTIONALIZATION OF THE CLIENT.
PA96	COULD THE EXISTING DENTURE(S) BE RELINED OR REBASED? IF NOT, PLEASE EXPLAIN WHY NOT.
PA97	REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL STANDARDS OF PRACTICE.
PA98	PLEASE INDICATE IF THE CLIENT IS CURRENTLY BEING TUBE FED.
PB02	PLEASE PROVIDE THE REQUIRED DATED SIGNATURES ON THE ATTACHMENTS.

Denial Code	Long Description
PB03	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING THE LOSS/DESTRUCTION/THEFT OF THE HEARING AID.
PB04	DESCRIBE THE CLIENTS ABILITY TO STAND OR AMBULATE SUFFICIENTLY TO ACCOMPLISH SELF-CARE ACTIVITIES.
PB07	PLEASE SUBMIT AN ORTHODONTIC STUDY MODEL OR DIAGNOSTIC CASTS.
PB09	PLEASE PROVIDE A PHOTOGRAPH OF THE INVOLVED AREA(S).
PB10	PLEASE PROVIDE AN ESTIMATION (IN GRAMS) OF THE TOTAL AMOUNT OF TISSUE TO BE RESECTED.
PB11	PLEASE SUBMIT THE PLAN OF CARE FOR CO-TREATMENT.
PB12	FURNISH A DETAILED DESCRIPTION FOR THE PROCEDURE CODE REQUESTED.
PB13	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB15	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB18	PLEASE COMPLETE THE ATTACHED OUT-OF-STATE PROVIDER DATA SHEET, F-11001, AND RESUBMIT.
PB20	A SIGNED AND DATED PRESCRIPTION IS REQUIRED WITHIN THREE MONTHS OF RECEIPT BY COLORADO MEDICAID FOR INITIAL REQUESTS AND WITHIN 12 MONTHS OF RECEIPT BY COLORADO MEDICAID FOR SUBSEQUENT REQUESTS.
PB21	PLEASE COMPLETE THE APPROPRIATE PRIOR AUTHORIZATION ATTACHMENT. CONTACT PROVIDER SERVICES OR THE PRIOR AUTHORIZATION UNIT FOR ASSISTANCE.
PB23	PHYSICAL THERAPY ASSISTANT NOTES AND ALL FORMS SUBMITTED MUST BE COSIGNED BY A REGISTERED PHYSICAL THERAPIST.
PB31	ARE YOU REQUESTING A COMPLETE APPLIANCE, OR REPLACEMENT PARTS?
PB32	THE PROCEDURE CODE INDICATED ON THE REQUEST DOES NOT MATCH THE DESCRIPTION OF SERVICE; PLEASE CORRECT AND RESUBMIT.
PB35	THE SERVICE REQUESTED DOES NOT REQUIRE PRIOR AUTHORIZATION.
PB41	PLEASE FURNISH A CURRENT MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT, F-11090 (DATED WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID).
PB45	THE CERTIFICATION PERIOD ON THE PLAN OF CARE (POC) DOES NOT COVER THE REQUESTED GRANT/START DATE. PLEASE RESUBMIT YOUR REQUEST WITH A NEW POC.
PB49	A CERTIFIED OCCUPATIONAL THERAPY ASSISTANTS NOTES MUST BE COSIGNED BY AN OCCUPATIONAL THERAPIST REGISTERED.
PB51	ADDITIONAL INFORMATION IS REQUIRED ON PRIOR AUTHORIZATION TO ENABLE PRICING.
PB54	REQUESTED SERVICES DO NOT MATCH SERVICES ON THE PHYSICIANS ORDERS.
PB59	PLEASE PROVIDE AN INDIVIDUAL EDUCATIONAL PLAN (IEP), WHICH HAS BEEN SIGNED BY THE PROVIDER NO EARLIER THAN NINE MONTHS PRIOR TO RECEIPT AT COLORADO MEDICAID; OTHERWISE, DOCUMENT WHY NO IEP EXISTS.
PB65	PLEASE FURNISH THE ANTICIPATED TOTAL CHARGES FOR THIS REQUEST.
PB66	A PHOTOCOPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED; THE DATE MUST BE WITHIN SIX MONTHS OF RECEIPT BY COLORADO MEDICAID.
PB67	THE PRESCRIPTION DATE MUST INCLUDE MONTH, DAY, AND YEAR.
PB68	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID.
PB73	THE SERVICES IDENTIFIED ON THE PLAN OF CARE DO NOT APPEAR APPROPRIATE FOR THE PROCEDURE CODE(S) REQUESTED ON THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018.
PB74	THE CLIENT/PROVIDER DOES NOT HAVE RETROACTIVE ENROLLMENT.
PB75	THE REQUESTED START DATE IS MORE THAN 14 DAYS BEFORE OR 62 DAYS AFTER RECEIPT.
PB82	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
PB83	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A HOME HEALTH AIDE. PLEASE RESUBMIT AS A PERSONAL CARE WORKER OR PROVIDE ADDITIONAL DOCUMENTATION.
PB86	THE SERVICES REQUESTED ARE NOT BEING PROVIDED IN THE CLIENTS RESIDENCE. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL.
PB87	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A NURSE. PLEASE RESUBMIT AS A HOME HEALTH AIDE OR PROVIDE ADDITIONAL DOCUMENTATION.
PB92	PLEASE FURNISH THE CLIENTS COMPLETE ADDRESS.
PB94	IF THE CLIENT IS A RESIDENT OF A NURSING HOME, SUPPLY THE COMPLETE NAME AND ADDRESS OF THE NURSING HOME.

Denial Code	Long Description
PB99	THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018, MUST BE SIGNED AND DATED.
PC01	PLEASE SUPPLY THE RENDERING PROVIDERS PROVIDER NUMBER.
PC03	THE DRUG ENFORCEMENT ADMINISTRATION NUMBER IS MISSING OR INVALID.
PC06	PLEASE DESCRIBE YOUR PROGRAM; INCLUDE ENTRY DATE, TERMINATION DATE, HOURS PER WEEK, AND NUMBER OF WEEKS OF PRIMARY INTENSIVE SERVICE REQUESTED.
PC07	PLEASE DESCRIBE YOUR "AFTERCARE/FOLLOW-UP" PLANS FOR THIS CLIENT.
PC08	PLEASE SUPPLY DOCUMENTATION OF PREVIOUS SUBSTANCE ABUSE SERVICES WITH DATE(S) AND OUTCOME.
PC09	PLEASE DESCRIBE IN DETAIL THE TREATMENT OBJECTIVES/GOALS FOR THIS CLIENT.
PC10	PLEASE DESCRIBE THE FAMILY SITUATION/DYNAMICS. EXPLAIN HOW THE FAMILY WILL BE INCORPORATED INTO THE CLIENTS PLAN OF CARE.
PC12	PLEASE EXPLAIN IF YOUR SERVICE ENCOURAGES THE CLIENT TO ATTEND SELF-HELP GROUPS.
PC13	PLEASE SUPPLY A SPECIFIC SCHEDULE OF ACTIVITIES, INCLUDING DAY, TIME OF DAY, LENGTH OF SESSION, AND SERVICE TO BE RENDERED DURING THAT TIME.
PC15	PLEASE FURNISH DIAGNOSTIC RATIONALE.
PC17	PLEASE DOCUMENT IF THE CLIENT EVER RECEIVED SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT.
PC19	PLEASE FURNISH MORE EXTENSIVE AND IN-DEPTH HISTORICAL AND PSYCHOSOCIAL DATA.
PC20	PLEASE SUPPLY THE DATE THE CLIENT BECAME TOTALLY ENDENTULOUS.
PC23	PLEASE SUBMIT A PHYSICIANS STATEMENT REGARDING THE MEDICAL NECESSITY OF DENTURES FOR THIS CLIENT. THE PHYSICIANS STATEMENT MUST DOCUMENT THE MEDICAL NEED FOR DENTURES.
PC24	THE SERVICE REQUESTED WAS PREVIOUSLY AUTHORIZED. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT INDICATING THIS FACT IS REQUIRED.
PC25	PLEASE SUPPLY SUFFICIENT MITIGATING CIRCUMSTANCES TO WARRANT THE CONSTRUCTION OF NEW DENTURES(S).
PC26	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
PC28	PLEASE SUBMIT A PHYSICIANS STATEMENT INDICATING DENTURES ARE NECESSARY FOR THIS NURSING HOME CLIENT.
PC29	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING LOSS OR DESTRUCTION OF DENTURE(S). INCLUDE SIGNED STATEMENT FROM CLIENT OR FACILITY DIRECTOR REGARDING HOW, WHEN AND WHERE LOST.
PC30	PLEASE PROVIDE COMPLETE INTRAORAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PC31	PLEASE DESCRIBE ANY RELATED DEFORMITIES OF THE FEET.
PC34	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD WITH REQUESTED DME ITEM(S) AND DOCUMENT IF THE CLIENT CAN USE SAFELY AND INDEPENDENTLY.
PC35	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD AND DESCRIBE THE RESULTS AND EFFECTIVENESS OF THE SERVICE REQUESTED.
PC39	PLEASE INDICATE LITER FLOW PER MINUTE, HOURS OF USE PER 24 HOUR PERIOD, AND THE EXPECTED DURATION OF NEED.
PC40	THE ITEM DOES NOT REQUIRE PRIOR AUTHORIZATION UNTIL THE LIFE EXPECTANCY HAS BEEN REACHED.
PC41	PLEASE SUPPLY INFORMATION INDICATING THE NECESSITY OF POSITIONING THE CLIENT'S BODY IN MULTIPLE POSITIONS.
PC42	PLEASE INDICATE IF THE BED HEIGHT MUST BE CHANGED TO ALLOW FOR SAFE TRANSFER OR ADEQUATE BED CARE.
PC43	SUPPLY A PHYSICIANS STATEMENT INDICATING TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR UNIT HAS REDUCED PAIN, IMPROVED/INCREASED THE CLIENTS ACTIVITY LEVEL, AND/OR REDUCED CLIENTS USE OF PAIN MEDICATION.
PC44	A CURRENT AUTHORIZATION FOR THIS SERVICE IS ON FILE FOR ANOTHER PROVIDER. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT OF THAT FACT IS REQUIRED BY THE CLIENT OF FIRST PROVIDER.
PC59	DOCUMENT DECLINE OR PROGRESS IN SPECIFIC, MEASURABLE, OBJECTIVE TERMS.
PC60	DOCUMENT IF CLIENT HAS DEMONSTRATED A GOOD APPOINTMENT COMPLIANCE RECORD.
PC61	THE PHYSICIANS SIGNATURE DATE MUST NOT EXCEED 90 DAYS FROM THE DATE OF RECEIPT BY COLORADO MEDICAID.

Denial Code	Long Description
PC62	REQUESTS FOR A CONTINUATION OF THERAPY SHOULD NOT BE SUBMITTED MORE THAN FOUR WEEKS PRIOR TO THE EXPIRATION DATE OF THE CURRENT AUTHORIZATION.
PC63	PLEASE FURNISH THE STYLE AND MANUFACTURER OF THE FRAME.
PC64	PLEASE FURNISH THE CLIENTS LENS FORMULA.
PC66	ALL REQUESTS FOR TINTS REQUIRE DOCUMENTATION OF THE VISUAL OR MEDICAL CONDITION RELATED TO PHOTOPHOBIA.
PC67	PLEASE DOCUMENT THE REASON AND JUSTIFICATION FOR REPLACEMENT BEYOND THE FIRST LENS/FRAME.
PC68	DOCUMENT IF ALL REMAINING MAXILLARY AND/OR MANDIBULAR TEETH ARE DECAY-FREE, PROPERLY RESTORED, AND PERIODONTICALLY SOUND.
PC72	SUPPLY MORE DETAIL REGARDING PROGRESS (ATTACHMENT OF GOALS, ETC.). CORRELATE PROGRESS TO PREVIOUS GOALS AND IDENTIFIED LIMITATIONS.
PC77	PLEASE SUBMIT A PLAN OF CARE DESCRIBING THE SERVICES THAT WOULD BE PROVIDED.
PC78	PLEASE DOCUMENT SPECIFIC, MEASURABLE GOALS.
PC82	THE PRIOR AUTHORIZATION (PA) SYSTEM CAN PROCESS ONLY 26 DETAILS PER PA REQUEST. PLEASE RESUBMIT YOUR REQUEST WITH NO MORE THAN 26 DETAILS.
PC83	PLEASE SUPPLY A PHYSICIANS PRESCRIPTION DATED WITHIN ONE MONTH OF REQUESTED SUBSTANCE ABUSE DAY TREATMENT.
PC84	PLEASE PROVIDE INFORMATION INDICATING THIS CLIENT IS APPROPRIATELY DETOXIFIED FROM ALCOHOL AND/OR OTHER DRUGS.
PC85	PLEASE PROVIDE INFORMATION TO INDICATE THE CLIENTS ABILITY TO ABSTAIN FROM ALCOHOL OR DRUGS WHILE IN THE SUBSTANCE ABUSE DAY TREATMENT PROGRAM.
PC86	PLEASE INDICATE IF THIS CLIENT IS WILLING TO PARTICIPATE IN AFTERCARE OR CONTINUING CARE SERVICES.
PC87	PROVIDE MORE INFORMATION ON TREATMENT HISTORY; INCLUDE SERVICE PROVIDED, DATES, AND OUTCOME. PROVIDE DETAIL OF PREVIOUS TREATMENT.
PC88	PLEASE PROVIDE MORE RATIONALE FOR THE APPROPRIATENESS AND MEDICAL NECESSITY OF SUBSTANCE ABUSE DAY TREATMENT.
PC89	PROVIDE A TREATMENT PLAN THAT CONTAINS MEASURABLE GOALS AND OBJECTIVES CORRESPONDING TO THE IDENTIFIED DEFICIT.
PC91	PLEASE PROVIDE MORE INFORMATION ON FAMILY INVOLVEMENT TREATMENT.
PC92	PLEASE PROVIDE MORE HISTORY AND EXPLANATION ABOUT THE ISSUE OF ABSTINENCE FOR THIS CLIENT.
PC94	PLEASE PROVIDE THE ANTICIPATED BEGINNING DATE AND/OR THE ESTIMATED SUBSTANCE ABUSE DAY TREATMENT DISCHARGE DATE.
PC95	PLEASE SUPPLY JUSTIFICATION FOR BEGINNING CLIENT IN SERVICE PRIOR TO AUTHORIZATION BEING OBTAINED.
PC96	THE INITIAL THREE HOURS OF SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IN A CALENDAR YEAR DO NOT REQUIRE PRIOR AUTHORIZATION.
PC97	REIMBURSEMENT FOR INITIAL SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IS LIMITED TO THREE HOURS IN A CALENDAR YEAR AND DOES NOT REQUIRE PRIOR AUTHORIZATION.
PC98	THIS DRUG IS CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE BILL USING THE APPROPRIATE NATIONAL DRUG CODE (NDC) OR SUBMIT A COMPLETED DRUG ADDITION REQUEST FORM IF THE NDC IS NOT LISTED IN THE DRUG INDEX.
PC99	THIS DRUG IS NOT CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL, CURRENT ADMINISTRATIVE RULE, OR COLORADO DRUG INDEX FOR COVERAGE LIMITATIONS.
PD01	DOCUMENT THAT CLIENT HAS ACHIEVED GOOD ORAL HYGIENE, PERIODONTAL CASE TYPE 1 OR 2, AND IS MOTIVATED TO MAINTAIN SAME.
PD03	PLEASE PROVIDE AN ARTERIAL BLOOD GAS READING OR PULSE OXIMETRY RESULTS DONE ON ROOM AIR SIGNED AND DATED BY A MEDICAL DOCTOR. THIS SHOULD BE DONE WITHIN 60 DAYS OF REQUESTED SERVICE.
PD04	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 30 DAYS OF RECEIPT BY COLORADO MEDICAID.

Denial Code	Long Description
PD07	SUBMIT A PHOTOCOPY OF A VALID PRESCRIPTION, ISSUED WITHIN THE PAST YEAR, OR COMPLETE SECTION B OF THE PRIOR AUTHORIZATION/DRUG ATTACHMENT (PA/DGA), F-11049.
PD10	BRAND MEDICALLY NECESSARY MUST BE IN THE PRESCRIBERS OWN HANDWRITING AND WRITTEN DIRECTLY ON THE PRESCRIPTION OR A SEPARATE ORDER ATTACHED TO THE ORIGINAL PRESCRIPTION.
PD12	COMPLETE DENTURES, PARTIAL DENTURES, DENTURE RELINES, AND FIXED PROSTHODONTIC SERVICES ARE NOT COVERED SERVICES FOR ADULTS FOR DATES OF SERVICE ON AND AFTER OCTOBER 1, 1995.
PD22	PLEASE COMPLETE ALL REQUIRED ELEMENTS ON THE PERSONAL CARE SCREENING TOOL (PCST), F-11133.
PD24	THIS PRIOR AUTHORIZATION REQUEST IS UNABLE TO BE PROCESSED. PLEASE RESUBMIT WITH ADDITIONAL REQUIRED FORMS, INCLUDING THE ENTIRE PERSONAL CARE SCREENING TOOL (PCST), F-11133; PERSONAL CARE ADDENDUM, F-11136; AND SUPPORTING DOCUMENTATION, AS DIRECTED.
PD25	THERE IS A PERSONAL CARE SCREENING TOOL (PCST), F-11133, COMPLETED BY ANOTHER AGENCY. CONTACT THE AGENCY TO TRANSFER SCREEN.
PD26	THERE IS A LIMITED TERM CARE FUNCTIONAL SCREEN (LTC-FS) COMPLETED BY ANOTHER AGENCY. THE PERSONAL CARE SCREENING TOOL (PCST), F-11133, INFORMATION IS IN CONFLICT WITH LTC-FS.
PD27	ONLY ONE LEVEL OF FUNCTION MAY BE SELECTED FOR ALL ELEMENTS EXCEPT TOILETING. COLORADO MEDICAID IS UNABLE TO PROCESS THE PRIOR AUTHORIZATION REQUEST.
PD28	NO UNITS MAY BE REQUESTED USING THIS PRIOR AUTHORIZATION PROCESS. PLEASE SUBMIT WITH THE APPROPRIATE ATTACHMENTS FOR REQUESTING SPECIFIC PERSONAL CARE WORKER UNITS.
PD29	CLIENT IS NOT ELIGIBLE FOR THE REQUESTED SERVICE(S) AS OF THE REQUESTED START DATE.
PD30	NO TRAVEL TIME MAY BE AUTHORIZED WHEN NO PERSONAL CARE WORKER SERVICE IS AUTHORIZED.
PD32	PROVIDER NOT CERTIFIED TO RENDER THE SERVICE(S) REQUESTED.
PD34	BASED ON THE DOCUMENTATION SUBMITTED, THIS REQUEST CAN NOT BE PRIOR AUTHORIZED. REFER TO THE PA MESSAGES FROM THE CONSULTANT FOR COMPLETE EXPLANATION.
PD98	PLEASE DOCUMENT HOW AND WHEN EACH PREVIOUSLY AUTHORIZED PRO RE NATA VISIT WAS USED.

Targeted Case Management (TCM)

Denial Code	Long Description
0201	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
0233	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0235	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0237	CLIENT IDENTIFICATION NUMBER DOES NOT MATCH CLIENTS FIRST NAME.
0238	THE CLIENT IDENTIFICATION NUMBER DOES NOT MATCH THE CLIENTS LAST NAME.
0242	SECONDARY DIAGNOSIS CODE IS INVALID.
0248	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0249	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0251	PROCEDURE CODE MODIFIER IN FIRST POSITION IS INVALID.
0252	THE PROCEDURE CODE MODIFIER IN SECOND POSITION IS INVALID FOR REQUESTED START DATE OR DATE OF RECEIPT.
0253	THE PROCEDURE CODE MODIFIER IN THIRD POSITION IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
0258	THE PRIMARY DIAGNOSIS CODE IS REQUIRED.
0272	THE PRIMARY DIAGNSOSIS CODE IS INVALID.
0400	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0853	HCPCS - ANNUAL UPDATE
0885	NEVER EVENTS MODIFIERS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
0886	NEVER EVENTS DIAGNOSIS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.

Denial Code	Long Description
1000	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
1002	RENDERING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1003	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1007	RENDERING PROVIDER ID IS NOT ON FILE.
1047	THE RENDERING PROVIDERS CERTIFICATION HAS BEEN CANCELLED.
1048	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1801	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
1804	A CERTIFIED SUBSTANCE ABUSE DAY TREATMENT PROVIDER MUST SUBMIT A SUBSTANCE ABUSE DAY TREATMENT PROCEDURE CODE.
1806	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
1808	THE BILLING PROVIDER DOES NOT HAVE THE REQUIRED CERTIFICATION ADDENDUM ON FILE.
1900	THE BILLING PROVIDERS TAXONOMY CODE IS INVALID.
1901	THE RENDERING PROVIDERS TAXONOMY CODE IS INVALID.
1927	A NATIONAL PROVIDER IDENTIFIER IS REQUIRED FOR THE BILLING PROVIDER.
1934	A NATIONAL PROVIDER INDENTIFIER IS REQUIRED FOR THE RENDERING PROVIDER.
1936	THE BILLING PROVIDER NUMBER IS INVALID.
1937	THE RENDERING PROVIDER NUMBER IS INVALID.
1960	INTERNAL PROCESSING IS REQUIRED.
1963	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.
1964	THE BILLING PROVIDER INDICATED IS NOT ALLOWABLE AS A BILLING PROVIDER.
1965	RENDERING PROVIDER NUMBER IS MISSING/INVALID FOR THIS PROCEDURE PROVIDER.
1974	PRESCRIBING/REFERRING/ORDERING PROVIDER INDICATED IS NOT CERTIFIED AS A PRESCRIBING/REFERRING/ORDERING PROVIDER.
1975	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
1976	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
2001	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2003	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2017	THE CLIENT IS ENROLLED IN A MEDICAID OR OTHER MANAGED CARE PROGRAM.
2037	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2603	CLIENT LOCKED-IN TO A PROVIDER OR ENROLLED IN A HOSPICE. CONTACT CLIENTS HOSPICE FOR PAYMENT OF SERVICES OR RESUBMIT WITH DOCUMENTATION OF UNRELATED NATURE OF CARE.
3324	THE MODIFIER HAS BEEN DISCONTINUED BY THE CENTERS OF MEDICARE AND MEDICAID SERVICES OR THE AMERICAN MEDICAL ASSOCIATION FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
3337	THE PROCEDURE CODE HAS BEEN TERMINATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AMERICAN MEDICAL ASSOCIATION, OR AMERICAN DENTAL ASSOCIATION FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT. RESUBMIT WITH VALID A PROCEDURE CODE.
3339	THE PROCEDURE BILLED IS NOT PAYABLE ACCORDING TO DEFICIT REDUCTION ACT (DEFRA) GUIDELINES.
3351	THE PROCEDURE IS NOT COVERED FOR CLIENTS WITH A NURSING HOME AUTHORIZATION ON THE REQUESTED START DATE OR DATE OF RECEIPT.
3353	THE PROCEDURE IS NOT A COVERED SERVICE FOR HOME AND COMMUNITY-BASED WAIVER CLIENTS.
4021	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4027	THE DIAGNOSIS CODE IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
4031	THE PROCEDURE SUBMITTED IS NOT APPROPRIATE FOR CLIENTS GENDER.
4032	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4034	THE PROCEDURE CODE HAS AN AGE RESTRICTION.
4036	THE PLACE OF SERVICE CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4040	THE PRIMARY DIAGNOSIS CODE IS NOT ON FILE.
4041	THE SECONDARY DIAGNOSIS IS NOT ON FILE.
4046	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4127	INTERNAL PROCESSING IS REQUIRED.
4131	INTERNAL PROCESSING IS REQUIRED.
4141	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.

Denial Code	Long Description
4149	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4150	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4236	ETIOLOGY DIAGNOSIS CODE(S) (E-CODES) ARE INVALID AS THE PRIMARY DIAGNOSIS.
4244	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4245	THE FOURTH POSITION MODIFIER IS INVALID FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT.
4256	THE PROCEDURE CODE AND MODIFIER COMBINATION IS NOT PAYABLE FOR THE CLIENTS BENEFIT PLAN.
4257	THE MODIFIERS SUBMITTED ARE EITHER INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT OR THE MODIFIERS ARE MISSING.
4311	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4315	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4316	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4371	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4372	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4711	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR CLIENTS AGE.
4714	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS AGE.
4731	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS DIAGNOSIS.
4742	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4743	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4744	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4745	DIAGNOSIS AND/OR PROCEDURE AND/OR PLACE OF SERVICE (POS) CODE IS NOT COVERED FOR EXPRESS ENROLLMENT CLIENTS.
4746	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4801	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4802	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
4821	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
4871	PLEASE REFER TO PA MESSAGES FOR RETURN INFORMATION.
4963	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS GENDER.
4990	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
7500	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
7509	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
C001	This prior authorization was denied because the prior authorization form was not completed or the necessary attachment was not included.
C002	This prior authorization was denied because the client does not meet the criteria to receive a non-preferred product on the Colorado Medicaid Preferred Drug List.
C003	This prior authorization was denied because of a non-approved diagnosis. See Prior Authorization criteria (APPENDIX P) for approved diagnoses for this drug at http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1201542571132.
C004	This prior authorization was denied because the quantity limits have been exceeded. See Drug Limits for the allowable quantities for this medication at http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1201542571132.
C005	This prior authorization was denied because of the dosing schedule. See Prior Authorization criteria (APPENDIX P) for the approved dosing schedule for this drug at http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1201542571132.
C006	This prior authorization was denied because medications administered in a hospital, physician office or dialysis unit should be billed directly by those facilities as a medical item. These medications are not a pharmacy benefit under Colorado Medicaid.
C007	This prior authorization was denied because DESI drugs (medications determined not to be safe and effective by the FDA) and non-rebate able drugs (medications that have not signed a rebate agreement with the Centers for Medicare and Medicaid Services) are not a benefit of Colorado Medicaid.
C008	This prior authorization (PA) was denied because a pain evaluation was not submitted to the Prior Authorization Helpdesk with the PA form. Please fax a pain evaluation to the PA Helpdesk for reconsideration.

Denial Code	Long Description
C009	This prior authorization was denied because the client has exceeded the 90 day lifetime benefit for smoking cessation products
C010	This prior authorization was denied because durable medical equipment (DME) and supplies are a medical benefit of Colorado Medicaid and need to be billed as a medical cl DME are not a pharmacy benefit.
C011	This prior authorization was denied because the client does not meet the criteria for approval. See Prior Authorization criteria (APPENDIX P) at http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1201542571132.
C01Z	This is not a final denial. Please do not submit an appeal request. The required Client State Id number is missing or invalid. Please resubmit PAR request with the corrected information to CFMC via FAX at: 303-790-4643.
C02Z	*INACTIVE* This is not a final denial. Please do not submit an appeal request. The required Client State Id number does not match the Client Name. Please resubmit PAR request with the corrected information to CFMC via FAX at: 303-790-4643.
C03Z	*INACTIVE* This is not a final denial. Please do not submit an appeal request. The required Client date of birth is missing or invalid. Please resubmit PAR request with the corrected information to CFMC via FAX at: 303-790-4643.
C04Z	*INACTIVE* This is not a final denial. Please do not submit an appeal request. The required Requesting Provider Number is missing or invalid. Please resubmit PAR request with the corrected information to CFMC via FAX at: 303-790-4643.
C05Z	*INACTIVE* This is not a final denial. Please do not submit an appeal request. The required Billing Provider Number is missing or invalid. Please resubmit PAR request with the corrected information to CFMC via FAX at: 303-790-4643.
C100	The item or service requested is not a Medicaid benefit.
C101	*INACTIVE* DENIAL 1 The procedure is not a benefit of the Colorado Medicaid program.
C102	*INACTIVE* Denial 2 The procedure is not a benefit for children, recipients age birth through age 20.
C103	*INACTIVE* Denial 3 The procedure is not a benefit for adults, recipients age 21 and older.
C104	*INACTIVE* Denial 4 A report of the dental condition which supports the need for service was not submitted. ELECTRONIC PAR: 1. You can re-submit this PAR. 2. Click on the PROVIDER TAB during electronic dental prior authorization. 3. Describe the DENTAL CONDITION that supports the need for service. PAPER PAR: 1. You can re-submit this PAR. 2. On the ADA claim in area 32 "remarks for unusual services" 3. Describe the DENTAL CONDITION that supports the need for service.
C105	*INACTIVE* Denial 5 Report of dental condition/concurrent med condition which supports need not submitted. ELECTRONIC PAR 1. Re-submit PAR. 2. Click PROVIDER TAB during electronic dental PAR, 3. Describe DENTAL CONDITION supporting need for service. 4. Describe CONCURRENT MEDICAL CONDITION supporting need for service. PAPER PAR 1. You can re-submit this PAR. 2. On the ADA claim in area 32 "remarks for unusual services" 3. Describe DENTAL CONDITION supporting need for service. 4. Describe CONCURRENT MEDICAL CONDITION supporting need for service.
C106	*INACTIVE* Denial 6 The procedure code is not valid for the described procedure. ELECTRONIC AND PAPER PAR 1. You can re-submit this PAR. 2. Please refer to the DECEMBER 1998 Medicaid bulletin 3. See current codes and their descriptions. 4. You may submit ADA or Medicaid codes.
C107	*INACTIVE* Denial 07 The procedure code is not a benefit for this tooth number. ELECTRONIC AND PAPER 1. You can re-submit this PAR. 2. Please refer to the DECEMBER 1998 Medicaid bulletin 3. See procedure code tooth number limitations.
C108	*INACTIVE* Denial 8 The tooth surface designation submitted is not valid for this tooth number.
C109	*INACTIVE* Denial 9 The procedure is a duplicate service.
C110	*INACTIVE* Denial 10 Info required for PAR review not submitted. ELECTRONIC PAR 1. Re-submit this PAR. 2. Click on PROVIDER TAB during electronic dental PAR, 3. See the December 1998 Medicaid bulletin for this procedure code. 4. Briefly describe the information required as listed in the last column. PAPER PAR 1. You can resubmit this PAR. 2. On the ADA claim in area 32 " remarks for unusual services" 3. See the December 1998 Medicaid bulletin for the procedure code. 4. Briefly describe the information required as listed in the last column.

Denial Code	Long Description
C111	*INACTIVE* Denial 11 Periodontal diag and class not submitted. ELECTRONIC PAR 1. Re-submit this PAR. 2. Click on PROVIDER TAB during electronic dental PAR, 3. Briefly describe PERIODONTAL DIAGNOSIS supporting need for service. 4. Write the PERIODONTAL CLASSIFICATION supporting need for service. PAPER PAR 1. Re-submit this PAR. 2. On the ADA claim in are 32 "remarks for unusual services" 3. Briefly describe PERIODONTAL DIAGNOSIS supporting need for service. 4. Write the PERIODONTAL CLASSIFICATION supporting need for service.
C112	*INACTIVE* Denial 12 The orthodontic diagnosis which supports the need for the procedure was not submitted. ELECTRONIC PAR 1. You can re-submit this PAR. 2. Click on the PROVIDER TAB during electronic dental prior authorization. 3. Describe the ORTHODONTIC DIAGNOSIS supporting need for service. PAPER PAR 1. You can re-submit this PAR. 2. On the ADA claim in area 32 "remarks for unusual services" 3. Describe the ORTHODONTIC DIAGNOSIS supporting need for service.
C113	*INACTIVE* Denial 13 The info submitted does not support need for procedure. ELECTRONIC PAR 1. Re-submit this PAR. 2. Click on PROVIDER TAB during electronic dental PAR. 3. Describe in more detail DENTAL CONDITION supporting need for service. 4. Describe in more detail CONCURRENT MEDICAL CONDITION supporting need for service. PAPER PAR 1. Re-submit PAR. 2. On ADA claim in 32 "remarks for unusual services" 3. Describe in more detail DENTAL CONDITION need for service. 4. Describe in more detail CONCURRENT MEDICAL CONDITION need for service.
C114	*INACTIVE* Denial 14 Submitted information does not support a favorable prognosis.
C115	*INACTIVE* Denial 15 The "TMJ Pre-surgical evaluation form" for primary surgeon was not submitted. PAPER PAR 1. You can re-submit this PAR. 2. This prior authorization must be submitted on paper. 3. We need the ADA claim form and TMJ Pre-surgical evaluation form. 4. Contact ACS at 534-0109, ext 724 request a copy of the TMJ Pre-surgical evaluation form. 5. This is the only attachment in addition to the ADA claim form which is required for review.
C116	*INACTIVE* 16 PAR cannot be approved after the service has been started.
C117	Client ID is missing or invalid. Please resubmit with a correct client ID.
C120	*INACTIVE* The PAR that you sent directly to ACS is being denied. Please send this PAR to the authorizing agent: CFMC, P.O. Box 17300, Denver, CO 80217. Upon approval, CFMC will forward the PAR to ACS for PAR entry.
C121	*INACTIVE* The item or service requested is not a Medicaid Home Health benefit.
C122	*INACTIVE* The item or service requested is available under other Colorado Medicaid benefits for which the client is eligible. (eg. Private Duty Nursing, HCBS Personal Care, School Health and Related Services, outpatient therapy)
C123	*INACTIVE* The information submitted does not support the need for the services requested, you may re-submit the PAR describing in more detail current medical conditions supporting the need for services.
C124	*INACTIVE* The requested information has not been submitted. You may submit a new PAR with the requested information-Home Health plan of care and/or therapy assessments, current clinical summary.
C125	*INACTIVE* The requested information has not been submitted. You may submit a new PAR with the requested information-Written documentation of the results of the EPSDT medical screening, or other equivalent examination results provided by the client's third-party insurance.
C126	*INACTIVE* This service does not require prior authorization. Submit charges on the appropriate claim form.
C127	*INACTIVE* The revenue code is already authorized for this client, this provider, this date span. Please bill using the information on the original PAR, or submit a new PAR for revision to increase services.
C128	*INACTIVE* The clinical information does not substantiate medical necessity.
C129	*INACTIVE* The information submitted is insufficient. Completion of the prior authorization request information is required to review this Prior Authorization.
C130	*INACTIVE* The agency is not a Medicaid Provider.
C131	*INACTIVE* No services shall be approved for dates of service prior to the date of receipt of the complete prior authorization request by the State or its agent.
C132	*INACTIVE* Extended Home Health Aide visits requested without submitting sufficient information about services on each visit.
C133	*INACTIVE* Therapy services requested are not included in the plan of care, which does not list the specific procedures and modalities to be used nor the amount, duration, and frequency.

Denial Code	Long Description
C134	*INACTIVE* Detailed information on each planned Home Health visit, including the times in and out, all tasks to be performed on each visit, and the place of service for each service is not included on the prior authorization request.
C135	Nursing visits solely for psychiatric counseling are not reimbursable.
C136	*INACTIVE* Any visit made solely for supervision of the Home Health Aide shall not be reimbursed.
C151	*INACTIVE* This item or service requested is not a Home and Community Based Services-Brain Injury program/ Medicaid benefit.
C152	*INACTIVE* The requested clinical information does not substantiate how the device or service will result in enhancement of the clients ability to perform activities of daily living, or to perceive, control or communicate with the environment in which they live.
C153	Item is not of direct medical or remedial benefit to the client.
C154	This item is primarily for a vocational or education application. Funding must first be pursued through the Division of Vocational Rehabilitation/Dept. of Education.
C155	Home modification request/environmental modification does not contain supporting documentation, which substantiates the necessity of the modification.
C156	*INACTIVE* The requested modification is not a direct medical or remedial benefit to the client.
C157	*INACTIVE* The Prior Authorization Request does not contain the required documentation of an Occupational Therapist or Physical Therapist in home assessment.
C158	Home modification request is not reasonable in cost when compared to usual and customary charges.
C159	*INACTIVE* Non-medical transportation request does not provide transportation for services, which prevent institutionalization.
C160	Transitional living prior authorization was requested for a client who does not meet the definition of "in need" according to 10 C.C.R. 2505-10, Sec. 8.516.30.B.2-3.
C161	Prior authorization period exceeds benefit defined in 10 C.C.R. 2505-10, sec.8.516.30.C.5.
C162	Prior authorization period exceeds benefit defined in 10 C.C.R. 2505-10, sec.8.516.30.C.5.
C163	The prior authorization request must include: a medical prescription, the name and Medicaid identification number of the client, the clinic name, business address, phone number, and Medicaid provider number, the referring physician name, business address, phone number, the rendering therapist name, provider number, business address, and phone number, Billing Provider information, a service plan for the client, Physical therapy history (including home health program involvement). Medicaid Bulletin B0200140.
C164	The prior authorization request is not needed. The original prior authorization is still in effect. Medicaid Bulletin B0200139.
C165	The service requested for this client is covered under another program (i.e., Home Health or Hospital Services, DME, etc.).
C166	Therapy services for this client have been authorized to a different provider. Medicaid Bulletin B0200139.
C167	*INACTIVE* Category of Handicapping Malocclusion not checked.
C168	Procedure does not require Prior Authorization approval for this client.
C169	Outpatient individual and individual brief counseling visits are limited to 35 visits per state fiscal year.
C170	Documentation supporting medical necessity is not sufficient.
C171	The Prior authorization request shall include: * a medical prescription, * client name and Medicaid identification * clinic name, business address, phone number and Medicaid provider number, * the rendering therapist name, provider number, business address and phone number, * billing provider information, * a service plan for the client, * mental health history (including the Mental Health Capitation Program (MHASA) or Home Health Program Involvement).
C172	Service requested for this client is covered under another program (i.e. 10 C.C.R. 2505-10, section 8.212 Mental Health Capitation Program).
C173	Mental Health visits for this client have been authorized to a different provider.
C174	This client is exempted from prefabricated crown services if the client was scheduled for hospitalization for dental services before May 13, 2004.
C175	Procedure does not require a prior authorization.
C176	*INACTIVE* The PAR that you sent directly to ACS is being denied. Please send this PAR to the authorizing agent: CFMC, Attention Medicaid/DME PARS, 23 Inverness Way East, Suite 100, Englewood, CO 80112-5708.

Denial Code	Long Description
C177	*INACTIVE* The PAR that you sent directly to ACS is being denied. Please send this PAR to the authorizing agent: CFMC, Attention Medicaid/DME PARs, to the fax server number at 303 695-3377.
C190	Item or service requested is not a benefit of the Home and Community Based Services Persons with Brain Injury Waiver.
C191	Alternative funding for modification has not been considered.
C192	Modification did not include two bids.
C193	Cost of modification exceeds lifetime cap.
C194	Requested clinical information does not substantiate how the device or service will result in enhancement of the client's ability to perform activities of daily living, or to perceive, control or communicate within the client's environment.
C195	Modification is not a direct medical or remedial benefit to the client.
C196	Documentation was not provided from an Occupational Therapist or Physical Therapist.
C197	Request for non-medical transportation request is not required by care plan to prevent institutionalization.
C200	The Diagnosis/clinical information does not substantiate medical necessity.
C201	*INACTIVE* Client has not utilized the equipment in the manner for which it was intended. Repairs and/or replacement of equipment will not be allowed in cases of repeated misuse.
C202	*INACTIVE* This product cannot be approved as its primary purpose is to either enhance the personal comfort of the client or provide Convenience for the client caregiver.
C203	*INACTIVE* The information submitted does not meet the Colorado Medicaid Program guidelines for medical necessity.
C204	*INACTIVE* This product has been provided in the recent past. Please submit additional information documenting the reason for its being requested once again.
C205	*INACTIVE* This request is for a WHEELCHAIR. The Colorado Medicaid Program has provided a similar product within the last few years. It is Medicaid policy that the original wheelchair should be utilized for a minimum of 5 years. Please submit additional information documenting the need for a new wheelchair at this point in time.
C206	*INACTIVE* It is the responsibility of the provider to service, repair and supply necessary parts for any Durable Medical Equipment product covered by a warranty during the warranty period. No replacement parts or repairs will be reimbursed by Colorado Medicaid during the warranty period.
C207	*INACTIVE* This product would more appropriately be provided on a rental basis.
C208	*INACTIVE* This product intended usage is for exercise. Colorado Medicaid does not cover products that are prescribed primarily for exercise.
C209	*INACTIVE* This product has been requested for a client who is currently residing in a nursing facility or hospital setting. Therefore, it will not be reimbursed through the Durable Medical Equipment program of Colorado Medicaid. It is the responsibility of the facility to provide this product.
C210	*INACTIVE* Please resubmit on paper. Prior Authorization Requests (PARS) must be submitted on paper for the following items: Electric Wheelchairs, Scooters, Orthotics and Prosthetics, Augmentative Communication Devices. Medicaid Bulletin B9900014, May 1999, Front Page Send paper PARS for these items directly to: CFMC, Attention: Medicaid/DME PARS, PO Box 17300, Denver, Colorado 80217 - 0300
C211	*INACTIVE* This product is not a benefit of the Durable Medical Equipment program. However, it may be covered under one of the Department waiver programs
C212	*INACTIVE* The information submitted does not support the need for the equipment requested. You may re-submit the Prior Authorization Request describing in more detail the current medical conditions that support the need for the equipment.
C213	*INACTIVE* The information submitted does not support the need for the medical supplies requested. You may re-submit the Prior Authorization Request describing in more detail the current medical conditions that support the need for the supplies.
C214	*INACTIVE* The requested information has not been submitted.
C215	*INACTIVE* The requested additional information is insufficient. Completion of the requested information is required to review this Prior Authorization Request.
C216	*INACTIVE* This product does not require prior authorization. Submit charges on the appropriate claim form.
C217	*INACTIVE* Serial number is required for all repairs. Please resubmit Prior Authorization Request with the serial number. Medicaid Bulletin B0100089, January 2001, Page 3
C218	*INACTIVE* Please send invoiced acquisition cost for this item.

Denial Code	Long Description
C219	*INACTIVE* Following info needed to review request for SPECIALIZED BED. 1. Hours a day client in bed? 2. What bed does client have now? 3. Why does current bed not meet needs? 3. Other alternatives tried? 4. Can client work controls, change positions independently? 5. Does client have caregiver assistant? 6. Medical necessity semi-electric or total electric bed will meet? 7. Explain why manual hospital bed will not meet needs. Submit letter with info requested and return to ACS, PARS Unit, P.O. Box 30, Denver, Colorado 80201-0030.
C220	*INACTIVE* WHEELCHAIR purchases must have the manufacturer, brand name, model name and serial number. Medicaid Bulletin B0100089, January 2001, Page 3. Please submit this letter with the information requested and return to ACS, PARS Unit, P.O. Box 30, Denver, Colorado 80201-0030.
C221	*INACTIVE* Following info needed to review request for SEAT LIFT. 1. Does client have severe hip arthritis/knee or severe neuromuscular disease? 2. Is seat lift mechanism part of physician course of treatment and prescribed to effect improvement or arrest or retard deterioration in patient condition? 3. Is client completely incapable of standing from any chair in home? 4. Once standing, can client ambulate independently? Submit this letter with info requested and return to ACS, PARS Unit, P.O. Box 30, Denver, Colorado 80201-0030.
C222	*INACTIVE* Info needed to review request for PATIENT LIFT. 1. Does transfer between bed, chair, wheelchair or commode require assistance of more than one person? 2. Without use of lift will client be confined to bed? 3. Other alternatives tried? 4. How long will client require use of lift? 5. Provide info about physical dimensions of home environment that should be taken into consideration. 10 C.C.R. 2505-10, Sec. 8.593.02 (A) - (G). Submit this letter with info requested and return to ACS, PARS Unit, P.O. Box 30, Denver, Colorado 80201-0030
C223	*INACTIVE* Info needed to review request for ELECTRIC/POWER LIFT. 1. Identify spasticity of patient. 2. How lift allow approp position of patient with one caregiver? 3. Caregiver need for proximity or physical contact during transfer for safety reasons. 4. Desc how lift will provide safe method of transfer for caregivers with restrictions/dysfunctions. 5. Info about physical dimensions of home environ. 10 C.C.R. 2505-10, Sec. 8.593.02 (A) - (G). Submit letter with info requested to ACS, PARS Unit, P.O. Box 30, Denver, Colorado 80201-0030.
C224	*INACTIVE* The following information is needed to review this request for the MATTRESS. 1. Does the client have a history of skin breakdown or currently have skin breakdown? Please explain? 2. What other alternatives have been tried? 3. What is the length of necessity of the mattress? 10 C.C.R. 2505-10, Sec. 8.593.02 (A) - (G). Please submit this letter with the information requested and return to ACS, PARS Unit, P.O. Box 30, Denver, Colorado 80201-0030.
C225	*INACTIVE* The following information is needed to review this request for the BLOOD PRESSURE MONITOR. 1. Please send the latest three blood pressure readings, the dates of the readings, medication and how frequently the blood pressure needs to be monitored. 2. If ordering an automatic monitor, please explain why a manual monitor will not meet the client needs. 10 C.C.R. 2505-10, Sec. 8.593.02 (A) - (G). Please submit this letter with the information requested and return to ACS, PARS Unit, P.O. Box 30, Denver, Colorado 80201-0030.
C226	*INACTIVE* The following information is needed to review this request for the FORMULA. Please provide the brand name being requested and the number of calories required per day from the formula. Specialty Provider Manual, Supply/DME, Page 2. Please submit this letter with the information requested and return to ACS, PARS Unit, P.O. Box 30, Denver, Colorado 80201-0030.
C227	*INACTIVE* Prior Authorization does not indicate a physician signature. A physician signature is required.
C228	*INACTIVE* Info is needed: 1. During trial period, did TENS: A. Produce no relief? B. Produce greater discomfort? C. Alleviate pain? 2. List pain med/dosage prior to treatment? 3. Was pain med/dosage reduced after application? 4. Degree of mobility prior to treatment? 5. Did degree of mobility improve? 6. Did patient derive significant therapeutic benefit? 7. Does patient own TENS unit or owned/used TENS unit in past? 8. Alternative treatments and/or clinical results. A. Traction B. Trigger point injections C. Surgery D. Drugs.
C229	*INACTIVE* Prior Authorization Requests must be submitted on paper for the following items: electric wheelchairs, scooters, orthotics and prosthetics, augmentative communication devices. Please send the Prior Authorization Request for these items directly to CFMC, Attention Medicaid/DME PARs, 23 Inverness Way East, Suite 100, Englewood, CO 80112-5708.
C230	*INACTIVE* This product is not a benefit of the Durable Medical Equipment program.
C231	*INACTIVE* The information submitted does not support the need for the equipment requested. You may re-submit the Prior Authorization Request describing in more detail the current medical conditions that support the need for the equipment.
C232	*INACTIVE* The information submitted does not support the need for the medical supplies or equipment requested. You may resubmit the Prior Authorization Request describing in more detail the current medical conditions that support the need for the supplies.

Denial Code	Long Description
C233	*INACTIVE* This product does not require prior authorization. Submit charges on the appropriate claim form.
C234	*INACTIVE* Serial number is required for all repairs. Please resubmit Prior Authorization Request with the serial number. Medicaid Bulletin B0100089, January 2001, Page 3.
C235	*INACTIVE* Hospital Bed Questionnaire #1 is needed to review this request. Please submit this letter with the information requested.
C236	*INACTIVE* Wheelchair purchases must have the manufacturer, brand name and model name. Please submit this letter with the information requested.
C237	*INACTIVE* Seat Lift Questionnaire #4 is needed to review this request. Please submit this letter with the information requested.
C238	*INACTIVE* Patient Lift Questionnaire #3 is needed to review this request. Please submit this letter with the information requested.
C239	*INACTIVE* Electric/Power Lift Questionnaire #3 is needed to review this request. Please submit this letter with the information requested.
C240	*INACTIVE* Pressure Relief Mattress Questionnaire #2 is needed to review this request. Please submit this letter with the information requested.
C241	*INACTIVE* Blood Pressure Unit/Monitor Questionnaire #5 is needed to review this request. Please submit this letter with the information requested.
C242	*INACTIVE* Oral and Enteral Nutrition Formula Questionnaire #10 (with particular attention to the number of calories per day) is needed to review this request. Please submit this letter with the information requested.
C243	*INACTIVE* The Prior Authorization Request does not indicate a physician signature. A physician signature is required.
C244	*INACTIVE* TENS or NMES Questionnaire #9 is needed to review this request. Please submit this letter with the information requested.
C245	*INACTIVE* Service previously authorized to this provider or another provider. The procedure code is already authorized for this client, this date span.
C246	*INACTIVE* Service previously authorized to this provider. The procedure code is already authorized for this client, this provider, and this date span. Please bill using the information on the original PAR.
C247	*INACTIVE* Services authorized to another provider.
C248	*INACTIVE* Please send product information on this item.
C249	*INACTIVE* A serial number is required for all repairs. Please resubmit PAR with the serial number.
C250	*INACTIVE* The dates entered either on the Header or Detail lines are invalid. Please review the dates and submit a new Prior Authorization Request with valid dates, including correct dates.
C251	This individual is not a Medicaid-eligible individual under age 21.
C252	The item or service requested is not a Medicaid benefit.
C253	The requested information has not been submitted. You may submit a new Prior Authorization Request with the requested information-Early and Periodic Screening, Diagnosis and Treatment screen and additional documentation indicating medical necessity.
C254	The information submitted does not support the medical need for the services requested, you may re-submit the Prior Authorization Request describing in more detail current medical necessity supporting the need for services.
C255	The clinical information does not substantiate medical necessity.
C256	*INACTIVE* This agency/individual is not a Medicaid Provider.
C257	*INACTIVE* This audiological service is not a benefit of the Health Care Program for Children with Special Needs.
C258	*INACTIVE* This audiological service is not a benefit of the Health Care Program for Children with Special Needs.
C259	This vision service was not provided by an ophthalmologist, optometrist or optician.
C260	These eyeglasses were not ordered by an ophthalmologist or an optometrist.
C261	These eyeglasses were not dispensed by an optician.
C262	There is no prior authorization for these orthoptic vision treatment services.
C263	There is no prior authorization for these contact lenses.
C264	Service previously authorized to this provider. The procedure code is already authorized for this client, this provider, this date span. Please bill using the information on the original PAR.
C265	Services authorized to another provider.
C266	The dates entered either on the Header or Detail lines are invalid. Please review the dates and submit a new Prior Authorization Request with valid dates.

Denial Code	Long Description
C271	Client is not eligible for all or part of the dates covered in this prior authorization. Verify eligibility prior to performing services.
C290	Modification did not include two bids.
C291	Request for non-medical transportation is not required by care plan to prevent institutionalization.
C292	Item or service requested is not a benefit of the Home and Community Based Services for the Elderly, Blind, and Disabled Waiver.
C315	*INACTIVE* Info needed to complete PAR review: 1. During trial period did TENS: A. Produce no relief? B. Produce greater discomfort? C. Significantly alleviate pain? 2. Was patient on pain med before treatment? List med/dosage. 3. Was med/dosage reduced? 4. Degree of mobility prior to treatment? 5. Did mobility improve? 6. Do therapeutic benefits warrant continued use? 7. Does patient own or owned/used TENS unit? 8. Appropriateness of alternative treatments and/or the clinical results. A. Traction B. Trigger point injections C. Surgery D. Drugs
C316	*INACTIVE* The procedure code requested has been changed. Please note the new procedure code.
C317	*INACTIVE* Please review the dates and submit a new PAR with valid dates, including correct year. The dates entered either on the header or detail lines are invalid.
C318	*INACTIVE* Please provide the Medicaid Provider ID number of the Pharmacy or DME Supply company supplying the requested items
C351	*INACTIVE* The item or service requested is not a Medicaid Home Health benefit.
C352	The information submitted does not support the need for the services requested, you may re-submit the PAR describing in more detail current medical conditions supporting the need for services.
C353	*INACTIVE* The requested information has not been submitted. You may submit a new PAR with the requested information-Home Health plan of care and/or therapy assessments, current clinical summary.
C354	*INACTIVE* This service does not require prior authorization. Submit charges on the appropriate claim form (Acute Home Health or Long Term Home Health with Acute Episode).
C355	*INACTIVE* The revenue code is already authorized for this client, this provider, this date span. Please bill using the information on the original PAR, or submit a new PAR for revision to increase services.
C356	*INACTIVE* The PAR that you sent directly to ACS is being denied. Please send this PAR to the authorizing agent: Single Entry Point Agency in county of client residence.
C357	*INACTIVE* The clinical information does not substantiate medical necessity.
C358	*INACTIVE* The requested additional information is insufficient. Completion of the requested information is required to review this Prior Authorization.
C359	*INACTIVE* The agency is not a Medicaid Provider.
C360	*INACTIVE* Nursing visits solely for the purpose of assess and teach are not billable in this case.
C361	Nursing visits are unreasonable in amount, frequency, or duration.
C362	*INACTIVE* Home health Aide units are requested, no skilled tasks are identified.
C363	*INACTIVE* Health Aide visits are not medically necessary.
C364	*INACTIVE* Home Health services shall be provided at the client place of residence except for EPSDT extraordinary HH which is prior authorized using a different process and form.
C365	*INACTIVE* The client is 18 years old or over and skilled therapies are not a benefit under Long Term Home Health.
C366	*INACTIVE* Extended Home Health Aide visits requested without submitting sufficient information about services on each visit.
C367	*INACTIVE* Documentation to support PRN visits has not been submitted.
C368	*INACTIVE* Written instructions from the therapist or other medical professional are required to support the need for ROM when it is the only skilled service performed by a Home Health Aide.
C369	*INACTIVE* Medication set-up by a nurse is the only reason for visits and documentation that the pharmacy was contacted is missing.
C370	*INACTIVE* Documentation does not support the need for two Home Health Aides at the same time for a two-person transfer.
C371	*INACTIVE* Client PAR is sent to the wrong authorizing agent, EPSDT HH, PDN, and Outpatient Therapy should be submitted to CFMC at PO Box 17300, Denver, CO, 80217.
C372	*INACTIVE* Based on the needs of the client, authorization is being given for a lesser amount of services than requested.

Denial Code	Long Description
C373	*INACTIVE* PAR form has been submitted later than 10 days from the HCFA-485 "from" date. PAR dates have been adjusted.
C374	*INACTIVE* Revisions for increases in services shall be submitted and processed according to the same requirements as for new PARs, with a current written assessment/physician orders pertaining to the increase.
C377	*INACTIVE* Nursing visits solely for foot care shall be reimbursed only if the client has a documented diagnosis that supports the need for a nurse, and the client or family caregiver is not able or willing to provide the foot care.
C378	To be eligible for Long Term Home Health services, as set forth at Section 8.523.11K, Medicaid clients 18 years and over shall meet the level of care screening guidelines for Long Term Care Services at Section 10CCR 2505-10/8.401; 10CCR 2505-10/8.522.10.
C379	*INACTIVE* The PAR that you sent directly to the SEP is being denied. Please send this PAR to the authorizing agent: ACS.
C380	*INACTIVE* Client PAR is sent to the wrong authorizing agent, EPSDT HH, or Outpatient Therapy should be submitted to CFMC.
C381	*INACTIVE* Based on the needs of the client, authorization is being given for a lesser amount of services than requested.
C382	*INACTIVE* Any visit made solely for supervision of the Home Health Aide shall not be reimbursed.
C383	*INACTIVE* The requested information has not been submitted. You may submit a new PAR with the requested information-Home Health plan of care and/or therapy assessments, current clinical summary.
C384	*INACTIVE* Client PAR is sent to the wrong authorizing agent, Private Duty Nursing PARs and application paperwork should be submitted do DDM Ascend via fax to 877-431-9568.
C385	*INACTIVE* Improper billing may result from visits that are unreasonable in amount, frequency and duration or visits performed when skilled tasks performed are not medically necessary.
C386	*INACTIVE* Service previously authorized to this provider. The procedure code is already authorized for this client, this provider, this date span. Please bill using the information on the original PAR.
C387	*INACTIVE* Services authorized to another provider.
C390	*INACTIVE* Extended Home Health Aide visits requested without submitting sufficient information about services on each visit.
C391	*INACTIVE* Client PAR is sent to the wrong authorizing agent, EPSDT HH, and Outpatient Therapy should be submitted to CFMC.
C392	*INACTIVE* Based on the needs of the client, authorization is being given for a lesser amount of services than requested.
C393	*INACTIVE* PAR form has been submitted later than 10 days from the PAR start date. PAR units have been adjusted.
C394	*INACTIVE* The requested information has not been submitted. You may submit a new PAR with the requested information-Home Health plan of care and/or therapy assessments, current clinical summary.
C395	*INACTIVE* The PAR that you sent directly to ACS is being denied. Please send this PAR to the authorizing agent: Single Entry Point Agency in county of client residence.
C396	*INACTIVE* Service previously authorized to this provider. The procedure code is already authorized for this client, this provider, this date span. Please bill using the information on the original PAR.
C397	The dates entered either on the Header or Detail lines are invalid. Please review the dates and submit a new Prior Authorization Request with valid dates.
C400	The requested information has not been submitted. You may submit a new PAR with the requested information.
C401	*INACTIVE* The service is not a benefit of the Colorado Medicaid medical transportation program. 10 C.C.R. 2505-10, Sec. 8.680-8.691 OTHER HEALTH SERVICES - TRANSPORTATION (As of February 1, 2002, the citations will be: 10 C.C.R. 2505-10, Sec. 8.680-8.688 NON-EMERGENT MEDICAL TRANSPORTATION
C402	Transportation to medical treatment located on or at military facilities is excluded from the Colorado Medicaid medical transportation program. (As of February 1, 2002, the citation will be: 10 C.C.R. 2505-10, Sec. 8.682 BENEFITS/EXCLUSIONS.)
C403	Transportation to medical treatment to providers not enrolled in the Medicaid program when Medicaid is the primary payer is excluded from the Colorado Medicaid medical transportation program. (As of February 1, 2002, the citation will be: 10 C.C.R. 2505-10, Sec. 8.682 BENEFITS/EXCLUSIONS.)

Denial Code	Long Description
C404	Transportation to medical treatment to providers not enrolled in the Medicaid program when Medicaid is the primary payer is excluded from the Colorado Medicaid medical transportation program. (As of February 1, 2002, the citation will be: 10 C.C.R. 2505-10, Sec. 8.682 BENEFITS/EXCLUSIONS.)
C405	Transportation to pick up or deliver prescriptions, medical supplies, or durable medical equipment is excluded from the Colorado Medicaid medical transportation program. (As of February 1, 2002, the citation will be: 10 C.C.R. 2505-10, Sec. 8.682 BENEFITS/EXCLUSIONS.)
C406	Transportation for nursing facility or group home residents to any medical or rehabilitative services required to be part of the facility program by Federal or State law is excluded from the Colorado Medicaid medical transportation program. (As of February 1, 2002, the citation will be: 10 C.C.R. 2505-10, Sec. 8.682 BENEFITS/EXCLUSIONS.)
C407	Charges when the client is not in the vehicle is excluded from the Colorado Medicaid medical transportation program. (As of February 1, 2002, the citation will be: 10 C.C.R. 2505-10, Sec. 8.682 BENEFITS/EXCLUSIONS.)
C408	Transportation to court-ordered medical services that are not a benefit of Medicaid is excluded from the Colorado Medicaid medical transportation program. (As of February 1, 2002, the citation will be: 10 C.C.R. 2505-10, Sec. 8.682 BENEFITS/EXCLUSIONS.)
C409	Meals and lodging expenses when travel to and from a non-emergent medically necessary covered service can reasonably be completed in one calendar day is excluded from the Colorado Medicaid medical transportation program. (As of February 1, 2002, the citation will be: 10 C.C.R. 2505-10, Sec. 8.682 BENEFITS/EXCLUSIONS.)
C410	Reimbursement for travel expenses of an escort when the travel is not expected to extend beyond one calendar day is excluded from the Colorado Medicaid medical transportation program. (As of February 1, 2002, the citation will be: 10 C.C.R. 2505-10, Sec. 8.682 BENEFITS/EXCLUSIONS.)
C411	The required documentation was not submitted for authorization of out-of-state medical transportation. (As of February 1, 2002, the citation will be: 10 C.C.R. 2505-10, Sec. 8.686 OUT-OF-STATE TRANSPORTATION AUTHORIZATIONS.)
C412	The required documentation was not submitted for authorization of commercial airline or train transportation. (As of February 1, 2002, the citation will be: 10 C.C.R. 2505-10, Sec. 8.685.07 PRIOR AUTHORIZATION REQUIREMENTS/PROCEDURES, COMMERCIAL AIRLINE OR TRAIN.)
C413	The required documentation was not submitted for authorization of ambulance and air ambulance transportation. (As of February 1, 2002, the citation will be: 10 C.C.R. 2505-10, Sec. 8.685.08 PRIOR AUTHORIZATION REQUIREMENTS/PROCEDURES, AMBULANCE AND AIR AMBULANCE.)
C414	The required documentation was not submitted for authorization of ancillary services related to medical transportation. (As of February 1, 2002, the citation will be: 10 C.C.R. 2505-10, Sec. 8.685.09 PRIOR AUTHORIZATION REQUIREMENTS/PROCEDURES, ANCILLARY SERVICES.)
C415	Services authorized to another provider.
C420	Request for non-medical transportation is not required by care plan to prevent institutionalization.
C421	Item or service requested is not a benefit of the Home and Community Based Services for Persons Living with AIDS Waiver.
C430	Modification is not to prevent institutionalization of the client.
C431	Alternative funding for modification has not been considered.
C432	Modification did not include two bids.
C433	Amount of Modification exceeds cost containment.
C434	Cost of modification exceeds lifetime cap.
C435	Request for non-medical transportation is not required by care plan to prevent institutionalization.
C436	Item or service requested is not a benefit of the Home and Community Based Services for Persons with Mental Illness Waiver.
C437	Modification does not give client greater independence.
C438	Modification does not ensure the health safety and welfare of the client.
C439	Modification is not a direct medical or remedial benefit to the client.
C440	Modification duplicates an existing adaptation.
C441	Modification is part of new construction.
C442	Documentation was not provided from an Occupational Therapist or Physical Therapist.
C443	Modification includes purchase cost of durable medical equipment.
C444	Modification requested is not the most cost effective solution.

Denial Code	Long Description
C445	The dates entered either on the Header or Detail lines are invalid. Please review the dates and submit a new Prior Authorization Request with valid dates.
C451	Provider is not active for all or part of the dates on this Prior Authorization Request. Please verify provider number.
C452	The information submitted does not support the need for the services requested, you may re-submit the PAR describing in more detail current medical conditions supporting the need for services.
C453	The requested information has not been submitted. You may submit a new PAR with the requested information-nursing assessment, plan of care and/or therapy assessments, current clinical summary.
C454	The revenue code is already authorized for this client, this provider, this date span. Please bill using the information on the original PAR, or submit a new PAR for revision to increase or decrease services.
C455	The clinical information does not substantiate medical necessity.
C456	The requested additional information is insufficient. Completion of the requested information is required to review this Prior Authorization.
C457	The agency is not a Medicaid Provider.
C458	PDN PARs shall include only Private Duty Nursing RN or LPN services. Other services are included on this PAR.
C459	Based on the needs of the client, authorization is being given for a lesser amount of services than requested.
C460	Revisions for increases in services shall be submitted and processed according to the same requirements as for new PARs, with a current written assessment/physician orders pertaining to the increase.
C461	Services total more than twenty-four (24) hours per day.
C462	No services shall be approved for dates of service before the date that the completed PAR is received.
C463	Services requested are duplicative of care that is being reimbursed under another benefit or funding source, including but not limited to home health, other insurance, or medical foster care.
C464	*INACTIVE* Services requested are beyond the 20 hour per day benefit limitation as a result of an EPSDT medical screening however the correct documentation has not been received. (the EPSDT claim form does not meet this requirement.)
C465	*INACTIVE* A PAR shall cover a period of no longer than six (6) months.
C466	The plan of care you submitted with your PDN PAR does not indicate the frequency and the times of day that all technology-related care will be administered.
C467	The application you submitted for PDN is incomplete, please send the required information.
C468	This client is ineligible for Medicaid in the non-institutional setting.
C469	This client is ineligible for PDN.
C470	The hours requested on the PAR are greater than the plan of care orders.
C471	Nursing visits are unreasonable in amount, frequency, or duration.
C472	Information submitted does not support the need for the services requested, you may re-submit the PAR describing in more detail current medical conditions supporting the need for services.
C473	*INACTIVE* Client PAR is sent to the wrong authorizing agent, EPSDT HH, or Outpatient Therapy should be submitted to CFMC.
C474	Nursing visits solely for psychiatric counseling are not reimbursable.
C475	The requested additional information is insufficient. Completion of the requested information is required to review this Prior Authorization.
C476	Service previously authorized to this provider. The procedure code is already authorized for this client, this provider, this date span. Please bill using the information on the original PAR.
C477	Services authorized to another provider.
C478	Services requested are beyond the 16 hour per day benefit limitation as a result of an EPSDT medical screening however the correct documentation has not been received. (the EPSDT claim form does not meet this requirement.)
C479	The PAR shall cover a period of no longer than six (6) months.
C50A	*INACTIVE* The PAR that you sent directly to ACS is being denied. Please send this PAR to the authorizing agent: CFMC, Attention Medicaid/DME PARs, to the fax server number at 303-790-4643.
C518	*INACTIVE* Instructions from the therapist or other medical professional are required to support the need for ROM when it is the only skilled service performed by a Home Health Aide.

Denial Code	Long Description
C51A	*INACTIVE* This is not a final denial. Please do not submit an appeal request. The required Client State Id number is missing or invalid. Please resubmit the 5615 and ULTC 100.2 Certification page with the correct information to DDM Ascend via FAX at: 877-431-9568.
C52A	*INACTIVE* This is not a final denial. Please do not submit an appeal request. The Client State Id number does not match the Client name. Please resubmit the 5615 and ULTC 100.2 Certification page with the correct information to DDM Ascend via FAX at: 877-431-9568.
C53A	*INACTIVE* This is not a final denial. Please do not submit an appeal request. The required Client date of birth is missing or invalid. Please resubmit the 5615 and ULTC 100.2 Certification page with the correct information to DDM Ascend via FAX at: 877-431-9568.
C55A	*INACTIVE* This is not a final denial. Please do not submit an appeal request. The required Billing Provider number is missing or invalid. Please resubmit the 5615 and ULTC 100.2 Certification page with the correct information to DDM Ascend via FAX at: 877-431-9568.
C600	Service does not require prior authorization. Submit charges on the appropriate claim form.
C643	Cost containment information is missing. Please resubmit with required information.
C700	This vision service was not provided by an ophthalmologist, optometrist or optician.
C800	*INACTIVE* Service previously authorized to this provider. The procedure code is already authorized for this client, this provider, this date span. Please bill using the information on the original PAR.
C850	*INACTIVE* Services authorized to another provider.
C851	Services authorized to another provider.
C852	Duplicate requests cannot be processed. This prior authorization request (PAR) is a duplicate of another PAR that is currently in the system.
C899	The Prior Authorization did not include the appropriate procedure coding and/or modifier(s) for the effective dates submitted. Both the service and the administration fee must be included with the same effective dates. Please resubmit with corrected coding.
C900	Modification is not to prevent institutionalization of the client.
C901	Modification does not give client greater independence.
C902	Modification does not ensure the health safety and welfare of the client.
C903	Modification is not a direct medical or remedial benefit to the client.
C904	Modification duplicates an existing adaptation.
C905	Duplicates an existing adaptation.
C906	Documentation was not provided from an Occupational Therapist or Physical Therapist.
C907	Modification includes purchase cost of durable medical equipment.
C908	Modification requested is not the most cost effective solution.
C909	Alternative funding has not been considered.
C910	Modification did not include two bids.
C911	*INACTIVE* Amount of Modification exceeds cost containment.
C912	*INACTIVE* The item or service requested is not a Medicaid Home Health benefit.
C913	The item or service requested is not a Medicaid Private Duty Nursing (PDN) benefit.
C914	The procedure is not a benefit of the Colorado Medicaid program.
C915	The procedure is not a benefit for a child Medicaid client, age birth through age 20.
C916	The procedure is not a benefit for an adult Medicaid client, age 21 and older.
C917	A report of the dental condition that supports the need for service was not submitted for this child client.
C918	A report of dental condition and concurrent medical condition that supports the need for service not submitted for this adult client.
C919	The procedure code is not valid for the described procedure.
C920	The procedure code is not a benefit for this tooth number.
C921	The tooth surface designation submitted is not valid for this tooth number.
C922	The procedure is a duplicate service.
C923	Information required for prior authorization review was not submitted.
C924	Periodontal diagnosis and classification were not submitted.
C925	The information submitted does not support the need for the procedure.
C926	Submitted information does not support a favorable prognosis.

Denial Code	Long Description
C927	*INACTIVE* TMJ PAR information from the primary surgeon was incomplete or not D14 X COCT669 2004-01-1320.36.06
C928	PAR is not required for the assistant surgeon.
C929	Prior Authorization Request cannot be approved after the service has been started.
C930	*INACTIVE* Condition does not qualify as a Handicapping Malocclusion.
C931	*INACTIVE* No certification that orthodontics is not in preparation for corrective jaw surgery.
C933	Orthodontic treatment is not a benefit to treat dental conditions which are primarily cosmetic in nature.
C934	Orthodontic treatment is not a benefit when there is no severe Handicapping malocclusion, and self-esteem is the primary reason for treatment.
C935	Phase One orthodontic treatment is not a benefit for the reported condition/s.
C936	Orthodontic prior authorization cannot be approved when the requesting provider is not enrolled as a Medicaid orthodontic provider.
CA01	*INACTIVE* This is not a final denial. Please do not submit an appeal request. The required Client State Id number is missing or invalid. Please resubmit PAR request with the corrected information to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CA02	*INACTIVE* This is not a final denial. Please do not submit an appeal request. The required Client State Id number does not match the Client Name. Please resubmit PAR request with the corrected information to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CA03	*INACTIVE* This is not a final denial. Please do not submit an appeal request. The required Client date of birth is missing or invalid. Please resubmit PAR request with the corrected information to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CA04	*INACTIVE* This is not a final denial. Please do not submit an appeal request. The required Requesting Provider Number is missing or invalid. Please resubmit PAR request with the corrected information to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CA05	*INACTIVE* This is not a final denial. Please do not submit an appeal request. The required Billing Provider Number is missing or invalid. Please resubmit PAR request with the corrected information to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CA06	This is not a final denial. Please do not submit an appeal request. The required Client State ID number is missing or invalid. Please resubmit PAR request with the corrected information to the authorizing agency listed in Appendix D.
CA07	This is not a final denial. Please do not submit an appeal request. The required Client State ID number does not match the Client Name. Please resubmit PAR request with the corrected information to the authorizing agency listed in Appendix D.
CA08	This is not a final denial. Please do not submit an appeal request. The required Client date of birth is missing or invalid. Please resubmit PAR request with the corrected information to the authorizing agency listed in Appendix D.
CA09	This is not a final denial. Please do not submit an appeal request. The required Requesting Provider Number is missing or invalid. Please resubmit PAR request with the corrected information to the authorizing agency listed in Appendix D.
CA10	This is not a final denial. Please do not submit an appeal request. The required Billing Provider Number is missing or invalid. Please resubmit PAR request with the corrected information to the authorizing agency listed in Appendix D.
CA11	The PAR that you sent directly to ACS is being denied. Please send this PAR to the authorizing agency listed in Appendix D.
CA12	*INACTIVE* This is not a final denial. Please do not submit an appeal request. The required Client State ID number is missing or invalid. Please resubmit PAR request with the corrected information to the authorizing agency listed in Appendix D.
CA13	*INACTIVE* This is not a final denial. Please do not submit an appeal request. The required Client State ID number does not match the Client Name. Please resubmit PAR request with the corrected information to the authorizing agency listed in Appendix D.
CA14	*INACTIVE* This is not a final denial. Please do not submit an appeal request. The required Client date of birth is missing or invalid. Please resubmit PAR request with the corrected information to the authorizing agency listed in Appendix D.

Denial Code	Long Description
CA15	*INACTIVE* This is not a final denial. Please do not submit an appeal request. The required Requesting Provider Number is missing or invalid. Please resubmit PAR request with the corrected information to the authorizing agency listed in Appendix D.
CA16	*INACTIVE* This is not a final denial. Please do not submit an appeal request. The required Billing Provider Number is missing or invalid. Please resubmit PAR request with the corrected information to the authorizing agency listed in Appendix D.
CA17	Provider must be an enrolled in the Colorado Medical Assistance Program.
CA18	This is not a final denial. Please do not submit an appeal request. The required Client State Id number is missing or invalid. Please resubmit the 5615 and ULTC 100.2 Certification page with the correct information to the authorizing agency listed in Appendix D.
CA19	This is not a final denial. Please do not submit an appeal request. The Client State Id number does not match the Client name. Please resubmit the 5615 and ULTC 100.2 Certification page with the correct information to the authorizing agency listed in Appendix D.
CA20	This is not a final denial. Please do not submit an appeal request. The required Client date of birth is missing or invalid. Please resubmit the 5615 and ULTC 100.2 Certification page with the correct information to the authorizing agency listed in Appendix D.
CA21	This is not a final denial. Please do not submit an appeal request. The required Billing Provider number is missing or invalid. Please resubmit the 5615 and ULTC 100.2 Certification page with the correct information to the authorizing agency listed in Appendix D.
CC01	Consumer Directed Attendant Support (CDAS) services must be submitted on the same Prior Authorization Request (PAR) as the administration fee. Please resubmit the PAR with both the administration fee/modifier and the service procedure code.
CD01	*INACTIVE* Client has not utilized the equipment in the manner for which it was intended. Repairs and/or replacement of equipment will not be allowed in cases of repeated misuse.
CD02	*INACTIVE* This product cannot be approved as its primary purpose is to either enhance the personal comfort of the client or provide convenience for the client caregiver.
CD03	The information submitted does not meet the Colorado Medicaid Program guidelines for medical necessity.
CD04	Service previously authorized to this provider or another provider. The procedure code is already authorized for this client, this date span.
CD05	This request is for a WHEELCHAIR. The Colorado Medicaid Program has provided a similar product within the last few years. It is Medicaid policy that the original wheelchair should be utilized for a minimum of 5 years. Please submit additional information documenting the need for a new wheelchair at this point in time.
CD06	It is the responsibility of the provider to service, repair and supply necessary parts for any Durable Medical Equipment product covered by a warranty during the warranty period. No replacement parts or repairs will be reimbursed by Colorado Medicaid during the warranty period.
CD07	This product would more appropriately be provided on a rental basis.
CD08	This product intended usage is for exercise. Colorado Medicaid does not cover products that are prescribed primarily for exercise.
CD09	This product has been requested for a client who is currently residing in a nursing facility or hospital setting. Therefore, it will not be reimbursed through the Durable Medical Equipment program of Colorado Medicaid. It is the responsibility of the facility to provide this product.
CD10	*INACTIVE* Prior Authorization Requests must be faxed to CFMC for the following items: electric wheelchairs, scooters, orthotics and prosthetics, augmentative communication devices. Please send the Prior Authorization Request for these items directly to CFMC, Attention Medicaid/DME PARs, to the fax server line at 303-790-4643.
CD11	This product is not a benefit of the Durable Medical Equipment program.
CD14	The requested information has not been submitted.
CD16	This product does not require prior authorization. Submit charges on the appropriate claim form.
CD21	Prior authorizations requests must be submitted in a timely fashion. Retroactive requests beyond three months shall only be considered in cases of client retroactive program eligibility.
CD23	Effective August 1, 2007 Pulse Oximeters will have a maximum allowable rental cap of $750.00 per year. Once the total rental payment reaches $750.00 the equipment will convert to a purchase. This change is in accordance with the following Rule: 8.590.2.R. Rental Policy.
CD30	This product would be more appropriately provided as a purchase.

Denial Code	Long Description
CD31	As per Medicaid Bulletin March 2003, 1 unit equals 100. Your requested quantity has been divided by 100.
CD32	The amount requested exceeds the allowed quantity and has been reduced accordingly. Please refer to the current Medicaid Supply Bulletin and 10 C.C.R. 2505-10, Sec. 8.590.2.NP.
CD33	The amount requested is excessive for the diagnosis and has been reduced accordingly. Please refer to the current Medicaid Supply Bulletin and 10 C.C.R. 2505-10, Sec. 8. 590.2.NP.
CD35	Per Medicaid supply bulletin, A9900 is limited to specialized, detailed or complex work in the initial preparation of a product.
CD59	Prior Authorization is not required for Medicare Crossover claims. (8.590.3.B) Providers are required to bill Medicare first before billing Medicaid for this service. (Sec. 8.590.7.K)
CD60	*INACTIVE* Service previously authorized to this provider. The procedure code is already authorized for this client, this provider, this date span. Please bill using the information on the original PAR.
CD61	*INACTIVE* Services authorized to another provider.
CD63	This item is included in the rental/purchase of the equipment or service that has been approved. Please refer to the current Medicaid Supply Bulletin.
CDA1	*INACTIVE* This is not a final denial. Please do not submit an appeal request. The date(s) entered either on the Header or Detail lines are invalid. Please review the dates and submit a new PAR with valid dates to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDA2	*INACTIVE* This is not a final denial. Please do not submit an appeal request. The information submitted does not support the need for the medical supplies or equipment requested. Please resubmit the PAR describing in more detail the current medical conditions that support the need for the supplies to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDA3	*INACTIVE* This is not a final denial. Please do not submit an appeal request. The additional information submitted is insufficient. Completion of the requested information is required for review. Please resubmit PAR with the requested information to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDA4	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Serial number is required for all repairs. Please resubmit PAR with the serial number to: ACS, P.O. Box 30, Denver, CO 80201-0030. Current Medicaid Supply Bulletin and 10 C.C.R. 2505-10, Sec. 8.590.3 (A).
CDA5	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Please resubmit PAR with the invoiced acquisition cost for this item to: ACS, P.O. Box 30, Denver, CO 80201-0030. Current Medicaid Supply Bulletin and 10 C.C.R. 2505-10, Sec. 8.590.6 (A-IK).
CDA6	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Wheelchair purchases must have the manufacturer, brand name and model name. Please resubmit PAR with the information requested above to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDA7	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Requesting providers must have prescriptive authority for this item. Please resubmit PAR with the name of the prescribing physician to: ACS, P.O. Box 30, Denver, CO 80201-0030. Current Medicaid Supply Bulletin.
CDA8	*INACTIVE* This is not a final denial. Please do not submit an appeal request. The Prior Authorization Request requires a physician signature. Please resubmit PAR with a physician signature to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDA9	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Procedure Code requested is invalid/incorrect or incomplete. Please resubmit PAR with proper code(s) from the current Medicaid Supply Bulletin to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDB1	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Please resubmit PAR with the name of meds, frequency, route and length of need to: ACS, P.O. Box 30, Denver, CO 80201-0030. Current Medicaid Supply Bulletin and 10 C.C.R. 2505-10, Sec. 8. 590.3.d.
CDB2	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Please resubmit PAR with the number of units requested to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDB3	*INACTIVE* This is not a final denial. Please do not submit an appeal request. PAR dates must be for one year. Please resubmit PAR with corrected date span or provide an explanation as to why dates are less than one year to: ACS, P.O. Box 30, Denver, CO 80201-0030. Please refer to the current Medicaid Supply Bulletin.
CDB4	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Additional information is required for this item. Please resubmit PAR and include whether these items are intended for use with a client owned piece of equipment to: ACS, P.O. Box 30, Denver, CO 80201-0030. Current Medicaid Supply Bulletin.

Denial Code	Long Description
CDB5	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Additional information is required for this item. Please resubmit PAR and describe 1) the client level of impairment, 2) what has been used in the past, 3) if the client has available assistance 4) why this client is in need of this equipment/supply to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDB6	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Additional information is required for this item. Please resubmit PAR and describe 1) exactly why this item is needed, 2) what it will be used for, 3) the intended use for this item to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDB7	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Product information is required on this item. Please resubmit PAR with product information to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDB8	*INACTIVE* This is not a final denial. Please do not submit an appeal request. A serial number is required for all repairs. Please resubmit PAR with the serial number for the repair to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDB9	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Hospital Bed Questionnaire #1 is needed to review this request. Please resubmit PAR with the information requested to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDC1	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Pressure Relief Mattress Questionnaire #2 is needed to review this request. Please resubmit Prior Authorization Request with the information requested to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDC2	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Patient Lift Questionnaire #3 is needed to review this request. Please resubmit PAR with the information requested to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDC3	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Electric/Power Lift Questionnaire #3 is needed to review this request. Please resubmit PAR with the information requested to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDC4	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Seat Lift Questionnaire #4 is needed to review this request. Please resubmit PAR with the information requested to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDC5	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Blood Pressure Unit/Monitor Questionnaire #5 is needed to review this request. Please resubmit PAR with the information requested to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDC6	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Pulse Oximeter Questionnaire #6 (with SaO2 readings) is needed to review this request. Please resubmit PAR with the information requested to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDC7	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Apnea Monitor Questionnaire #7 is needed to review this request. Please resubmit PAR with the information requested to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDC8	*INACTIVE* This is not a final denial. Please do not submit an appeal request. CPAP/BiPAP Questionnaire #8 with copy of sleep study is needed to review this request. Please resubmit PAR with the information requested to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDC9	*INACTIVE* This is not a final denial. Please do not submit an appeal request. TENS or NMES Questionnaire #9 is needed to review this request. Please resubmit PAR with the information requested to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDD1	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Oral and Enteral Nutrition Formula Questionnaire #10 (with particular attention to the number of calories per day) is needed to review this request. Please resubmit PAR with the information requested to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDD2	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Adult Orthotics and Prosthetics Questionnaire #11 is needed to review this request. Please resubmit PAR with the information requested to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDD3	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Wound Closure Therapy Questionnaire #12 is needed to review this request. Please resubmit PAR with the information requested to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDD4	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Augmentative Communication Device Questionnaire #13 is needed to review this request. Please resubmit PAR with the information requested to: ACS, P.O. Box 30, Denver, CO 80201-0030.

Denial Code	Long Description
CDD5	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Mechanical High Frequency Chest Wall Oscillation Questionnaire #14 is needed to review this request. Please resubmit PAR with information requested to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDD6	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Wheelchair Tilt/Recline Device Questionnaire #15 is needed to review this request. Please resubmit PAR with the information requested to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CDD7	*INACTIVE* This is not a final denial. Please do not submit an appeal request. The Questionnaire form you submitted is no longer valid. Please resubmit PAR with the current Questionnaire form to: ACS, P.O. Box 30, Denver, CO 80201-0030.
CE01	This vision service was not provided by an ophthalmologist, optometrist or optician.
CE02	The clinical information does not substantiate medical necessity.
CF01	Proof of prior Medicaid orthodontic approval from another state was not submitted.
CF02	TMJ PAR information from the primary surgeon was incomplete
CF03	Condition does not qualify as a Handicapping Malocclusion.
CF04	Crowns and fixed prostheses that fail in less than five years do not meet a reasonable standard of care and the billing provider is expected to replace them at their own expense.
CF05	The services/treatments are not a covered benefit for Evaluation Procedures.
CF06	The services/treatments are not a covered benefit for Diagnostic Imaging Procedures.
CF07	The services/treatments are not a covered benefit for Preventive Services.
CF08	The services/treatments are not a covered benefit for Minor Restorative Services.
CF09	The services/treatments are not a covered benefit for Major Restorative Services.
CF10	The services/treatments are not a covered benefit for Endodontic Services.
CF11	The services/treatments are not a covered benefit for Periodontal Treatment.
CF12	The services/treatments are not a covered benefit for Removable Prosthetics.
CF13	The services/treatments are not a covered benefit for Oral Surgery, palliative treatment and anesthesia.
CF14	The services/treatments are not a covered benefit for Adult Clients under any circumstances.
CF15	Prior authorization request was not submitted.
CF16	Dental services shall only be provided by a licensed dentist or dental hygienist who is enrolled with Colorado Medicaid.
CF17	Dental services described in 8.201.2 shall be available to Adult Clients age 21 years and older.
CF18	Dental services for adults 21 years of age and older are limited to a total of $1,000 per adult Medicaid recipient per state fiscal year.
CH10	*INACTIVE* Nursing visits solely for the purpose of assess and teach are not billable in this case.
CH11	*INACTIVE* Nursing visits are unreasonable in amount, frequency, or duration.
CH12	*INACTIVE* Home Health Aide units are requested, no skilled tasks are identified.
CH13	*INACTIVE* Home Health Aide visits are not medically necessary.
CH14	*INACTIVE* Home Health services shall be provided at the client place of residence except for EPSDT extraordinary HH which is prior authorized using a different process and form.
CH15	*INACTIVE* The client is 18 years old or over and skilled therapies are not a benefit under Long Term Home Health.
CH16	*INACTIVE* Extended Home Health Aide visits requested without submitting sufficient information about services on each visit.
CH17	*INACTIVE* Documentation to support PRN visits has not been submitted.
CH18	*INACTIVE* Written instructions from the therapist or other medical professional are required to support the need for ROM when it is the only skilled service performed by a Home Health Aide.
CH19	*INACTIVE* Medication set-up by a nurse is the only reason for visits and documentation that the pharmacy was contacted is missing.
CH2	*INACTIVE* information submitted does not support the need for the services requested, you may re-submit the PAR describing in more detail current medical conditions supporting the need for services.
CH20	*INACTIVE* Documentation does not support the need for two Home Health Aides at the same time for a two-person transfer.
CH21	*INACTIVE* Client PAR is sent to the wrong authorizing agent, EPSDT HH, PDN and Outpatient Therapy should be submitted to CFMC at PO Box 17300, Denver, CO 80217.

Denial Code	Long Description
CH22	*INACTIVE* Based on the needs of the client, authorization is being given for a lesser amount of services than requested.
CH23	*INACTIVE* PAR form has been submitted later than 10 days from the HCFA-485 "from" date. PAR dates have been adjusted.
CH24	*INACTIVE* Revisions for increases in services shall be submitted and processed according to the same requirements as for new PARs, with a current written assessment/physician orders pertaining to the increase.
CH25	*INACTIVE* Nursing visits solely for psychiatric counseling are not reimbursable.
CH26	*INACTIVE* Any visit made solely for supervision of the Home Health aide shall not be reimbursed.
CH27	*INACTIVE* Nursing visits solely for foot care shall be reimbursed only if the client has a documented diagnosis that supports the need for a nurse, and the client or family caregiver is not able or willing to provide the foot care.
CH3	*INACTIVE* The requested information has not been submitted. You may submit a new PAR with the requested information-Home Health plan of care and/or therapy assessments, current clinical summary.
CH30	*INACTIVE* Client PAR is sent to the wrong authorizing agent, Private Duty Nursing PARs and application paperwork should be submitted do DDM Ascend via fax to 877-431-9568.
CH31	*INACTIVE* Improper billing may result from visits that are unreasonable in amount, frequency and duration or visits performed when skilled tasks performed are not medically necessary.
CH4	*INACTIVE* This service does not require prior authorization. Submit charges on the appropriate claim form (Acute Home Health or Long Term Home Health with Acute Episode)
CH5	*INACTIVE* The revenue code is already authorized for this client, this provider, this date span. Please bill using the information on the original PAR, or submit a new PAR for revision to increase services.
CH6	*INACTIVE* The PAR that you sent directly to ACS is being denied. Please send this PAR to the authorizing agent: Single Entry Point Agency in county of client residence.
CH7	*INACTIVE* The clinical information does not substantiate medical necessity.
CH8	*INACTIVE* The requested additional information is insufficient. Completion of the requested information is required to review this Prior Authorization.
CH9	*INACTIVE* The agency is not a Medicaid Provider.
CJ01	The service is not a benefit of the Colorado Medicaid medical transportation program.
CN01	This is not a final denial. Please do not submit an appeal request. The Required 5615 noted in the Nursing Facility Billing Manual; General Prior Authorization Requirements is missing or incomplete. Please resubmit the 5615 and ULTC 100.2 certification page to the authorizing agent.
CN02	This is not a final denial. Please do not submit an appeal request. The Required ULTC 100.2 certification page noted in the Nursing Facility Billing Manual; General Prior Authorization Requirements is missing or incomplete. Please resubmit the 5615 and ULTC 100.2 certification page to the authorizing agent.
CN03	This is a not final denial. Please do not submit an appeal request. The required client's social security number is invalid or does not match the social security number of file with the Colorado Medical Assistance Program. Please correct and resubmit both the 5615 and the UTLC 100.2 certification page to the authorizing agent.
CN04	This is not a final denial. Please do not submit an appeal request. The required Client State Id number is missing or invalid. Please resubmit the 5615 and ULTC 100.2 Certification page with the correct information to the authorizing agency listed in Appendix D.
CN05	This is not a final denial. Please do not submit an appeal request. The Client State Id number does not match the Client name. Please resubmit the 5615 and ULTC 100.2 Certification page with the correct information to the authorizing agency listed in Appendix D.
CN06	This is not a final denial. Please do not submit an appeal request. The required Client date of birth is missing or invalid. Please resubmit the 5615 and ULTC 100.2 Certification page with the correct information to the authorizing agency listed in Appendix D.
CN07	This is not a final denial. Please do not submit an appeal request. The required Billing Provider number is missing or invalid. Please resubmit the 5615 and ULTC 100.2 Certification page with the correct information to the authorizing agency listed in Appendix D.
CQ01	This is not a final denial. Please do not submit an appeal request. The date(s) entered either on the Header or Detail lines are invalid. Please review the dates and submit a new PAR with valid dates to the appropriate authorizing agency listed in Appendix D.

Denial Code	Long Description
CQ02	This is not a final denial. Please do not submit an appeal request. The information submitted does not support the need for the medical supplies or equipment requested. Please resubmit the PAR describing in more detail the current medical conditions that support the need for the supplies to the appropriate authorizing agency listed in Appendix D.
CQ03	This is not a final denial. Please do not submit an appeal request. The additional information submitted is insufficient. Completion of the requested information is required for review. Please resubmit PAR with the requested information to the appropriate authorizing agency listed in Appendix D.
CQ04	This is not a final denial. Please do not submit an appeal request. Serial number is required for all repairs. Please resubmit PAR with the serial number to the appropriate authorizing agency listed in Appendix D. Current Medicaid Supply Bulletin and 10 C.C.R. 2505-10, Sec. 8.590.3.D.8.
CQ05	This is not a final denial. Please do not submit an appeal request. Please resubmit PAR with the invoiced acquisition cost for this item to the appropriate authorizing agency listed in Appendix D. Current Medicaid Supply Bulletin and 10 C.C.R. 2505-10, Sec. 8.590.4.D.5.c.
CQ06	This is not a final denial. Please do not submit an appeal request. Wheelchair purchases must have the manufacturer, brand name and model name. Please resubmit PAR with the information requested above to the appropriate authorizing agency listed in Appendix D.
CQ07	This is not a final denial. Please do not submit an appeal request. Requesting providers must have prescriptive authority for this item. Please resubmit PAR with the name of the prescribing physician to the appropriate authorizing agency listed in Appendix D. Current Medicaid Supply Bulletin.
CQ08	This is not a final denial. Please do not submit an appeal request. The Prior Authorization Request requires a physician's signature. Please resubmit PAR with a physician's signature to the appropriate authorizing agency listed in Appendix D.
CQ09	This is not a final denial. Please do not submit an appeal request. Procedure Code requested is invalid/incorrect or incomplete. Please resubmit PAR with proper code(s) from the current Medicaid Supply Bulletin to the appropriate authorizing agency listed in Appendix D.
CQ10	This is not a final denial. Please do not submit an appeal request. Please resubmit PAR with the name of meds, frequency, route and length of need to the appropriate authorizing agency listed in Appendix D. Current Medicaid Supply Bulletin and 10 C.C.R. 2505-10, Sec. 8. 590.3.d.
CQ11	This is not a final denial. Please do not submit an appeal request. Please resubmit PAR with the number of units requested to the appropriate authorizing agency listed in Appendix D.
CQ12	This is not a final denial. Please do not submit an appeal request. PAR dates must be for one year. Please resubmit PAR with corrected date span or provide an explanation as to why dates are less than one year to the appropriate authorizing agency listed in Appendix D. Please refer to the current Medicaid Supply Bulletin.
CQ13	This is not a final denial. Please do not submit an appeal request. Additional information is required for this item. Please resubmit PAR and include whether these items are intended for use with a client owned piece of equipment to the appropriate authorizing agency listed in Appendix D. Current Medicaid Supply Bulletin.
CQ14	This is not a final denial. Please do not submit an appeal request. Additional information is required for this item. Please resubmit PAR and describe 1) the client's level of impairment, 2) what has been used in the past, 3) if the client has available assistance 4) why this client is in need of this equipment/supply to the appropriate authorizing agency listed in Appendix D.
CQ15	This is not a final denial. Please do not submit an appeal request. Additional information is required for this item. Please resubmit PAR and describe 1) exactly why this item is needed, 2) what it will be used for, 3) the intended use for this item to the appropriate authorizing agency listed in Appendix D.
CQ16	This is not a final denial. Please do not submit an appeal request. Product information is required on this item. Please resubmit PAR with product information to the appropriate authorizing agency listed in Appendix D.
CQ17	This is not a final denial. Please do not submit an appeal request. A serial number is required for all repairs. Please resubmit PAR with the serial number for the repair to the appropriate authorizing agency listed in Appendix D.
CQ18	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Hospital Bed Questionnaire #1 is needed to review this request. Please resubmit PAR with the information requested to the appropriate authorizing agency listed in Appendix D.
CQ19	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Pressure Relief Mattress Questionnaire #2 is needed to review this request. Please resubmit Prior Authorization Request with the information requested to the appropriate authorizing agency listed in Appendix D.

Denial Code	Long Description
CQ20	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Patient Lift Questionnaire #3 is needed to review this request. Please resubmit PAR with the information requested to the appropriate authorizing agency listed in Appendix D.
CQ21	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Electric/Power Lift Questionnaire #3 is needed to review this request. Please resubmit PAR with the information requested to the appropriate authorizing agency listed in Appendix D.
CQ22	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Seat Lift Questionnaire #4 is needed to review this request. Please resubmit PAR with the information requested to the appropriate authorizing agency listed in Appendix D.
CQ23	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Blood Pressure Unit/Monitor Questionnaire #5 is needed to review this request. Please resubmit PAR with the information requested to the appropriate authorizing agency listed in Appendix D.
CQ24	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Pulse Oximeter Questionnaire #6 (with SaO2 readings) is needed to review this request. Please resubmit PAR with the information requested to the appropriate authorizing agency listed in Appendix D.
CQ25	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Apnea Monitor Questionnaire #7 is needed to review this request. Please resubmit PAR with the information requested to the appropriate authorizing agency listed in Appendix D.
CQ26	*INACTIVE* This is not a final denial. Please do not submit an appeal request. CPAP/BiPAP Questionnaire #8 with copy of sleep study is needed to review this request. Please resubmit PAR with the information requested to the appropriate authorizing agency listed in Appendix D.
CQ27	*INACTIVE* This is not a final denial. Please do not submit an appeal request. TENS or NMES Questionnaire #9 is needed to review this request. Please resubmit PAR with the information requested to the appropriate authorizing agency listed in Appendix D.
CQ28	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Oral and Enteral Nutrition Formula Questionnaire #10 (with particular attention to the number of calories per day) is needed to review this request. Please resubmit PAR with the information requested to the appropriate authorizing agency listed in Appendix D.
CQ29	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Adult Orthotics and Prosthetics Questionnaire #11 is needed to review this request. Please resubmit PAR with the information requested to the appropriate authorizing agency listed in Appendix D.
CQ30	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Wound Closure Therapy Questionnaire #12 is needed to review this request. Please resubmit PAR with the information requested to the appropriate authorizing agency listed in Appendix D.
CQ31	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Augmentative Communication Device Questionnaire #13 is needed to review this request. Please resubmit PAR with the information requested to the appropriate authorizing agency listed in Appendix D.
CQ32	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Mechanical High Frequency Chest Wall Oscillation Questionnaire #14 is needed to review this request. Please resubmit PAR with the information requested to the appropriate authorizing agency listed in Appendix D.
CQ33	*INACTIVE* This is not a final denial. Please do not submit an appeal request. Wheelchair Tilt/Recline Device Questionnaire #15 is needed to review this request. Please resubmit PAR with the information requested to the appropriate authorizing agency listed in Appendix D.
CQ34	This is not a final denial. Please do not submit an appeal request. The Questionnaire form you submitted is no longer valid. Please resubmit PAR with the current Questionnaire form to the appropriate authorizing agency listed in Appendix D.
CQ35	Prior Authorization Requests must be submitted on paper for the following items: electric wheelchairs, scooters, orthotics and prosthetics, augmentative communication devices. Please send the Prior Authorization Request for these items directly to the appropriate authorizing agency listed in Appendix D.
CQ36	Client has not utilized the equipment in the manner for which it was intended. Repairs and/or replacement of equipment will not be allowed in cases of repeated misuse.
CQ37	This product cannot be approved as its primary purpose is to either enhance the personal comfort of the client or provide convenience for the client caregiver.

Denial Code	Long Description
CQ38	This is a rejection, not a final denial. Please do not submit an appeal request. Completion of PAR requirements have not been met.
CQ39	Same or similar services have already been previously approved for this client.
CY01	*INACTIVE* Client PAR is sent to the wrong authorizing agent. Please refer to Appendix D for the appropriate authorizing agency when submitting EPSDT HH, or Outpatient Therapy PARs.
CY03	*INACTIVE* PAR form has been submitted later than 10 business days from the PAR start date. PAR units have been adjusted.
CY04	*INACTIVE* PAR form has been submitted later than 10 business days from the PAR start date. PAR units have been adjusted.
CZ01	*INACTIVE* Client PAR is sent to the wrong authorizing agent. Please refer to Appendix D for the appropriate authorizing agency when submitting EPSDT HH, or Outpatient Therapy PARs.
CZ02	*INACTIVE* Based on the needs of the client, authorization is being given for a lesser amount of services than requested.
CZ03	PAR form has been submitted later than 10 business days from the PAR start date. PAR units have been adjusted.
CZ04	The requested information has not been submitted. You may submit a new PAR with the requested information-Home Health plan of care and/or therapy assessments, current clinical summary.
CZ05	*INACTIVE* Home Health services shall be provided at the client place of residence (excluding nursing facilities and hospitals) except for EPSDT extraordinary HH which is prior authorized using a different process and form.
CZ06	*INACTIVE* Client PAR is sent to the wrong authorizing agent, Private Duty Nursing PARs and application paperwork should be submitted to the authorizing agency listed in Appendix D.
CZ07	*INACTIVE* The revenue code is already authorized for this client, this provider, this date span. Please bill using the information on the original PAR, or submit a new PAR for revision to increase services.
CZ08	*INACTIVE* The clinical information does not substantiate medical necessity.
CZ09	*INACTIVE* The requested additional information is insufficient. Completion of the requested information is required to review this Prior Authorization.
CZ10	The agency is not a Medicaid Provider.
CZ11	*INACTIVE* Client PAR is sent to the wrong authorizing agent. Please refer to Appendix D for the appropriate authorizing agency.
CZ12	The item or service requested is not a Medicaid Home Health benefit.
CZ13	Skilled therapies are not a benefit under Adult Long Term Home Health.
CZ14	Revisions for increases to Home Health services shall be submitted and processed according to the same requirements defined for new PARs, and shall be submitted timely and include a current plan of care, physician's orders and any other required documentation to support the revision as listed in the Home Health Benefit Coverage Standard.
CZ15	Based on the needs of the client, authorization is being given for a lesser amount of services than requested.
CZ16	This client is 21 years or older and Home Health services shall be provided at the client place of residence (excluding nursing facilities and hospitals).
CZ17	The client is 18 years or older and the PAR was sent to the wrong authorizing agent; Adult Long Term Home Health PARs and applicable paperwork should be submitted to the authorizing agency listed in Appendix D.
CZ18	The revenue code is already authorized for this client, this provider and/or this date span. Please bill using the information on the original PAR, or submit a new PAR revision to increase or change services.
CZ19	The clinical information does not substantiate medical necessity.
CZ20	The information submitted is insufficient to make a medical necessity determination. Additional information is required to review this Prior Authorization.
CZ21	The Colorado Medical Assistance Program previously sent a letter notifying you of a decrease in your home health services and wants to make sure you have received all of the information you need. You may be eligible for a plan to decrease the amount of services over a three month period of time to help adjust to the change. You may talk with your case manager or home health provider to make a step-down plan if you need one. If you have not heard from your case manager or provider, or if you have any questions, please call 303-866-3447.
P001	THE BILLING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THE SERVICES.
P002	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.

Denial Code	Long Description
P003	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P005	THE PRIOR AUTHORIZATION CAN NOT BE END DATED. THE PRIOR AUTHORIZATION STATUS IS NOT APPROVED OR APPROVED WITH REVISIONS.
P006	PLEASE FURNISH THE PROCEDURE CODE AND CORRESPONDING DESCRIPTION.
P008	THE BILLING PROVIDER NUMBER IS INVALID.
P009	THE BILLING PROVIDER NUMBER IS INVALID.
P010	THE REQUESTED END DATE IS INVALID.
P011	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P012	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P013	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P014	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P015	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P016	THE REQUESTED START DATE IS MISSING OR INVALID.
P019	THE REQUESTED START DATE IS MISSING OR INVALID.
P020	THE RENDERING PROVIDER NUMBER IS INVALID.
P021	THE RENDERING PROVIDER NUMBER IS INVALID.
P022	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P023	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P024	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P026	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P027	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P030	FIRST MODIFIER IS INVALID.
P031	FIRST MODIFIER IS INVALID.
P032	SECOND MODIFIER IS INVALID.
P033	SECOND MODIFIER IS INVALID.
P034	THIRD MODIFIER IS INVALID.
P035	THIRD MODIFIER IS INVALID.
P036	FOURTH MODIFIER IS INVALID.
P037	FOURTH MODIFIER IS INVALID.
P038	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P039	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P040	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P041	CLIENTS FIRST NAME IS MISSING.
P042	CLIENTS LAST NAME IS MISSING.
P043	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P044	BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES REQUESTED.
P045	FIRST MODIFIER IS INVALID.
P046	SECOND MODIFIER IS INVALID.
P047	THIRD MODIFIER IS INVALID.
P048	FOURTH MODIFIER IS INVALID.
P052	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P053	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P054	RENDERING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES FOR THE BENEFIT PLAN.
P055	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P061	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.

Denial Code	Long Description
P062	THE CLIENT ID AND/OR NAME INDICATED ON THE PA REQUEST IS INCORRECT. THE CLIENT ID AND/OR NAME HAS BEEN UPDATED. PLEASE VERIFY THE ID AND/OR NAME IS CORRECT.
P064	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
P067	THE FREQUENCY OF HOURS REQUESTED ARE NOT APPROPRIATE FOR THIS CLIENT AND HAVE BEEN MODIFIED ACCORDINGLY.
P079	BILLING PROVIDER IS ON PAYMENT SUSPENSION DUE TO CREDIBLE ALLEGATION OF FRAUD.
P120	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAS BEEN REDUCED.
P121	THE SERVICE/ PROCEDURE REQUESTED IS NOT SUPPORTED BY SUBMITTED DOCUMENTATION.
P126	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
P128	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.
P138	SERVICE(S) DO NOT MEET COLORADO MEDICAID GUIDELINES.
P167	REQUESTED DOCUMENTATION HAS NOT BEEN SUBMITTED.
P178	THE SERVICE REQUESTED IS NOT MEDICALLY NECESSARY.
P179	THE MEDICAL NECESSITY FOR THIS SERVICE IS NOT SUPPORTED BY THE SUBMITTED DOCUMENTATION.
P233	THE DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE ADDITIONAL CARE.
P257	THIS CLIENTS FUNCTIONAL ASSESSMENT SCORES PLACE THIS CLIENT OUTSIDE ELIGIBILITY FOR DAY TREATMENT.
P274	OUR RECORDS INDICATE THIS CLIENT IS INVOLVED IN EFFECTIVE AND APPROPRIATE SERVICE ELSEWHERE.
P292	INTENSIVE REHABILITATION HOURS ARE NO LONGER APPROPRIATE AS INDICATED BY HISTORY, DIAGNOSIS, AND/ OR FUNCTIONAL ASSESSMENT SCORES.
P328	THE SERVICES REQUESTED INCLUDE NON-COVERED SERVICES, AND HOURS ARE REDUCED ACCORDINGLY.
P339	THE CLIENTS PAST HISTORY INDICATES REDUCED TREATMENT HOURS ARE WARRANTED.
P342	THE REQUEST DOES NOT MEET GENERALLY ACCEPTED CONDITIONS REQUIRING FLUORIDE TREATMENTS.
P346	SERVICES EXCEED COLORADO MEDICAID LIMITATION AND DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE MEDICAL NECESSITY OF THE SERVICE.
P349	THE SERVICE REQUESTED WAS PERFORMED LESS THAN FIVE YEARS AGO.
P353	THE EXISTING APPLIANCE HAS NOT BEEN WORN FOR THREE YEARS.
P367	THE CLIENT HAS BEEN TOTALLY WITHOUT TEETH AND AN APPLIANCE FOR FIVE YEARS.
P392	THE CLIENT IS MISSING AN ANTERIOR TOOTH AND/OR HAS TWO OR MORE POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P405	THE SERVICE(S) REQUESTED COULD ADEQUATELY BE PERFORMED IN THE DENTAL OFFICE.
P406	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE OF GOOD PERIODONTAL HEALTH (AMERICAN ACADEMY OF PERIODONTOLOGY PERIODONTAL CLASSIFICATION OF TYPE I OR II).
P407	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE VISIBLE ON RADIOGRAPHS THAT AT LEAST 50 PERCENT OF THE CLINICAL CROWN IS INTACT.
P409	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING SIX OR MORE TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED, INCLUDING THIRD MOLARS.
P410	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING ONE OR MORE ANTERIOR TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED.
P411	DOCUMENTATION DOES NOT SUPPORT THE NEED FOR PERIODONTIC SERVICES. POCKETS ARE LESS THAN 4MM AND/OR GREATER THAN 6MM FOR CLIENT AND/OR THE CLIENT IS UNDER THE AGE OF 13.
P412	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA.
P413	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA. THIS PA HAS BEEN GRANTED AS APPROVED NOT APPROVED WITH REVISIONS. THE DURATION REQUESTED MAY HAVE BEEN REDUCED TO REFLECT COVERAGE LIMITATIONS, PRESCRIBER ORDERS, CONFLICTI
P417	THE SERVICE(S) REQUESTED COULD BE ADEQUATELY PERFORMED WITH LOCAL ANESTHESIA.
P437	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO POOR ORAL HYGIENE.
P444	THIS LINE ITEM IS A DUPLICATE OF ANOTHER LINE ITEM ON THIS PRIOR AUTHORIZATION (PA) REQUEST. PLEASE CORRECT.
P446	THIS IS A DUPLICATE OF AN EXISTING PRIOR AUTHORIZATION (PA) REQUEST. YOU MAY CONTACT PROVIDER SERVICES IF YOU REQUIRE ASSISTANCE. DUPLICATE PA REQUEST

Denial Code	Long Description
P448	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO DECAY HISTORY.
P449	QUESTIONABLE LONG TERM PROGNOSIS DUE TO GUM AND BONE DISEASE.
P456	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO APPARENT ROOT INFECTION.
P457	OUR RECORDS INDICATE THIS CLIENT HAS EXCEEDED ESTABLISHED PROGRAM LIMITATIONS. COLORADO MEDICAID WILL NOT AUTHORIZE NEW DENTURES.
P458	DOCUMENTATION PROVIDED INDICATES A LESS ELABORATE PROCEDURE SHOULD BE CONSIDERED.
P502	RENTAL ONLY ALLOWED; MEDICAL NEED FOR PURCHASE HAS NOT BEEN DOCUMENTED.
P503	PURCHASE ONLY ALLOWED; MEDICAL NEED FOR RENTAL HAS NOT BEEN DOCUMENTED.
P504	OCCUPATIONAL THERAPY GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P505	THE SERVICE REQUESTED IS INCLUDED IN THE NURSING HOME RATE STRUCTURE.
P511	THIS NATIONAL DRUG CODE IS ONLY BILLABLE AS PART OF A COMPOUND DRUG.
P515	THE PRESENCE OF A HANDICAPPING MALOCCLUSION OR HANDICAPPING DENTOFACIAL DEFORMITY IS NOT SUPPORTED BY THE DOCUMENTATION SUBMITTED.
P521	THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVERED BY COLORADO MEDICAID.
P522	GASTRO-INTESTINAL SURGERY FOR THE PURPOSE OF WEIGHT CONTROL IS COVERED ONLY AS A LIFE THREATENING PROCEDURE.
P523	THE TREATMENT REQUEST IS NOT CONSISTENT WITH THE CLIENT'S DIAGNOSIS.
P524	PSYCHOTHERAPY PROVIDED IN THE CLIENTS HOME IS NOT A COVERED BENEFIT OF COLORADO MEDICAID.
P525	THE INFORMATION PROVIDED IS NOT CONSISTENT WITH THE INTENSITY OF SERVICES REQUESTED.
P526	INTENSIVE MULTIPLE MODALITY TREATMENT IS NOT CONSISTENT WITH THE INFORMATION PROVIDED.
P527	MULTIPLE PROVIDERS OF TREATMENT ARE NOT INDICATED FOR THIS CLIENT.
P528	THE DURATION OF TREATMENT SESSIONS EXCEED CURRENT COLORADO MEDICAID GUIDELINES.
P534	DOCUMENTATION OF POOR PHYSICAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P535	OTHER PHYSICAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P536	THE PHYSICAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P537	USE OF PHYSICAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P538	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF A PHYSICAL THERAPIST.
P539	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS AND LIVING ARRANGEMENT.
P540	GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P541	THE PROCEDURE(S) REQUESTED ARE NOT MEDICAL IN NATURE.
P542	DOCUMENTATION OF POOR OCCUPATIONAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P543	DOCUMENTATION OF POOR SPEECH THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P544	OTHER OCCUPATIONAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P546	THE OCCUPATIONAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P547	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF PHYSICAL THERAPY.
P548	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P549	ACTIVITIES TO PROMOTE DIVERSION OR GENERAL MOTIVATION ARE NONCOVERED COLORADO MEDICAID SERVICES.
P550	REVISIONS OF THE REQUEST IS NECESSITATED BY THE CLIENTS MINIMAL PROGRESS.
P551	RESTORATIVE NURSING INVOLVEMENT COULD BE INCREASED.

Denial Code	Long Description
P552	CLIENTS DEMONSTRATED RESPONSE TO CURRENT THERAPY DOES NOT WARRANT THE INTENSE FREQUENCY REQUESTED.
P553	MAINTENANCE IS TWO TIMES PER WEEK OR LESS.
P554	THE SPEECH THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P555	USE OF OCCUPATIONAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P556	USE OF SPEECH THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P557	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF AN OCCUPATIONAL THERAPIST.
P558	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
P559	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P560	THE MATERIALS/ SERVICES REQUESTED ARE PRINCIPALLY COSMETIC IN NATURE.
P561	THE LENS FORMULA DOES NOT JUSTIFY REPLACEMENT.
P562	THE CHANGE IN THE LENS FORMULA DOES NOT WARRANT MULTIPLE REPLACEMENTS.
P563	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P564	LENSES ONLY ARE APPROVED; PLEASE DISPENSE A CONTRACTED FRAME. THE NON-CONTRACTED FRAME IS NOT MEDICALLY JUSTIFIED.
P565	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P566	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P567	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF OCCUPATIONAL THERAPY.
P568	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF SPEECH THERAPY.
P569	LEVEL, INTENSITY, OR EXTENT OF SERVICE(S) REQUESTED HAS BEEN MODIFIED CONSISTENT WITH MEDICAL NEED AS DEFINED IN THE PLAN OF CARE.
P570	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P571	THE SERVICE ASKED FOR IS NOT COVERED BY COLORADO MEDICAID AS THESE TASKS CAN BE DONE BY NURSES OR ACTIVITY STAFF.
P572	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P573	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.
P574	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P575	MEDICAL NEED FOR EQUIPMENT/ SUPPLY REQUESTED IS NOT SUPPORTED BY DOCUMENTATION SUBMITTED.
P576	OTHER SPEECH THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P577	DOCUMENTATION SUBMITTED IDENTIFIES THAT THE CLIENT HAS FEWER THAN TWO POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P582	LESS EXPENSIVE ALTERNATIVE SERVICES ARE AVAILABLE FOR THIS CLIENT.
P634	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P711	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING PERIODONTAL SCALING AND ROOT PLANNING.
P712	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING GINGIVECTOMY.
P754	AN APPROVED SUBSTANCE ABUSE DAY TREATMENT PROGRAM CANNOT EXCEED A SIX WEEK PERIOD.
P761	THE CLIENT DOES NOT APPEAR TO BE ABLE OR WILLING TO ABSTAIN FROM ALCOHOL/DRUG USAGE WHILE IN TREATMENT. THEREFORE, SUBSTANCE ABUSE DAY TREATMENT SERVICES ARE NOT APPROVED.
P764	THIS CLIENT HAS COMPLETED INTENSIVE SUBSTANCE ABUSE TREATMENT WITHIN THE PAST 12 MONTHS. THE DOCUMENTATION PROVIDED IS NOT ADEQUATE TO JUSTIFY ADDITIONAL INTENSIVE TREATMENT AT THIS TIME.
P785	A LESS THAN SIX-WEEK HEALING PERIOD HAS BEEN SPECIFIED FOR THIS PRIOR AUTHORIZATION. THEREFORE IT IS NOT NECESSARY TO WAIT THE FULL SIX WEEKS AFTER EXTRACTIONS BEFORE TAKING DENTURE IMPRESSIONS.

Denial Code	Long Description
P818	SIX-WEEK HEALING TIME IS REQUIRED BETWEEN EDENTULATION AND FINAL IMPRESSIONS. PAYMENT FOR DENTURES WILL BE DENIED OR RECOUPED IF HEALING PERIOD IS NOT OBSERVED.
P849	COLORADO MEDICAID HAS DETERMINED THERE WERE (ARE) SEVERAL HOME HEALTH AGENCIES WILLING TO PROVIDE MEDICALLY NECESSARY SKILLED NURSING SERVICES TO THIS CLIENT.
P864	THE DOCUMENTATION YOU HAVE SUBMITTED DOES NOT MEET THE REQUIREMENTS OF COLORADO MEDICAID.
P873	THE MEDICAL NECESSITY FOR THE HOURS REQUESTED IS NOT SUPPORTED BY THE INFORMATION SUBMITTED.
P874	THE DOCUMENTATION SUBMITTED INDICATES THE TASKS SPECIFIED CAN BE COMPLETED DURING THE VISITS APPROVED.
P878	THE DOCUMENTATION SUBMITTED DOES NOT INDICATE THAT MEDICALLY ORIENTED TASKS ARE MEDICALLY NECESSARY; THEREFORE PERSONAL CARE SERVICES HAVE BEEN APPROVED.
P880	THE QUANTITY OF SERVICES AUTHORIZED FOR THIS CLIENTS PERSONAL CARE HAS BEEN AMENDED BASED ON INFORMATION RECEIVED FROM ONE OR MORE OF THESE SOURCES: THE CLIENT, THEIR PHYSICIAN, AND/OR THE IN-HOME VISIT BY STAFF OF THE OIG (OFFICE OF INSPECTOR GENERAL).
P885	THE USE OF THIS DRUG FOR THE INTENDED PURPOSE IS NOT COVERED BY COLORADO MEDICAID, CONSISTENT WITH COLORADO ADMINISTRATIVE CODE AND FEDERAL LAW.
P924	THE MEDICAL RECORDS SUBMITTED WITH THE CURRENT REQUEST CONFLICT OR DISAGREE WITH OUR MEDICAL RECORDS ON THIS CLIENT.
P950	INDEPENDENT NURSES, PLEASE NOTE PAYABLE SERVICES MAY NOT EXCEED 12 HOURS/DAY OR 60 HOURS/WEEK.
P951	SERVICES CAN ONLY BE AUTHORIZED THROUGH ONE YEAR FROM THE PRESCRIPTION DATE.
P952	LEAD INSPECTION IS A COVERED COLORADO MEDICAID SERVICE WHEN THE CHILD HAS BEEN SHOWN TO HAVE LEAD POISONING (E.G., CHILD HAS A BLOOD LEAD LEVEL > 19 UG/DL OR TWO CONSECUTIVE BLOOD LEAD LEVELS OF 15-19 UG/DL DONE AT LEAST 90 DAYS APART). THE INSPECTION MUS
P953	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P954	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P956	THE REQUEST CAN ONLY BE BACKDATED A MAXIMUM OF 14 DAYS FROM FIRST DATE RECEIVED BY COLORADO MEDICAID.
P957	COMPLETE PERIODONTAL CHARTING AT TIME OF SERVICE, AND SUBMIT CHARTING, COPY OF OPERATIVE REPORT, TOGETHER WITH A COPY OF THE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF), F-11035, TO PA UNIT ATTENTION DENTAL CONTSULTANT.
P958	NOTE THAT CODE D4341 HAS BEEN CHANGED. REFER TO THE DECISION NOTICE FOR AUTHORIZED QUANTITY.
P960	YOUR PA HAS BEEN APPROVED FOR 90 DAYS. THE 90 DAY APPROVAL DOES NOT IMPLY THE PA REQUEST MEETS PRIOR AUTHORIZATION CRITERIA. AFTER ADDITIONAL INFORMATION IS AVAILABLE IN INTERCHANGE, COLORADO MEDICAID WILL CREATE AN AMENDMENT REQUEST TO EXTEND THE PA FOR
P961	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P962	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
PA10	THE REQUESTED END DATE IS INVALID.
PA12	PLEASE FURNISH A WRITTEN DESCRIPTION OF THE CLIENTS DIAGNOSIS.
PA13	PROVIDE DIAGNOSES WITH DATES OF ONSET.
PA14	IDENTIFY PROBLEMS TO BE TREATED.
PA15	THE AUDIOLOGISTS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1), F-11020, AND PRIOR AUTHORIZATION REQUEST/HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2), F-11021.
PA16	THE PHYSICIANS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION/PHYSICIAN OTOLOGICAL REPORT (PA/POR), F-11019.

Denial Code	Long Description
PA17	SUBMIT BRIEF HISTORY WITH REFERRAL INFORMATION, LIVING SITUATION, FUNCTIONAL STATUS, AND OTHER PERTINENT INFORMATION. WHAT CHANGE OF STATUS RESULTED IN REFERRAL AT THIS TIME?
PA18	PLEASE FURNISH THE CLIENTS HEIGHT AND WEIGHT.
PA19	PLEASE SUBMIT CLINICAL INFORMATION SUFFICIENT TO VERIFY THE NEED FOR THE REQUESTED SERVICE(S).
PA20	PLEASE RESUBMIT WITH COMPLETE PERIODONTAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PA21	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL EDUCATIONAL PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA22	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL PROGRAM PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA23	REFER TO THE DURABLE MEDICAL EQUIPMENT INDEX FOR APPROPRIATE CODE AND DESCRIPTION. DO NOT USE AN "UNLISTED" CODE.
PA24	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUALIZED FAMILY SERVICE PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA25	INFORMATION ON THE REQUEST FORM IS ILLEGIBLE, AND THE REQUEST CANNOT BE PROCESSED.
PA26	RE-EVALUATE YOUR GOALS. EMPHASIS SHOULD BE ON FUNCTIONAL SELF-CARE. GOALS MUST BE RELATED TO FUNCTIONAL OUTCOME.
PA27	PLEASE CLARIFY THE NUMBER OF HOURS PER WEEK REQUESTED.
PA28	PLEASE CLARIFY THE NUMBER OF HOURS PER DAY REQUESTED.
PA29	PLEASE CLARIFY THE NUMBER OF VISITS PER DAY REQUESTED.
PA30	ATTACH SUPPORTIVE DOCUMENTATION; HOME EXERCISE PROGRAM AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA31	THE DIAGNOSIS CODE INDICATED ON THE REQUEST DOES NOT CORRESPOND TO THE DIAGNOSIS CODE DESCRIPTION.
PA32	PLEASE SUBMIT ADDITIONAL INFORMATION SUFFICIENT TO VERIFY APPROPRIATENESS AND NEED FOR TRANSPLANT.
PA33	PLEASE SUBMIT THE INITIAL AND PROGRESSIVE OBJECTIVE FINDINGS.
PA34	ATTACH SUPPORTIVE DOCUMENTATION, FACILITY PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA35	PLEASE SUBMIT THE CLIENTS ORIGINAL COMPLAINTS AND EXAMINATION FINDINGS.
PA36	ATTACH SUPPORTIVE DOCUMENTATION, IN-HOME AUTISM PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA37	PLEASE SUBMIT YOUR TREATMENT PLAN FOR THIS CLIENT.
PA38	ATTACH SUPPORTIVE DOCUMENTATION AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA39	INITIAL EVALUATIONS MUST BE PERFORMED BY AN OCCUPATIONAL THERAPIST REGISTERED (OTR), PER AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA) STANDARDS.
PA41	IDENTIFY THE PLACE OF SERVICE AND ITS EFFECT ON SUPPORTING THE DESIRED TREATMENT OUTCOME.
PA42	PLEASE INDICATE THE HOURS OF USE OF OXYGEN PER 24-HOUR PERIOD.
PA43	PROVIDE BASELINE DOCUMENTATION FOR THIS CLIENTS LIMITATIONS USING UNITS OF MEASUREMENT THAT ARE APPLIED CONSISTENTLY WHEN REPORTING STATUS.
PA44	IDENTIFY FUNCTIONAL LIMITATIONS AS THEY ARE RELATED TO IDENTIFIED CONDITIONS.
PA46	CORRELATE PLAN OF CARE TO REQUESTED PROCEDURE CODES.
PA47	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE FREQUENCY/DURATION REQUESTED.
PA48	PLEASE PROVIDE THE NAME AND CREDENTIALS OF THE RENDERING PROVIDER.
PA50	COLORADO MEDICAID RECORDS INDICATE THE CLIENT OWNS A WHEELCHAIR. DOCUMENT THE REASON AND NEED FOR REPLACEMENT AND COST TO REPAIR CURRENT WHEELCHAIR.
PA51	PLEASE DISTINGUISH PRIMARY AND SUPPORTIVE MODALITIES.
PA52	PLEASE SUBMIT A PROGRESS REPORT.
PA53	MULTIPLE FAMILY CLIENTS TREATMENT BY THE SAME PROVIDER REQUIRES FURTHER INFORMATION DOCUMENTING COORDINATION OF TREATMENT PLAN.

Denial Code	Long Description
PA54	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE MINUTES REQUESTED.
PA55	MEDICAL NECESSITY OF TREATMENT REQUIRES ADDITIONAL DOCUMENTATION.
PA56	GIVEN AGE, DIAGNOSES, CURRENT LEVEL OF FUNCTION, PAST RESPONSE TO TREATMENT, AND LIVING SITUATION, EXPAND ON POTENTIAL FOR SIGNIFICANT FUNCTIONAL PROGRESS WITHIN THE NEXT SIX MONTHS. EMPHASIZE WHY PROGRESS IS EXPECTED WITH SERVICES AT THIS TIME.
PA57	SUBMIT THE INITIAL FINDINGS. INCLUDE A COMPREHENSIVE EVALUATION.
PA58	SUBMIT PROGRESSIVE, OBJECTIVE FINDINGS. INCLUDE A PERTINENT RE-EVALUATION.
PA59	PLEASE SUPPLY INFORMATION REGARDING THE CLIENTS MEDICATION REQUIREMENTS, IF ANY.
PA60	PLEASE SPECIFY IF THE CLIENT IS IN AN EDUCATIONAL SETTING.
PA61	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA62	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
PA63	THE SKILLS OF A THERAPIST ARE PURPOSEFUL AND SKILLED INTERVENTIONS REQUIRED TO CONTINUALLY DESIGN, IMPLEMENT, REASSESS, MODIFY/GRADE, AND/OR DISCONTINUE A PLAN OF CARE IN A TIMELY MANNER, BASED ON THE COMPLEXITY OF THE CLIENTS MEDICAL CONDITION AND/OR CO
PA64	PLEASE SUBMIT A THERAPY PLAN OF CARE, INCLUDING A CURRENT, DATED EVALUATION.
PA65	A PLAN OF CARE SIGNED AND DATED BY THE PHYSICIAN IS REQUIRED.
PA66	THE SKILLS OF A THERAPIST ARE REQUIRED WHEN ONLY THE THERAPIST CAN SAFELY AND EFFECTIVELY DELIVER THE THERAPEUTIC PROCEDURES BECAUSE OF THEIR UNIQUE KNOWLEDGE, TRAINING, AND EXPERTISE. DESCRIBE THE REASON THAT SOMEONE OTHER THAN A THERAPIST CANNOT SAFELY
PA67	PLEASE SPECIFY IF THE CLIENTS WORK SITE DEMANDS GOOD BINAURAL HEARING.
PA68	DESCRIBE THE REASON, BASED ON THE CLIENTS COGNITIVE, PHYSICAL, COMMUNICATION, OR RESOURCE STATUS, THAT A HOME PROGRAM, EQUIPMENT, OR ENVIRONMENTAL ADAPTATIONS ALONE CANNOT MEET CLIENTS NEEDS.
PA69	PLEASE SPECIFY IF THE CLIENT HAS AN ACCOMPANYING DISABILITY THAT ADDS TO THE HEARING PROBLEM.
PA70	DISTINGUISH REQUESTED PROCEDURES AND GOALS FROM OTHER SERVICES THIS CLIENT RECEIVES. THEY MAY NOT BE DUPLICATIVE.
PA71	PLEASE INDICATE THE NUMBER OF DAYS REQUESTED.
PA73	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA74	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA75	PLEASE DOCUMENT CARRYOVER OF THE THERAPY PROGRAM TO NURSING.
PA76	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA79	PROVIDE EVIDENCE OF SIGNIFICANT FUNCTIONAL PROGRESS IN LAST SIX MONTHS.
PA84	THE GRANT DATE OF THIS REQUEST CANNOT BE PRIOR TO THE SIGNATURE DATE OF THE PRESCRIBING PHYSICIAN.
PA86	PROVIDE EVIDENCE OF SKILLS GAINED IN THERAPY CARRYING OVER TO OTHER SETTINGS WITHIN SIX MONTHS.
PA87	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE NUMBER OF SESSIONS REQUESTED.
PA88	THE REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL SCOPE OF PRACTICE.
PA89	PRIOR AUTHORIZATION IS NOT REQUIRED UNTIL LIMITATION OF SERVICE HAS BEEN REACHED.
PA91	PLEASE SUBMIT REQUIRED X-RAYS.
PA92	PLEASE PROVIDE AN EXPLANATION FOR THE MATERIAL SUBMITTED WITH THE REQUEST.
PA95	PLEASE DESCRIBE HOW THE PROVISION OF THIS SERVICE WOULD PREVENT INSTITUTIONALIZATION OF THE CLIENT.
PA96	COULD THE EXISTING DENTURE(S) BE RELINED OR REBASED? IF NOT, PLEASE EXPLAIN WHY NOT.
PA97	REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL STANDARDS OF PRACTICE.
PA98	PLEASE INDICATE IF THE CLIENT IS CURRENTLY BEING TUBE FED.
PB02	PLEASE PROVIDE THE REQUIRED DATED SIGNATURES ON THE ATTACHMENTS.

Denial Code	Long Description
PB03	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING THE LOSS/DESTRUCTION/THEFT OF THE HEARING AID.
PB04	DESCRIBE THE CLIENTS ABILITY TO STAND OR AMBULATE SUFFICIENTLY TO ACCOMPLISH SELF-CARE ACTIVITIES.
PB07	PLEASE SUBMIT AN ORTHODONTIC STUDY MODEL OR DIAGNOSTIC CASTS.
PB09	PLEASE PROVIDE A PHOTOGRAPH OF THE INVOLVED AREA(S).
PB10	PLEASE PROVIDE AN ESTIMATION (IN GRAMS) OF THE TOTAL AMOUNT OF TISSUE TO BE RESECTED.
PB11	PLEASE SUBMIT THE PLAN OF CARE FOR CO-TREATMENT.
PB12	FURNISH A DETAILED DESCRIPTION FOR THE PROCEDURE CODE REQUESTED.
PB13	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB15	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB18	PLEASE COMPLETE THE ATTACHED OUT-OF-STATE PROVIDER DATA SHEET, F-11001, AND RESUBMIT.
PB20	A SIGNED AND DATED PRESCRIPTION IS REQUIRED WITHIN THREE MONTHS OF RECEIPT BY COLORADO MEDICAID FOR INITIAL REQUESTS AND WITHIN 12 MONTHS OF RECEIPT BY COLORADO MEDICAID FOR SUBSEQUENT REQUESTS.
PB21	PLEASE COMPLETE THE APPROPRIATE PRIOR AUTHORIZATION ATTACHMENT. CONTACT PROVIDER SERVICES OR THE PRIOR AUTHORIZATION UNIT FOR ASSISTANCE.
PB23	PHYSICAL THERAPY ASSISTANT NOTES AND ALL FORMS SUBMITTED MUST BE COSIGNED BY A REGISTERED PHYSICAL THERAPIST.
PB31	ARE YOU REQUESTING A COMPLETE APPLIANCE, OR REPLACEMENT PARTS?
PB32	THE PROCEDURE CODE INDICATED ON THE REQUEST DOES NOT MATCH THE DESCRIPTION OF SERVICE; PLEASE CORRECT AND RESUBMIT.
PB35	THE SERVICE REQUESTED DOES NOT REQUIRE PRIOR AUTHORIZATION.
PB41	PLEASE FURNISH A CURRENT MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT, F-11090 (DATED WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID).
PB45	THE CERTIFICATION PERIOD ON THE PLAN OF CARE (POC) DOES NOT COVER THE REQUESTED GRANT/START DATE. PLEASE RESUBMIT YOUR REQUEST WITH A NEW POC.
PB49	A CERTIFIED OCCUPATIONAL THERAPY ASSISTANTS NOTES MUST BE COSIGNED BY AN OCCUPATIONAL THERAPIST REGISTERED.
PB51	ADDITIONAL INFORMATION IS REQUIRED ON PRIOR AUTHORIZATION TO ENABLE PRICING.
PB54	REQUESTED SERVICES DO NOT MATCH SERVICES ON THE PHYSICIANS ORDERS.
PB59	PLEASE PROVIDE AN INDIVIDUAL EDUCATIONAL PLAN (IEP), WHICH HAS BEEN SIGNED BY THE PROVIDER NO EARLIER THAN NINE MONTHS PRIOR TO RECEIPT AT COLORADO MEDICAID; OTHERWISE, DOCUMENT WHY NO IEP EXISTS.
PB65	PLEASE FURNISH THE ANTICIPATED TOTAL CHARGES FOR THIS REQUEST.
PB66	A PHOTOCOPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED; THE DATE MUST BE WITHIN SIX MONTHS OF RECEIPT BY COLORADO MEDICAID.
PB67	THE PRESCRIPTION DATE MUST INCLUDE MONTH, DAY, AND YEAR.
PB68	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID.
PB73	THE SERVICES IDENTIFIED ON THE PLAN OF CARE DO NOT APPEAR APPROPRIATE FOR THE PROCEDURE CODE(S) REQUESTED ON THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018.
PB74	THE CLIENT/PROVIDER DOES NOT HAVE RETROACTIVE ENROLLMENT.
PB75	THE REQUESTED START DATE IS MORE THAN 14 DAYS BEFORE OR 62 DAYS AFTER RECEIPT.
PB82	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
PB83	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A HOME HEALTH AIDE. PLEASE RESUBMIT AS A PERSONAL CARE WORKER OR PROVIDE ADDITIONAL DOCUMENTATION.
PB86	THE SERVICES REQUESTED ARE NOT BEING PROVIDED IN THE CLIENTS RESIDENCE. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL.
PB87	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A NURSE. PLEASE RESUBMIT AS A HOME HEALTH AIDE OR PROVIDE ADDITIONAL DOCUMENTATION.
PB92	PLEASE FURNISH THE CLIENTS COMPLETE ADDRESS.
PB94	IF THE CLIENT IS A RESIDENT OF A NURSING HOME, SUPPLY THE COMPLETE NAME AND ADDRESS OF THE NURSING HOME.

Denial Code	Long Description
PB99	THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018, MUST BE SIGNED AND DATED.
PC01	PLEASE SUPPLY THE RENDERING PROVIDERS PROVIDER NUMBER.
PC03	THE DRUG ENFORCEMENT ADMINISTRATION NUMBER IS MISSING OR INVALID.
PC06	PLEASE DESCRIBE YOUR PROGRAM; INCLUDE ENTRY DATE, TERMINATION DATE, HOURS PER WEEK, AND NUMBER OF WEEKS OF PRIMARY INTENSIVE SERVICE REQUESTED.
PC07	PLEASE DESCRIBE YOUR "AFTERCARE/FOLLOW-UP" PLANS FOR THIS CLIENT.
PC08	PLEASE SUPPLY DOCUMENTATION OF PREVIOUS SUBSTANCE ABUSE SERVICES WITH DATE(S) AND OUTCOME.
PC09	PLEASE DESCRIBE IN DETAIL THE TREATMENT OBJECTIVES/GOALS FOR THIS CLIENT.
PC10	PLEASE DESCRIBE THE FAMILY SITUATION/DYNAMICS. EXPLAIN HOW THE FAMILY WILL BE INCORPORATED INTO THE CLIENTS PLAN OF CARE.
PC12	PLEASE EXPLAIN IF YOUR SERVICE ENCOURAGES THE CLIENT TO ATTEND SELF-HELP GROUPS.
PC13	PLEASE SUPPLY A SPECIFIC SCHEDULE OF ACTIVITIES, INCLUDING DAY, TIME OF DAY, LENGTH OF SESSION, AND SERVICE TO BE RENDERED DURING THAT TIME.
PC15	PLEASE FURNISH DIAGNOSTIC RATIONALE.
PC17	PLEASE DOCUMENT IF THE CLIENT EVER RECEIVED SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT.
PC19	PLEASE FURNISH MORE EXTENSIVE AND IN-DEPTH HISTORICAL AND PSYCHOSOCIAL DATA.
PC20	PLEASE SUPPLY THE DATE THE CLIENT BECAME TOTALLY ENDENTULOUS.
PC23	PLEASE SUBMIT A PHYSICIANS STATEMENT REGARDING THE MEDICAL NECESSITY OF DENTURES FOR THIS CLIENT. THE PHYSICIANS STATEMENT MUST DOCUMENT THE MEDICAL NEED FOR DENTURES.
PC24	THE SERVICE REQUESTED WAS PREVIOUSLY AUTHORIZED. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT INDICATING THIS FACT IS REQUIRED.
PC25	PLEASE SUPPLY SUFFICIENT MITIGATING CIRCUMSTANCES TO WARRANT THE CONSTRUCTION OF NEW DENTURES(S).
PC26	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
PC28	PLEASE SUBMIT A PHYSICIANS STATEMENT INDICATING DENTURES ARE NECESSARY FOR THIS NURSING HOME CLIENT.
PC29	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING LOSS OR DESTRUCTION OF DENTURE(S). INCLUDE SIGNED STATEMENT FROM CLIENT OR FACILITY DIRECTOR REGARDING HOW, WHEN AND WHERE LOST.
PC30	PLEASE PROVIDE COMPLETE INTRAORAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PC31	PLEASE DESCRIBE ANY RELATED DEFORMITIES OF THE FEET.
PC34	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD WITH REQUESTED DME ITEM(S) AND DOCUMENT IF THE CLIENT CAN USE SAFELY AND INDEPENDENTLY.
PC35	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD AND DESCRIBE THE RESULTS AND EFFECTIVENESS OF THE SERVICE REQUESTED.
PC39	PLEASE INDICATE LITER FLOW PER MINUTE, HOURS OF USE PER 24 HOUR PERIOD, AND THE EXPECTED DURATION OF NEED.
PC40	THE ITEM DOES NOT REQUIRE PRIOR AUTHORIZATION UNTIL THE LIFE EXPECTANCY HAS BEEN REACHED.
PC41	PLEASE SUPPLY INFORMATION INDICATING THE NECESSITY OF POSITIONING THE CLIENT'S BODY IN MULTIPLE POSITIONS.
PC42	PLEASE INDICATE IF THE BED HEIGHT MUST BE CHANGED TO ALLOW FOR SAFE TRANSFER OR ADEQUATE BED CARE.
PC43	SUPPLY A PHYSICIANS STATEMENT INDICATING TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR UNIT HAS REDUCED PAIN, IMPROVED/INCREASED THE CLIENTS ACTIVITY LEVEL, AND/OR REDUCED CLIENTS USE OF PAIN MEDICATION.
PC44	A CURRENT AUTHORIZATION FOR THIS SERVICE IS ON FILE FOR ANOTHER PROVIDER. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT OF THAT FACT IS REQUIRED BY THE CLIENT OF FIRST PROVIDER.
PC59	DOCUMENT DECLINE OR PROGRESS IN SPECIFIC, MEASURABLE, OBJECTIVE TERMS.
PC60	DOCUMENT IF CLIENT HAS DEMONSTRATED A GOOD APPOINTMENT COMPLIANCE RECORD.
PC61	THE PHYSICIANS SIGNATURE DATE MUST NOT EXCEED 90 DAYS FROM THE DATE OF RECEIPT BY COLORADO MEDICAID.

Denial Code	Long Description
PC62	REQUESTS FOR A CONTINUATION OF THERAPY SHOULD NOT BE SUBMITTED MORE THAN FOUR WEEKS PRIOR TO THE EXPIRATION DATE OF THE CURRENT AUTHORIZATION.
PC63	PLEASE FURNISH THE STYLE AND MANUFACTURER OF THE FRAME.
PC64	PLEASE FURNISH THE CLIENTS LENS FORMULA.
PC66	ALL REQUESTS FOR TINTS REQUIRE DOCUMENTATION OF THE VISUAL OR MEDICAL CONDITION RELATED TO PHOTOPHOBIA.
PC67	PLEASE DOCUMENT THE REASON AND JUSTIFICATION FOR REPLACEMENT BEYOND THE FIRST LENS/FRAME.
PC68	DOCUMENT IF ALL REMAINING MAXILLARY AND/OR MANDIBULAR TEETH ARE DECAY-FREE, PROPERLY RESTORED, AND PERIODONTICALLY SOUND.
PC72	SUPPLY MORE DETAIL REGARDING PROGRESS (ATTACHMENT OF GOALS, ETC.). CORRELATE PROGRESS TO PREVIOUS GOALS AND IDENTIFIED LIMITATIONS.
PC77	PLEASE SUBMIT A PLAN OF CARE DESCRIBING THE SERVICES THAT WOULD BE PROVIDED.
PC78	PLEASE DOCUMENT SPECIFIC, MEASURABLE GOALS.
PC82	THE PRIOR AUTHORIZATION (PA) SYSTEM CAN PROCESS ONLY 26 DETAILS PER PA REQUEST. PLEASE RESUBMIT YOUR REQUEST WITH NO MORE THAN 26 DETAILS.
PC83	PLEASE SUPPLY A PHYSICIANS PRESCRIPTION DATED WITHIN ONE MONTH OF REQUESTED SUBSTANCE ABUSE DAY TREATMENT.
PC84	PLEASE PROVIDE INFORMATION INDICATING THIS CLIENT IS APPROPRIATELY DETOXIFIED FROM ALCOHOL AND/OR OTHER DRUGS.
PC85	PLEASE PROVIDE INFORMATION TO INDICATE THE CLIENTS ABILITY TO ABSTAIN FROM ALCOHOL OR DRUGS WHILE IN THE SUBSTANCE ABUSE DAY TREATMENT PROGRAM.
PC86	PLEASE INDICATE IF THIS CLIENT IS WILLING TO PARTICIPATE IN AFTERCARE OR CONTINUING CARE SERVICES.
PC87	PROVIDE MORE INFORMATION ON TREATMENT HISTORY; INCLUDE SERVICE PROVIDED, DATES, AND OUTCOME. PROVIDE DETAIL OF PREVIOUS TREATMENT.
PC88	PLEASE PROVIDE MORE RATIONALE FOR THE APPROPRIATENESS AND MEDICAL NECESSITY OF SUBSTANCE ABUSE DAY TREATMENT.
PC89	PROVIDE A TREATMENT PLAN THAT CONTAINS MEASURABLE GOALS AND OBJECTIVES CORRESPONDING TO THE IDENTIFIED DEFICIT.
PC91	PLEASE PROVIDE MORE INFORMATION ON FAMILY INVOLVEMENT TREATMENT.
PC92	PLEASE PROVIDE MORE HISTORY AND EXPLANATION ABOUT THE ISSUE OF ABSTINENCE FOR THIS CLIENT.
PC94	PLEASE PROVIDE THE ANTICIPATED BEGINNING DATE AND/OR THE ESTIMATED SUBSTANCE ABUSE DAY TREATMENT DISCHARGE DATE.
PC95	PLEASE SUPPLY JUSTIFICATION FOR BEGINNING CLIENT IN SERVICE PRIOR TO AUTHORIZATION BEING OBTAINED.
PC96	THE INITIAL THREE HOURS OF SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IN A CALENDAR YEAR DO NOT REQUIRE PRIOR AUTHORIZATION.
PC97	REIMBURSEMENT FOR INITIAL SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IS LIMITED TO THREE HOURS IN A CALENDAR YEAR AND DOES NOT REQUIRE PRIOR AUTHORIZATION.
PC98	THIS DRUG IS CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE BILL USING THE APPROPRIATE NATIONAL DRUG CODE (NDC) OR SUBMIT A COMPLETED DRUG ADDITION REQUEST FORM IF THE NDC IS NOT LISTED IN THE DRUG INDEX.
PC99	THIS DRUG IS NOT CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL, CURRENT ADMINISTRATIVE RULE, OR COLORADO DRUG INDEX FOR COVERAGE LIMITATIONS.
PD01	DOCUMENT THAT CLIENT HAS ACHIEVED GOOD ORAL HYGIENE, PERIODONTAL CASE TYPE 1 OR 2, AND IS MOTIVATED TO MAINTAIN SAME.
PD03	PLEASE PROVIDE AN ARTERIAL BLOOD GAS READING OR PULSE OXIMETRY RESULTS DONE ON ROOM AIR SIGNED AND DATED BY A MEDICAL DOCTOR. THIS SHOULD BE DONE WITHIN 60 DAYS OF REQUESTED SERVICE.
PD04	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 30 DAYS OF RECEIPT BY COLORADO MEDICAID.

Denial Code	Long Description
PD07	SUBMIT A PHOTOCOPY OF A VALID PRESCRIPTION, ISSUED WITHIN THE PAST YEAR, OR COMPLETE SECTION B OF THE PRIOR AUTHORIZATION/DRUG ATTACHMENT (PA/DGA), F-11049.
PD10	BRAND MEDICALLY NECESSARY MUST BE IN THE PRESCRIBERS OWN HANDWRITING AND WRITTEN DIRECTLY ON THE PRESCRIPTION OR A SEPARATE ORDER ATTACHED TO THE ORIGINAL PRESCRIPTION.
PD12	COMPLETE DENTURES, PARTIAL DENTURES, DENTURE RELINES, AND FIXED PROSTHODONTIC SERVICES ARE NOT COVERED SERVICES FOR ADULTS FOR DATES OF SERVICE ON AND AFTER OCTOBER 1, 1995.
PD22	PLEASE COMPLETE ALL REQUIRED ELEMENTS ON THE PERSONAL CARE SCREENING TOOL (PCST), F-11133.
PD24	THIS PRIOR AUTHORIZATION REQUEST IS UNABLE TO BE PROCESSED. PLEASE RESUBMIT WITH ADDITIONAL REQUIRED FORMS, INCLUDING THE ENTIRE PERSONAL CARE SCREENING TOOL (PCST), F-11133; PERSONAL CARE ADDENDUM, F-11136; AND SUPPORTING DOCUMENTATION, AS DIRECTED.
PD25	THERE IS A PERSONAL CARE SCREENING TOOL (PCST), F-11133, COMPLETED BY ANOTHER AGENCY. CONTACT THE AGENCY TO TRANSFER SCREEN.
PD26	THERE IS A LIMITED TERM CARE FUNCTIONAL SCREEN (LTC-FS) COMPLETED BY ANOTHER AGENCY. THE PERSONAL CARE SCREENING TOOL (PCST), F-11133, INFORMATION IS IN CONFLICT WITH LTC-FS.
PD27	ONLY ONE LEVEL OF FUNCTION MAY BE SELECTED FOR ALL ELEMENTS EXCEPT TOILETING. COLORADO MEDICAID IS UNABLE TO PROCESS THE PRIOR AUTHORIZATION REQUEST.
PD28	NO UNITS MAY BE REQUESTED USING THIS PRIOR AUTHORIZATION PROCESS. PLEASE SUBMIT WITH THE APPROPRIATE ATTACHMENTS FOR REQUESTING SPECIFIC PERSONAL CARE WORKER UNITS.
PD29	CLIENT IS NOT ELIGIBLE FOR THE REQUESTED SERVICE(S) AS OF THE REQUESTED START DATE.
PD30	NO TRAVEL TIME MAY BE AUTHORIZED WHEN NO PERSONAL CARE WORKER SERVICE IS AUTHORIZED.
PD32	PROVIDER NOT CERTIFIED TO RENDER THE SERVICE(S) REQUESTED.
PD34	BASED ON THE DOCUMENTATION SUBMITTED, THIS REQUEST CAN NOT BE PRIOR AUTHORIZED. REFER TO THE PA MESSAGES FROM THE CONSULTANT FOR COMPLETE EXPLANATION.
PD98	PLEASE DOCUMENT HOW AND WHEN EACH PREVIOUSLY AUTHORIZED PRO RE NATA VISIT WAS USED.
0201	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
0233	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0235	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0237	CLIENT IDENTIFICATION NUMBER DOES NOT MATCH CLIENTS FIRST NAME.
0238	THE CLIENT IDENTIFICATION NUMBER DOES NOT MATCH THE CLIENTS LAST NAME.
0242	SECONDARY DIAGNOSIS CODE IS INVALID.
0248	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0249	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0258	THE PRIMARY DIAGNOSIS CODE IS REQUIRED.
0272	THE PRIMARY DIAGNSOSIS CODE IS INVALID.
0339	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0340	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0363	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0400	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0853	HCPCS - ANNUAL UPDATE
0885	NEVER EVENTS MODIFIERS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
0886	NEVER EVENTS DIAGNOSIS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
1000	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
1002	RENDERING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1003	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1007	RENDERING PROVIDER ID IS NOT ON FILE.
1048	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1801	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
1806	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
1900	THE BILLING PROVIDERS TAXONOMY CODE IS INVALID.

Denial Code	Long Description
1901	THE RENDERING PROVIDERS TAXONOMY CODE IS INVALID.
1927	A NATIONAL PROVIDER IDENTIFIER IS REQUIRED FOR THE BILLING PROVIDER.
1934	A NATIONAL PROVIDER INDENTIFIER IS REQUIRED FOR THE RENDERING PROVIDER.
1936	THE BILLING PROVIDER NUMBER IS INVALID.
1960	INTERNAL PROCESSING IS REQUIRED.
1964	THE BILLING PROVIDER INDICATED IS NOT ALLOWABLE AS A BILLING PROVIDER.
1965	RENDERING PROVIDER NUMBER IS MISSING/INVALID FOR THIS PROCEDURE PROVIDER.
1974	PRESCRIBING/REFERRING/ORDERING PROVIDER INDICATED IS NOT CERTIFIED AS A PRESCRIBING/REFERRING/ORDERING PROVIDER.
1975	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
1976	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
2001	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2003	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2017	THE CLIENT IS ENROLLED IN A MEDICAID OR OTHER MANAGED CARE PROGRAM.
2037	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2603	CLIENT LOCKED-IN TO A PROVIDER OR ENROLLED IN A HOSPICE. CONTACT CLIENTS HOSPICE FOR PAYMENT OF SERVICES OR RESUBMIT WITH DOCUMENTATION OF UNRELATED NATURE OF CARE.
4027	THE DIAGNOSIS CODE IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
4031	THE PROCEDURE SUBMITTED IS NOT APPROPRIATE FOR CLIENTS GENDER.
4040	THE PRIMARY DIAGNOSIS CODE IS NOT ON FILE.
4041	THE SECONDARY DIAGNOSIS IS NOT ON FILE.
4046	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4053	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4067	THE SERVICE IS NOT A BENEFIT ON THE REQUESTED START DATE OR DATE OF RECEIPT.
4127	INTERNAL PROCESSING IS REQUIRED.
4131	INTERNAL PROCESSING IS REQUIRED.
4151	THE PROVIDER IS NOT AUTHORIZED TO PERFORM THE PROCEDURE.
4227	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4236	ETIOLOGY DIAGNOSIS CODE(S) (E-CODES) ARE INVALID AS THE PRIMARY DIAGNOSIS.
4244	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4321	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4322	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4374	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4711	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR CLIENTS AGE.
4733	DIAGNOSIS AND/OR PROCEDURE AND/OR PLACE OF SERVICE (POS) CODE IS NOT COVERED FOR EXPRESS ENROLLMENT CLIENTS.
4765	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4802	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
4804	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4874	PLEASE REFER TO PA MESSAGES FOR RETURN INFORMATION.
4944	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS GENDER.
4975	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
7500	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
P001	THE BILLING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THE SERVICES.
P002	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P003	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P005	THE PRIOR AUTHORIZATION CAN NOT BE END DATED. THE PRIOR AUTHORIZATION STATUS IS NOT APPROVED OR APPROVED WITH REVISIONS.
P006	PLEASE FURNISH THE PROCEDURE CODE AND CORRESPONDING DESCRIPTION.

Denial Code	Long Description
P008	THE BILLING PROVIDER NUMBER IS INVALID.
P009	THE BILLING PROVIDER NUMBER IS INVALID.
P010	THE REQUESTED END DATE IS INVALID.
P011	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P012	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P013	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P014	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P015	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P016	THE REQUESTED START DATE IS MISSING OR INVALID.
P019	THE REQUESTED START DATE IS MISSING OR INVALID.
P020	THE RENDERING PROVIDER NUMBER IS INVALID.
P021	THE RENDERING PROVIDER NUMBER IS INVALID.
P022	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P023	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P024	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P026	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P027	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P030	FIRST MODIFIER IS INVALID.
P031	FIRST MODIFIER IS INVALID.
P032	SECOND MODIFIER IS INVALID.
P033	SECOND MODIFIER IS INVALID.
P034	THIRD MODIFIER IS INVALID.
P035	THIRD MODIFIER IS INVALID.
P036	FOURTH MODIFIER IS INVALID.
P037	FOURTH MODIFIER IS INVALID.
P038	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P039	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P040	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P041	CLIENTS FIRST NAME IS MISSING.
P042	CLIENTS LAST NAME IS MISSING.
P043	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P044	BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES REQUESTED.
P045	FIRST MODIFIER IS INVALID.
P046	SECOND MODIFIER IS INVALID.
P047	THIRD MODIFIER IS INVALID.
P048	FOURTH MODIFIER IS INVALID.
P052	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P053	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P054	RENDERING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES FOR THE BENEFIT PLAN.
P055	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P058	PLEASE FURNISH THE INTERNATIONAL CLASSIFICATION OF DIAGNOSIS, NINTH REVISION, CLINICIAL MODIFICATION SURGICAL PROCEDURE CODE AND CORRESPONDING DESCRIPTION.
P061	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P062	THE CLIENT ID AND/OR NAME INDICATED ON THE PA REQUEST IS INCORRECT. THE CLIENT ID AND/OR NAME HAS BEEN UPDATED. PLEASE VERIFY THE ID AND/OR NAME IS CORRECT.

Denial Code	Long Description
P064	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
P067	THE FREQUENCY OF HOURS REQUESTED ARE NOT APPROPRIATE FOR THIS CLIENT AND HAVE BEEN MODIFIED ACCORDINGLY.
P079	BILLING PROVIDER IS ON PAYMENT SUSPENSION DUE TO CREDIBLE ALLEGATION OF FRAUD.
P120	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAS BEEN REDUCED.
P121	THE SERVICE/ PROCEDURE REQUESTED IS NOT SUPPORTED BY SUBMITTED DOCUMENTATION.
P126	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
P128	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.
P138	SERVICE(S) DO NOT MEET COLORADO MEDICAID GUIDELINES.
P167	REQUESTED DOCUMENTATION HAS NOT BEEN SUBMITTED.
P178	THE SERVICE REQUESTED IS NOT MEDICALLY NECESSARY.
P179	THE MEDICAL NECESSITY FOR THIS SERVICE IS NOT SUPPORTED BY THE SUBMITTED DOCUMENTATION.
P233	THE DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE ADDITIONAL CARE.
P257	THIS CLIENTS FUNCTIONAL ASSESSMENT SCORES PLACE THIS CLIENT OUTSIDE ELIGIBILITY FOR DAY TREATMENT.
P274	OUR RECORDS INDICATE THIS CLIENT IS INVOLVED IN EFFECTIVE AND APPROPRIATE SERVICE ELSEWHERE.
P292	INTENSIVE REHABILITATION HOURS ARE NO LONGER APPROPRIATE AS INDICATED BY HISTORY, DIAGNOSIS, AND/ OR FUNCTIONAL ASSESSMENT SCORES.
P328	THE SERVICES REQUESTED INCLUDE NON-COVERED SERVICES, AND HOURS ARE REDUCED ACCORDINGLY.
P339	THE CLIENTS PAST HISTORY INDICATES REDUCED TREATMENT HOURS ARE WARRANTED.
P342	THE REQUEST DOES NOT MEET GENERALLY ACCEPTED CONDITIONS REQUIRING FLUORIDE TREATMENTS.
P346	SERVICES EXCEED COLORADO MEDICAID LIMITATION AND DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE MEDICAL NECESSITY OF THE SERVICE.
P349	THE SERVICE REQUESTED WAS PERFORMED LESS THAN FIVE YEARS AGO.
P353	THE EXISTING APPLIANCE HAS NOT BEEN WORN FOR THREE YEARS.
P367	THE CLIENT HAS BEEN TOTALLY WITHOUT TEETH AND AN APPLIANCE FOR FIVE YEARS.
P392	THE CLIENT IS MISSING AN ANTERIOR TOOTH AND/OR HAS TWO OR MORE POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P405	THE SERVICE(S) REQUESTED COULD ADEQUATELY BE PERFORMED IN THE DENTAL OFFICE.
P406	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE OF GOOD PERIODONTAL HEALTH (AMERICAN ACADEMY OF PERIODONTOLOGY PERIODONTAL CLASSIFICATION OF TYPE I OR II).
P407	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE VISIBLE ON RADIOGRAPHS THAT AT LEAST 50 PERCENT OF THE CLINICAL CROWN IS INTACT.
P409	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING SIX OR MORE TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED, INCLUDING THIRD MOLARS.
P410	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING ONE OR MORE ANTERIOR TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED.
P411	DOCUMENTATION DOES NOT SUPPORT THE NEED FOR PERIODONTIC SERVICES. POCKETS ARE LESS THAN 4MM AND/OR GREATER THAN 6MM FOR CLIENT AND/OR THE CLIENT IS UNDER THE AGE OF 13.
P412	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA.
P413	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA. THIS PA HAS BEEN GRANTED AS APPROVED NOT APPROVED WITH REVISIONS. THE DURATION REQUESTED MAY HAVE BEEN REDUCED TO REFLECT COVERAGE LIMITATIONS, PRESCRIBER ORDERS, CONFLICTI
P417	THE SERVICE(S) REQUESTED COULD BE ADEQUATELY PERFORMED WITH LOCAL ANESTHESIA.
P437	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO POOR ORAL HYGIENE.
P444	THIS LINE ITEM IS A DUPLICATE OF ANOTHER LINE ITEM ON THIS PRIOR AUTHORIZATION (PA) REQUEST. PLEASE CORRECT.
P446	THIS IS A DUPLICATE OF AN EXISTING PRIOR AUTHORIZATION (PA) REQUEST. YOU MAY CONTACT PROVIDER SERVICES IF YOU REQUIRE ASSISTANCE. DUPLICATE PA REQUEST
P448	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO DECAY HISTORY.
P449	QUESTIONABLE LONG TERM PROGNOSIS DUE TO GUM AND BONE DISEASE.

Denial Code	Long Description
P456	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO APPARENT ROOT INFECTION.
P457	OUR RECORDS INDICATE THIS CLIENT HAS EXCEEDED ESTABLISHED PROGRAM LIMITATIONS. COLORADO MEDICAID WILL NOT AUTHORIZE NEW DENTURES.
P458	DOCUMENTATION PROVIDED INDICATES A LESS ELABORATE PROCEDURE SHOULD BE CONSIDERED.
P502	RENTAL ONLY ALLOWED; MEDICAL NEED FOR PURCHASE HAS NOT BEEN DOCUMENTED.
P503	PURCHASE ONLY ALLOWED; MEDICAL NEED FOR RENTAL HAS NOT BEEN DOCUMENTED.
P504	OCCUPATIONAL THERAPY GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P505	THE SERVICE REQUESTED IS INCLUDED IN THE NURSING HOME RATE STRUCTURE.
P511	THIS NATIONAL DRUG CODE IS ONLY BILLABLE AS PART OF A COMPOUND DRUG.
P515	THE PRESENCE OF A HANDICAPPING MALOCCLUSION OR HANDICAPPING DENTOFACIAL DEFORMITY IS NOT SUPPORTED BY THE DOCUMENTATION SUBMITTED.
P521	THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVERED BY COLORADO MEDICAID.
P522	GASTRO-INTESTINAL SURGERY FOR THE PURPOSE OF WEIGHT CONTROL IS COVERED ONLY AS A LIFE THREATENING PROCEDURE.
P523	THE TREATMENT REQUEST IS NOT CONSISTENT WITH THE CLIENT'S DIAGNOSIS.
P524	PSYCHOTHERAPY PROVIDED IN THE CLIENTS HOME IS NOT A COVERED BENEFIT OF COLORADO MEDICAID.
P525	THE INFORMATION PROVIDED IS NOT CONSISTENT WITH THE INTENSITY OF SERVICES REQUESTED.
P526	INTENSIVE MULTIPLE MODALITY TREATMENT IS NOT CONSISTENT WITH THE INFORMATION PROVIDED.
P527	MULTIPLE PROVIDERS OF TREATMENT ARE NOT INDICATED FOR THIS CLIENT.
P528	THE DURATION OF TREATMENT SESSIONS EXCEED CURRENT COLORADO MEDICAID GUIDELINES.
P534	DOCUMENTATION OF POOR PHYSICAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P535	OTHER PHYSICAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P536	THE PHYSICAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P537	USE OF PHYSICAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P538	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF A PHYSICAL THERAPIST.
P539	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS AND LIVING ARRANGEMENT.
P540	GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P541	THE PROCEDURE(S) REQUESTED ARE NOT MEDICAL IN NATURE.
P542	DOCUMENTATION OF POOR OCCUPATIONAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P543	DOCUMENTATION OF POOR SPEECH THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P544	OTHER OCCUPATIONAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P546	THE OCCUPATIONAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P547	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF PHYSICAL THERAPY.
P548	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P549	ACTIVITIES TO PROMOTE DIVERSION OR GENERAL MOTIVATION ARE NONCOVERED COLORADO MEDICAID SERVICES.
P550	REVISIONS OF THE REQUEST IS NECESSITATED BY THE CLIENTS MINIMAL PROGRESS.
P551	RESTORATIVE NURSING INVOLVEMENT COULD BE INCREASED.
P552	CLIENTS DEMONSTRATED RESPONSE TO CURRENT THERAPY DOES NOT WARRANT THE INTENSE FREQUENCY REQUESTED.
P553	MAINTENANCE IS TWO TIMES PER WEEK OR LESS.

Denial Code	Long Description
P554	THE SPEECH THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P555	USE OF OCCUPATIONAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P556	USE OF SPEECH THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P557	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF AN OCCUPATIONAL THERAPIST.
P558	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
P559	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P560	THE MATERIALS/ SERVICES REQUESTED ARE PRINCIPALLY COSMETIC IN NATURE.
P561	THE LENS FORMULA DOES NOT JUSTIFY REPLACEMENT.
P562	THE CHANGE IN THE LENS FORMULA DOES NOT WARRANT MULTIPLE REPLACEMENTS.
P563	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P564	LENSES ONLY ARE APPROVED; PLEASE DISPENSE A CONTRACTED FRAME. THE NON-CONTRACTED FRAME IS NOT MEDICALLY JUSTIFIED.
P565	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P566	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P567	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF OCCUPATIONAL THERAPY.
P568	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF SPEECH THERAPY.
P569	LEVEL, INTENSITY, OR EXTENT OF SERVICE(S) REQUESTED HAS BEEN MODIFIED CONSISTENT WITH MEDICAL NEED AS DEFINED IN THE PLAN OF CARE.
P570	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P571	THE SERVICE ASKED FOR IS NOT COVERED BY COLORADO MEDICAID AS THESE TASKS CAN BE DONE BY NURSES OR ACTIVITY STAFF.
P572	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P573	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.
P574	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P575	MEDICAL NEED FOR EQUIPMENT/ SUPPLY REQUESTED IS NOT SUPPORTED BY DOCUMENTATION SUBMITTED.
P576	OTHER SPEECH THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P577	DOCUMENTATION SUBMITTED IDENTIFIES THAT THE CLIENT HAS FEWER THAN TWO POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P582	LESS EXPENSIVE ALTERNATIVE SERVICES ARE AVAILABLE FOR THIS CLIENT.
P634	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P711	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING PERIODONTAL SCALING AND ROOT PLANNING.
P712	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING GINGIVECTOMY.
P754	AN APPROVED SUBSTANCE ABUSE DAY TREATMENT PROGRAM CANNOT EXCEED A SIX WEEK PERIOD.
P761	THE CLIENT DOES NOT APPEAR TO BE ABLE OR WILLING TO ABSTAIN FROM ALCOHOL/DRUG USAGE WHILE IN TREATMENT. THEREFORE, SUBSTANCE ABUSE DAY TREATMENT SERVICES ARE NOT APPROVED.
P764	THIS CLIENT HAS COMPLETED INTENSIVE SUBSTANCE ABUSE TREATMENT WITHIN THE PAST 12 MONTHS. THE DOCUMENTATION PROVIDED IS NOT ADEQUATE TO JUSTIFY ADDITIONAL INTENSIVE TREATMENT AT THIS TIME.
P785	A LESS THAN SIX-WEEK HEALING PERIOD HAS BEEN SPECIFIED FOR THIS PRIOR AUTHORIZATION. THEREFORE IT IS NOT NECESSARY TO WAIT THE FULL SIX WEEKS AFTER EXTRACTIONS BEFORE TAKING DENTURE IMPRESSIONS.
P818	SIX-WEEK HEALING TIME IS REQUIRED BETWEEN EDENTULATION AND FINAL IMPRESSIONS. PAYMENT FOR DENTURES WILL BE DENIED OR RECOUPED IF HEALING PERIOD IS NOT OBSERVED.
P849	COLORADO MEDICAID HAS DETERMINED THERE WERE (ARE) SEVERAL HOME HEALTH AGENCIES WILLING TO PROVIDE MEDICALLY NECESSARY SKILLED NURSING SERVICES TO THIS CLIENT.

Denial Code	Long Description
P864	THE DOCUMENTATION YOU HAVE SUBMITTED DOES NOT MEET THE REQUIREMENTS OF COLORADO MEDICAID.
P873	THE MEDICAL NECESSITY FOR THE HOURS REQUESTED IS NOT SUPPORTED BY THE INFORMATION SUBMITTED.
P874	THE DOCUMENTATION SUBMITTED INDICATES THE TASKS SPECIFIED CAN BE COMPLETED DURING THE VISITS APPROVED.
P878	THE DOCUMENTATION SUBMITTED DOES NOT INDICATE THAT MEDICALLY ORIENTED TASKS ARE MEDICALLY NECESSARY; THEREFORE PERSONAL CARE SERVICES HAVE BEEN APPROVED.
P880	THE QUANTITY OF SERVICES AUTHORIZED FOR THIS CLIENTS PERSONAL CARE HAS BEEN AMENDED BASED ON INFORMATION RECEIVED FROM ONE OR MORE OF THESE SOURCES: THE CLIENT, THEIR PHYSICIAN, AND/OR THE IN-HOME VISIT BY STAFF OF THE OIG (OFFICE OF INSPECTOR GENERAL).
P885	THE USE OF THIS DRUG FOR THE INTENDED PURPOSE IS NOT COVERED BY COLORADO MEDICAID, CONSISTENT WITH COLORADO ADMINISTRATIVE CODE AND FEDERAL LAW.
P924	THE MEDICAL RECORDS SUBMITTED WITH THE CURRENT REQUEST CONFLICT OR DISAGREE WITH OUR MEDICAL RECORDS ON THIS CLIENT.
P950	INDEPENDENT NURSES, PLEASE NOTE PAYABLE SERVICES MAY NOT EXCEED 12 HOURS/DAY OR 60 HOURS/WEEK.
P951	SERVICES CAN ONLY BE AUTHORIZED THROUGH ONE YEAR FROM THE PRESCRIPTION DATE.
P952	LEAD INSPECTION IS A COVERED COLORADO MEDICAID SERVICE WHEN THE CHILD HAS BEEN SHOWN TO HAVE LEAD POISONING (E.G., CHILD HAS A BLOOD LEAD LEVEL > 19 UG/DL OR TWO CONSECUTIVE BLOOD LEAD LEVELS OF 15-19 UG/DL DONE AT LEAST 90 DAYS APART). THE INSPECTION MUS
P953	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P954	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P956	THE REQUEST CAN ONLY BE BACKDATED A MAXIMUM OF 14 DAYS FROM FIRST DATE RECEIVED BY COLORADO MEDICAID.
P957	COMPLETE PERIODONTAL CHARTING AT TIME OF SERVICE, AND SUBMIT CHARTING, COPY OF OPERATIVE REPORT, TOGETHER WITH A COPY OF THE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF), F-11035, TO PA UNIT ATTENTION DENTAL CONTSULTANT.
P958	NOTE THAT CODE D4341 HAS BEEN CHANGED. REFER TO THE DECISION NOTICE FOR AUTHORIZED QUANTITY.
P960	YOUR PA HAS BEEN APPROVED FOR 90 DAYS. THE 90 DAY APPROVAL DOES NOT IMPLY THE PA REQUEST MEETS PRIOR AUTHORIZATION CRITERIA. AFTER ADDITIONAL INFORMATION IS AVAILABLE IN INTERCHANGE, COLORADO MEDICAID WILL CREATE AN AMENDMENT REQUEST TO EXTEND THE PA FOR
P961	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P962	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
PA10	THE REQUESTED END DATE IS INVALID.
PA12	PLEASE FURNISH A WRITTEN DESCRIPTION OF THE CLIENTS DIAGNOSIS.
PA13	PROVIDE DIAGNOSES WITH DATES OF ONSET.
PA14	IDENTIFY PROBLEMS TO BE TREATED.
PA15	THE AUDIOLOGISTS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1), F-11020, AND PRIOR AUTHORIZATION REQUEST/HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2), F-11021.
PA16	THE PHYSICIANS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION/PHYSICIAN OTOLOGICAL REPORT (PA/POR), F-11019.
PA17	SUBMIT BRIEF HISTORY WITH REFERRAL INFORMATION, LIVING SITUATION, FUNCTIONAL STATUS, AND OTHER PERTINENT INFORMATION. WHAT CHANGE OF STATUS RESULTED IN REFERRAL AT THIS TIME?
PA18	PLEASE FURNISH THE CLIENTS HEIGHT AND WEIGHT.
PA19	PLEASE SUBMIT CLINICAL INFORMATION SUFFICIENT TO VERIFY THE NEED FOR THE REQUESTED SERVICE(S).

Denial Code	Long Description
PA20	PLEASE RESUBMIT WITH COMPLETE PERIODONTAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PA21	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL EDUCATIONAL PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA22	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL PROGRAM PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA23	REFER TO THE DURABLE MEDICAL EQUIPMENT INDEX FOR APPROPRIATE CODE AND DESCRIPTION. DO NOT USE AN "UNLISTED" CODE.
PA24	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUALIZED FAMILY SERVICE PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA25	INFORMATION ON THE REQUEST FORM IS ILLEGIBLE, AND THE REQUEST CANNOT BE PROCESSED.
PA26	RE-EVALUATE YOUR GOALS. EMPHASIS SHOULD BE ON FUNCTIONAL SELF-CARE. GOALS MUST BE RELATED TO FUNCTIONAL OUTCOME.
PA27	PLEASE CLARIFY THE NUMBER OF HOURS PER WEEK REQUESTED.
PA28	PLEASE CLARIFY THE NUMBER OF HOURS PER DAY REQUESTED.
PA29	PLEASE CLARIFY THE NUMBER OF VISITS PER DAY REQUESTED.
PA30	ATTACH SUPPORTIVE DOCUMENTATION; HOME EXERCISE PROGRAM AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA31	THE DIAGNOSIS CODE INDICATED ON THE REQUEST DOES NOT CORRESPOND TO THE DIAGNOSIS CODE DESCRIPTION.
PA32	PLEASE SUBMIT ADDITIONAL INFORMATION SUFFICIENT TO VERIFY APPROPRIATENESS AND NEED FOR TRANSPLANT.
PA33	PLEASE SUBMIT THE INITIAL AND PROGRESSIVE OBJECTIVE FINDINGS.
PA34	ATTACH SUPPORTIVE DOCUMENTATION, FACILITY PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA35	PLEASE SUBMIT THE CLIENTS ORIGINAL COMPLAINTS AND EXAMINATION FINDINGS.
PA36	ATTACH SUPPORTIVE DOCUMENTATION, IN-HOME AUTISM PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA37	PLEASE SUBMIT YOUR TREATMENT PLAN FOR THIS CLIENT.
PA38	ATTACH SUPPORTIVE DOCUMENTATION AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA39	INITIAL EVALUATIONS MUST BE PERFORMED BY AN OCCUPATIONAL THERAPIST REGISTERED (OTR), PER AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA) STANDARDS.
PA41	IDENTIFY THE PLACE OF SERVICE AND ITS EFFECT ON SUPPORTING THE DESIRED TREATMENT OUTCOME.
PA42	PLEASE INDICATE THE HOURS OF USE OF OXYGEN PER 24-HOUR PERIOD.
PA43	PROVIDE BASELINE DOCUMENTATION FOR THIS CLIENTS LIMITATIONS USING UNITS OF MEASUREMENT THAT ARE APPLIED CONSISTENTLY WHEN REPORTING STATUS.
PA44	IDENTIFY FUNCTIONAL LIMITATIONS AS THEY ARE RELATED TO IDENTIFIED CONDITIONS.
PA46	CORRELATE PLAN OF CARE TO REQUESTED PROCEDURE CODES.
PA47	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE FREQUENCY/DURATION REQUESTED.
PA48	PLEASE PROVIDE THE NAME AND CREDENTIALS OF THE RENDERING PROVIDER.
PA50	COLORADO MEDICAID RECORDS INDICATE THE CLIENT OWNS A WHEELCHAIR. DOCUMENT THE REASON AND NEED FOR REPLACEMENT AND COST TO REPAIR CURRENT WHEELCHAIR.
PA51	PLEASE DISTINGUISH PRIMARY AND SUPPORTIVE MODALITIES.
PA52	PLEASE SUBMIT A PROGRESS REPORT.
PA53	MULTIPLE FAMILY CLIENTS TREATMENT BY THE SAME PROVIDER REQUIRES FURTHER INFORMATION DOCUMENTING COORDINATION OF TREATMENT PLAN.
PA54	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE MINUTES REQUESTED.
PA55	MEDICAL NECESSITY OF TREATMENT REQUIRES ADDITIONAL DOCUMENTATION.
PA56	GIVEN AGE, DIAGNOSES, CURRENT LEVEL OF FUNCTION, PAST RESPONSE TO TREATMENT, AND LIVING SITUATION, EXPAND ON POTENTIAL FOR SIGNIFICANT FUNCTIONAL PROGRESS WITHIN THE NEXT SIX MONTHS. EMPHASIZE WHY PROGRESS IS EXPECTED WITH SERVICES AT THIS TIME.

Denial Code	Long Description
PA57	SUBMIT THE INITIAL FINDINGS. INCLUDE A COMPREHENSIVE EVALUATION.
PA58	SUBMIT PROGRESSIVE, OBJECTIVE FINDINGS. INCLUDE A PERTINENT RE-EVALUATION.
PA59	PLEASE SUPPLY INFORMATION REGARDING THE CLIENTS MEDICATION REQUIREMENTS, IF ANY.
PA60	PLEASE SPECIFY IF THE CLIENT IS IN AN EDUCATIONAL SETTING.
PA61	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA62	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
PA63	THE SKILLS OF A THERAPIST ARE PURPOSEFUL AND SKILLED INTERVENTIONS REQUIRED TO CONTINUALLY DESIGN, IMPLEMENT, REASSESS, MODIFY/GRADE, AND/OR DISCONTINUE A PLAN OF CARE IN A TIMELY MANNER, BASED ON THE COMPLEXITY OF THE CLIENTS MEDICAL CONDITION AND/OR CO
PA64	PLEASE SUBMIT A THERAPY PLAN OF CARE, INCLUDING A CURRENT, DATED EVALUATION.
PA65	A PLAN OF CARE SIGNED AND DATED BY THE PHYSICIAN IS REQUIRED.
PA66	THE SKILLS OF A THERAPIST ARE REQUIRED WHEN ONLY THE THERAPIST CAN SAFELY AND EFFECTIVELY DELIVER THE THERAPEUTIC PROCEDURES BECAUSE OF THEIR UNIQUE KNOWLEDGE, TRAINING, AND EXPERTISE. DESCRIBE THE REASON THAT SOMEONE OTHER THAN A THERAPIST CANNOT SAFELY
PA67	PLEASE SPECIFY IF THE CLIENTS WORK SITE DEMANDS GOOD BINAURAL HEARING.
PA68	DESCRIBE THE REASON, BASED ON THE CLIENTS COGNITIVE, PHYSICAL, COMMUNICATION, OR RESOURCE STATUS, THAT A HOME PROGRAM, EQUIPMENT, OR ENVIRONMENTAL ADAPTATIONS ALONE CANNOT MEET CLIENTS NEEDS.
PA69	PLEASE SPECIFY IF THE CLIENT HAS AN ACCOMPANYING DISABILITY THAT ADDS TO THE HEARING PROBLEM.
PA70	DISTINGUISH REQUESTED PROCEDURES AND GOALS FROM OTHER SERVICES THIS CLIENT RECEIVES. THEY MAY NOT BE DUPLICATIVE.
PA71	PLEASE INDICATE THE NUMBER OF DAYS REQUESTED.
PA73	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA74	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA75	PLEASE DOCUMENT CARRYOVER OF THE THERAPY PROGRAM TO NURSING.
PA76	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA79	PROVIDE EVIDENCE OF SIGNIFICANT FUNCTIONAL PROGRESS IN LAST SIX MONTHS.
PA84	THE GRANT DATE OF THIS REQUEST CANNOT BE PRIOR TO THE SIGNATURE DATE OF THE PRESCRIBING PHYSICIAN.
PA86	PROVIDE EVIDENCE OF SKILLS GAINED IN THERAPY CARRYING OVER TO OTHER SETTINGS WITHIN SIX MONTHS.
PA87	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE NUMBER OF SESSIONS REQUESTED.
PA88	THE REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL SCOPE OF PRACTICE.
PA89	PRIOR AUTHORIZATION IS NOT REQUIRED UNTIL LIMITATION OF SERVICE HAS BEEN REACHED.
PA91	PLEASE SUBMIT REQUIRED X-RAYS.
PA92	PLEASE PROVIDE AN EXPLANATION FOR THE MATERIAL SUBMITTED WITH THE REQUEST.
PA95	PLEASE DESCRIBE HOW THE PROVISION OF THIS SERVICE WOULD PREVENT INSTITUTIONALIZATION OF THE CLIENT.
PA96	COULD THE EXISTING DENTURE(S) BE RELINED OR REBASED? IF NOT, PLEASE EXPLAIN WHY NOT.
PA97	REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL STANDARDS OF PRACTICE.
PA98	PLEASE INDICATE IF THE CLIENT IS CURRENTLY BEING TUBE FED.
PB02	PLEASE PROVIDE THE REQUIRED DATED SIGNATURES ON THE ATTACHMENTS.
PB03	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING THE LOSS/DESTRUCTION/THEFT OF THE HEARING AID.
PB04	DESCRIBE THE CLIENTS ABILITY TO STAND OR AMBULATE SUFFICIENTLY TO ACCOMPLISH SELF-CARE ACTIVITIES.
PB07	PLEASE SUBMIT AN ORTHODONTIC STUDY MODEL OR DIAGNOSTIC CASTS.
PB09	PLEASE PROVIDE A PHOTOGRAPH OF THE INVOLVED AREA(S).

Denial Code	Long Description
PB10	PLEASE PROVIDE AN ESTIMATION (IN GRAMS) OF THE TOTAL AMOUNT OF TISSUE TO BE RESECTED.
PB11	PLEASE SUBMIT THE PLAN OF CARE FOR CO-TREATMENT.
PB12	FURNISH A DETAILED DESCRIPTION FOR THE PROCEDURE CODE REQUESTED.
PB13	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB15	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB18	PLEASE COMPLETE THE ATTACHED OUT-OF-STATE PROVIDER DATA SHEET, F-11001, AND RESUBMIT.
PB20	A SIGNED AND DATED PRESCRIPTION IS REQUIRED WITHIN THREE MONTHS OF RECEIPT BY COLORADO MEDICAID FOR INITIAL REQUESTS AND WITHIN 12 MONTHS OF RECEIPT BY COLORADO MEDICAID FOR SUBSEQUENT REQUESTS.
PB21	PLEASE COMPLETE THE APPROPRIATE PRIOR AUTHORIZATION ATTACHMENT. CONTACT PROVIDER SERVICES OR THE PRIOR AUTHORIZATION UNIT FOR ASSISTANCE.
PB23	PHYSICAL THERAPY ASSISTANT NOTES AND ALL FORMS SUBMITTED MUST BE COSIGNED BY A REGISTERED PHYSICAL THERAPIST.
PB31	ARE YOU REQUESTING A COMPLETE APPLIANCE, OR REPLACEMENT PARTS?
PB32	THE PROCEDURE CODE INDICATED ON THE REQUEST DOES NOT MATCH THE DESCRIPTION OF SERVICE; PLEASE CORRECT AND RESUBMIT.
PB35	THE SERVICE REQUESTED DOES NOT REQUIRE PRIOR AUTHORIZATION.
PB41	PLEASE FURNISH A CURRENT MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT, F-11090 (DATED WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID).
PB45	THE CERTIFICATION PERIOD ON THE PLAN OF CARE (POC) DOES NOT COVER THE REQUESTED GRANT/START DATE. PLEASE RESUBMIT YOUR REQUEST WITH A NEW POC.
PB49	A CERTIFIED OCCUPATIONAL THERAPY ASSISTANTS NOTES MUST BE COSIGNED BY AN OCCUPATIONAL THERAPIST REGISTERED.
PB51	ADDITIONAL INFORMATION IS REQUIRED ON PRIOR AUTHORIZATION TO ENABLE PRICING.
PB54	REQUESTED SERVICES DO NOT MATCH SERVICES ON THE PHYSICIANS ORDERS.
PB59	PLEASE PROVIDE AN INDIVIDUAL EDUCATIONAL PLAN (IEP), WHICH HAS BEEN SIGNED BY THE PROVIDER NO EARLIER THAN NINE MONTHS PRIOR TO RECEIPT AT COLORADO MEDICAID; OTHERWISE, DOCUMENT WHY NO IEP EXISTS.
PB65	PLEASE FURNISH THE ANTICIPATED TOTAL CHARGES FOR THIS REQUEST.
PB66	A PHOTOCOPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED; THE DATE MUST BE WITHIN SIX MONTHS OF RECEIPT BY COLORADO MEDICAID.
PB67	THE PRESCRIPTION DATE MUST INCLUDE MONTH, DAY, AND YEAR.
PB68	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID.
PB73	THE SERVICES IDENTIFIED ON THE PLAN OF CARE DO NOT APPEAR APPROPRIATE FOR THE PROCEDURE CODE(S) REQUESTED ON THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018.
PB74	THE CLIENT/PROVIDER DOES NOT HAVE RETROACTIVE ENROLLMENT.
PB75	THE REQUESTED START DATE IS MORE THAN 14 DAYS BEFORE OR 62 DAYS AFTER RECEIPT.
PB82	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
PB83	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A HOME HEALTH AIDE. PLEASE RESUBMIT AS A PERSONAL CARE WORKER OR PROVIDE ADDITIONAL DOCUMENTATION.
PB86	THE SERVICES REQUESTED ARE NOT BEING PROVIDED IN THE CLIENTS RESIDENCE. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL.
PB87	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A NURSE. PLEASE RESUBMIT AS A HOME HEALTH AIDE OR PROVIDE ADDITIONAL DOCUMENTATION.
PB92	PLEASE FURNISH THE CLIENTS COMPLETE ADDRESS.
PB94	IF THE CLIENT IS A RESIDENT OF A NURSING HOME, SUPPLY THE COMPLETE NAME AND ADDRESS OF THE NURSING HOME.
PB99	THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018, MUST BE SIGNED AND DATED.
PC01	PLEASE SUPPLY THE RENDERING PROVIDERS PROVIDER NUMBER.
PC03	THE DRUG ENFORCEMENT ADMINISTRATION NUMBER IS MISSING OR INVALID.
PC06	PLEASE DESCRIBE YOUR PROGRAM; INCLUDE ENTRY DATE, TERMINATION DATE, HOURS PER WEEK, AND NUMBER OF WEEKS OF PRIMARY INTENSIVE SERVICE REQUESTED.

Denial Code	Long Description
PC07	PLEASE DESCRIBE YOUR "AFTERCARE/FOLLOW-UP" PLANS FOR THIS CLIENT.
PC08	PLEASE SUPPLY DOCUMENTATION OF PREVIOUS SUBSTANCE ABUSE SERVICES WITH DATE(S) AND OUTCOME.
PC09	PLEASE DESCRIBE IN DETAIL THE TREATMENT OBJECTIVES/GOALS FOR THIS CLIENT.
PC10	PLEASE DESCRIBE THE FAMILY SITUATION/DYNAMICS. EXPLAIN HOW THE FAMILY WILL BE INCORPORATED INTO THE CLIENTS PLAN OF CARE.
PC12	PLEASE EXPLAIN IF YOUR SERVICE ENCOURAGES THE CLIENT TO ATTEND SELF-HELP GROUPS.
PC13	PLEASE SUPPLY A SPECIFIC SCHEDULE OF ACTIVITIES, INCLUDING DAY, TIME OF DAY, LENGTH OF SESSION, AND SERVICE TO BE RENDERED DURING THAT TIME.
PC15	PLEASE FURNISH DIAGNOSTIC RATIONALE.
PC17	PLEASE DOCUMENT IF THE CLIENT EVER RECEIVED SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT.
PC19	PLEASE FURNISH MORE EXTENSIVE AND IN-DEPTH HISTORICAL AND PSYCHOSOCIAL DATA.
PC20	PLEASE SUPPLY THE DATE THE CLIENT BECAME TOTALLY ENDENTULOUS.
PC23	PLEASE SUBMIT A PHYSICIANS STATEMENT REGARDING THE MEDICAL NECESSITY OF DENTURES FOR THIS CLIENT. THE PHYSICIANS STATEMENT MUST DOCUMENT THE MEDICAL NEED FOR DENTURES.
PC24	THE SERVICE REQUESTED WAS PREVIOUSLY AUTHORIZED. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT INDICATING THIS FACT IS REQUIRED.
PC25	PLEASE SUPPLY SUFFICIENT MITIGATING CIRCUMSTANCES TO WARRANT THE CONSTRUCTION OF NEW DENTURES(S).
PC26	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
PC28	PLEASE SUBMIT A PHYSICIANS STATEMENT INDICATING DENTURES ARE NECESSARY FOR THIS NURSING HOME CLIENT.
PC29	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING LOSS OR DESTRUCTION OF DENTURE(S). INCLUDE SIGNED STATEMENT FROM CLIENT OR FACILITY DIRECTOR REGARDING HOW, WHEN AND WHERE LOST.
PC30	PLEASE PROVIDE COMPLETE INTRAORAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PC31	PLEASE DESCRIBE ANY RELATED DEFORMITIES OF THE FEET.
PC34	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD WITH REQUESTED DME ITEM(S) AND DOCUMENT IF THE CLIENT CAN USE SAFELY AND INDEPENDENTLY.
PC35	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD AND DESCRIBE THE RESULTS AND EFFECTIVENESS OF THE SERVICE REQUESTED.
PC39	PLEASE INDICATE LITER FLOW PER MINUTE, HOURS OF USE PER 24 HOUR PERIOD, AND THE EXPECTED DURATION OF NEED.
PC40	THE ITEM DOES NOT REQUIRE PRIOR AUTHORIZATION UNTIL THE LIFE EXPECTANCY HAS BEEN REACHED.
PC41	PLEASE SUPPLY INFORMATION INDICATING THE NECESSITY OF POSITIONING THE CLIENT'S BODY IN MULTIPLE POSITIONS.
PC42	PLEASE INDICATE IF THE BED HEIGHT MUST BE CHANGED TO ALLOW FOR SAFE TRANSFER OR ADEQUATE BED CARE.
PC43	SUPPLY A PHYSICIANS STATEMENT INDICATING TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR UNIT HAS REDUCED PAIN, IMPROVED/INCREASED THE CLIENTS ACTIVITY LEVEL, AND/OR REDUCED CLIENTS USE OF PAIN MEDICATION.
PC44	A CURRENT AUTHORIZATION FOR THIS SERVICE IS ON FILE FOR ANOTHER PROVIDER. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT OF THAT FACT IS REQUIRED BY THE CLIENT OF FIRST PROVIDER.
PC59	DOCUMENT DECLINE OR PROGRESS IN SPECIFIC, MEASURABLE, OBJECTIVE TERMS.
PC60	DOCUMENT IF CLIENT HAS DEMONSTRATED A GOOD APPOINTMENT COMPLIANCE RECORD.
PC61	THE PHYSICIANS SIGNATURE DATE MUST NOT EXCEED 90 DAYS FROM THE DATE OF RECEIPT BY COLORADO MEDICAID.
PC62	REQUESTS FOR A CONTINUATION OF THERAPY SHOULD NOT BE SUBMITTED MORE THAN FOUR WEEKS PRIOR TO THE EXPIRATION DATE OF THE CURRENT AUTHORIZATION.
PC63	PLEASE FURNISH THE STYLE AND MANUFACTURER OF THE FRAME.
PC64	PLEASE FURNISH THE CLIENTS LENS FORMULA.
PC66	ALL REQUESTS FOR TINTS REQUIRE DOCUMENTATION OF THE VISUAL OR MEDICAL CONDITION RELATED TO PHOTOPHOBIA.

Denial Code	Long Description
PC67	PLEASE DOCUMENT THE REASON AND JUSTIFICATION FOR REPLACEMENT BEYOND THE FIRST LENS/FRAME.
PC68	DOCUMENT IF ALL REMAINING MAXILLARY AND/OR MANDIBULAR TEETH ARE DECAY-FREE, PROPERLY RESTORED, AND PERIODONTICALLY SOUND.
PC72	SUPPLY MORE DETAIL REGARDING PROGRESS (ATTACHMENT OF GOALS, ETC.). CORRELATE PROGRESS TO PREVIOUS GOALS AND IDENTIFIED LIMITATIONS.
PC77	PLEASE SUBMIT A PLAN OF CARE DESCRIBING THE SERVICES THAT WOULD BE PROVIDED.
PC78	PLEASE DOCUMENT SPECIFIC, MEASURABLE GOALS.
PC82	THE PRIOR AUTHORIZATION (PA) SYSTEM CAN PROCESS ONLY 26 DETAILS PER PA REQUEST. PLEASE RESUBMIT YOUR REQUEST WITH NO MORE THAN 26 DETAILS.
PC83	PLEASE SUPPLY A PHYSICIANS PRESCRIPTION DATED WITHIN ONE MONTH OF REQUESTED SUBSTANCE ABUSE DAY TREATMENT.
PC84	PLEASE PROVIDE INFORMATION INDICATING THIS CLIENT IS APPROPRIATELY DETOXIFIED FROM ALCOHOL AND/OR OTHER DRUGS.
PC85	PLEASE PROVIDE INFORMATION TO INDICATE THE CLIENTS ABILITY TO ABSTAIN FROM ALCOHOL OR DRUGS WHILE IN THE SUBSTANCE ABUSE DAY TREATMENT PROGRAM.
PC86	PLEASE INDICATE IF THIS CLIENT IS WILLING TO PARTICIPATE IN AFTERCARE OR CONTINUING CARE SERVICES.
PC87	PROVIDE MORE INFORMATION ON TREATMENT HISTORY; INCLUDE SERVICE PROVIDED, DATES, AND OUTCOME. PROVIDE DETAIL OF PREVIOUS TREATMENT.
PC88	PLEASE PROVIDE MORE RATIONALE FOR THE APPROPRIATENESS AND MEDICAL NECESSITY OF SUBSTANCE ABUSE DAY TREATMENT.
PC89	PROVIDE A TREATMENT PLAN THAT CONTAINS MEASURABLE GOALS AND OBJECTIVES CORRESPONDING TO THE IDENTIFIED DEFICIT.
PC91	PLEASE PROVIDE MORE INFORMATION ON FAMILY INVOLVEMENT TREATMENT.
PC92	PLEASE PROVIDE MORE HISTORY AND EXPLANATION ABOUT THE ISSUE OF ABSTINENCE FOR THIS CLIENT.
PC94	PLEASE PROVIDE THE ANTICIPATED BEGINNING DATE AND/OR THE ESTIMATED SUBSTANCE ABUSE DAY TREATMENT DISCHARGE DATE.
PC95	PLEASE SUPPLY JUSTIFICATION FOR BEGINNING CLIENT IN SERVICE PRIOR TO AUTHORIZATION BEING OBTAINED.
PC96	THE INITIAL THREE HOURS OF SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IN A CALENDAR YEAR DO NOT REQUIRE PRIOR AUTHORIZATION.
PC97	REIMBURSEMENT FOR INITIAL SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IS LIMITED TO THREE HOURS IN A CALENDAR YEAR AND DOES NOT REQUIRE PRIOR AUTHORIZATION.
PC98	THIS DRUG IS CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE BILL USING THE APPROPRIATE NATIONAL DRUG CODE (NDC) OR SUBMIT A COMPLETED DRUG ADDITION REQUEST FORM IF THE NDC IS NOT LISTED IN THE DRUG INDEX.
PC99	THIS DRUG IS NOT CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL, CURRENT ADMINISTRATIVE RULE, OR COLORADO DRUG INDEX FOR COVERAGE LIMITATIONS.
PD01	DOCUMENT THAT CLIENT HAS ACHIEVED GOOD ORAL HYGIENE, PERIODONTAL CASE TYPE 1 OR 2, AND IS MOTIVATED TO MAINTAIN SAME.
PD03	PLEASE PROVIDE AN ARTERIAL BLOOD GAS READING OR PULSE OXIMETRY RESULTS DONE ON ROOM AIR SIGNED AND DATED BY A MEDICAL DOCTOR. THIS SHOULD BE DONE WITHIN 60 DAYS OF REQUESTED SERVICE.
PD04	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 30 DAYS OF RECEIPT BY COLORADO MEDICAID.
PD07	SUBMIT A PHOTOCOPY OF A VALID PRESCRIPTION, ISSUED WITHIN THE PAST YEAR, OR COMPLETE SECTION B OF THE PRIOR AUTHORIZATION/DRUG ATTACHMENT (PA/DGA), F-11049.
PD10	BRAND MEDICALLY NECESSARY MUST BE IN THE PRESCRIBERS OWN HANDWRITING AND WRITTEN DIRECTLY ON THE PRESCRIPTION OR A SEPARATE ORDER ATTACHED TO THE ORIGINAL PRESCRIPTION.
PD12	COMPLETE DENTURES, PARTIAL DENTURES, DENTURE RELINES, AND FIXED PROSTHODONTIC SERVICES ARE NOT COVERED SERVICES FOR ADULTS FOR DATES OF SERVICE ON AND AFTER OCTOBER 1, 1995.
PD22	PLEASE COMPLETE ALL REQUIRED ELEMENTS ON THE PERSONAL CARE SCREENING TOOL (PCST), F-11133.

Denial Code	Long Description
PD24	THIS PRIOR AUTHORIZATION REQUEST IS UNABLE TO BE PROCESSED. PLEASE RESUBMIT WITH ADDITIONAL REQUIRED FORMS, INCLUDING THE ENTIRE PERSONAL CARE SCREENING TOOL (PCST), F-11133; PERSONAL CARE ADDENDUM, F-11136; AND SUPPORTING DOCUMENTATION, AS DIRECTED.
PD25	THERE IS A PERSONAL CARE SCREENING TOOL (PCST), F-11133, COMPLETED BY ANOTHER AGENCY. CONTACT THE AGENCY TO TRANSFER SCREEN.
PD26	THERE IS A LIMITED TERM CARE FUNCTIONAL SCREEN (LTC-FS) COMPLETED BY ANOTHER AGENCY. THE PERSONAL CARE SCREENING TOOL (PCST), F-11133, INFORMATION IS IN CONFLICT WITH LTC-FS.
PD27	ONLY ONE LEVEL OF FUNCTION MAY BE SELECTED FOR ALL ELEMENTS EXCEPT TOILETING. COLORADO MEDICAID IS UNABLE TO PROCESS THE PRIOR AUTHORIZATION REQUEST.
PD28	NO UNITS MAY BE REQUESTED USING THIS PRIOR AUTHORIZATION PROCESS. PLEASE SUBMIT WITH THE APPROPRIATE ATTACHMENTS FOR REQUESTING SPECIFIC PERSONAL CARE WORKER UNITS.
PD29	CLIENT IS NOT ELIGIBLE FOR THE REQUESTED SERVICE(S) AS OF THE REQUESTED START DATE.
PD30	NO TRAVEL TIME MAY BE AUTHORIZED WHEN NO PERSONAL CARE WORKER SERVICE IS AUTHORIZED.
PD32	PROVIDER NOT CERTIFIED TO RENDER THE SERVICE(S) REQUESTED.
PD34	BASED ON THE DOCUMENTATION SUBMITTED, THIS REQUEST CAN NOT BE PRIOR AUTHORIZED. REFER TO THE PA MESSAGES FROM THE CONSULTANT FOR COMPLETE EXPLANATION.
PD98	PLEASE DOCUMENT HOW AND WHEN EACH PREVIOUSLY AUTHORIZED PRO RE NATA VISIT WAS USED.

Transplants

Denial Code	Long Description
0201	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
0233	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0235	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0237	CLIENT IDENTIFICATION NUMBER DOES NOT MATCH CLIENTS FIRST NAME.
0238	THE CLIENT IDENTIFICATION NUMBER DOES NOT MATCH THE CLIENTS LAST NAME.
0242	SECONDARY DIAGNOSIS CODE IS INVALID.
0248	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0249	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0258	THE PRIMARY DIAGNOSIS CODE IS REQUIRED.
0272	THE PRIMARY DIAGNSOSIS CODE IS INVALID.
0339	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0340	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0363	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0400	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0853	HCPCS - ANNUAL UPDATE
0885	NEVER EVENTS MODIFIERS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
0886	NEVER EVENTS DIAGNOSIS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
1000	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
1002	RENDERING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1003	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1007	RENDERING PROVIDER ID IS NOT ON FILE.
1048	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1801	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
1806	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
1900	THE BILLING PROVIDERS TAXONOMY CODE IS INVALID.
1901	THE RENDERING PROVIDERS TAXONOMY CODE IS INVALID.

Denial Code	Long Description
1927	A NATIONAL PROVIDER IDENTIFIER IS REQUIRED FOR THE BILLING PROVIDER.
1934	A NATIONAL PROVIDER INDENTIFIER IS REQUIRED FOR THE RENDERING PROVIDER.
1936	THE BILLING PROVIDER NUMBER IS INVALID.
1960	INTERNAL PROCESSING IS REQUIRED.
1964	THE BILLING PROVIDER INDICATED IS NOT ALLOWABLE AS A BILLING PROVIDER.
1965	RENDERING PROVIDER NUMBER IS MISSING/INVALID FOR THIS PROCEDURE PROVIDER.
1974	PRESCRIBING/REFERRING/ORDERING PROVIDER INDICATED IS NOT CERTIFIED AS A PRESCRIBING/REFERRING/ORDERING PROVIDER.
1975	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
1976	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
2001	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2003	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2017	THE CLIENT IS ENROLLED IN A MEDICAID OR OTHER MANAGED CARE PROGRAM.
2037	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2603	CLIENT LOCKED-IN TO A PROVIDER OR ENROLLED IN A HOSPICE. CONTACT CLIENTS HOSPICE FOR PAYMENT OF SERVICES OR RESUBMIT WITH DOCUMENTATION OF UNRELATED NATURE OF CARE.
4027	THE DIAGNOSIS CODE IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
4031	THE PROCEDURE SUBMITTED IS NOT APPROPRIATE FOR CLIENTS GENDER.
4040	THE PRIMARY DIAGNOSIS CODE IS NOT ON FILE.
4041	THE SECONDARY DIAGNOSIS IS NOT ON FILE.
4046	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4053	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4067	THE SERVICE IS NOT A BENEFIT ON THE REQUESTED START DATE OR DATE OF RECEIPT.
4127	INTERNAL PROCESSING IS REQUIRED.
4131	INTERNAL PROCESSING IS REQUIRED.
4151	THE PROVIDER IS NOT AUTHORIZED TO PERFORM THE PROCEDURE.
4227	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4236	ETIOLOGY DIAGNOSIS CODE(S) (E-CODES) ARE INVALID AS THE PRIMARY DIAGNOSIS.
4244	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4321	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4322	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4374	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4711	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR CLIENTS AGE.
4733	DIAGNOSIS AND/OR PROCEDURE AND/OR PLACE OF SERVICE (POS) CODE IS NOT COVERED FOR EXPRESS ENROLLMENT CLIENTS.
4765	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4802	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
4804	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4874	PLEASE REFER TO PA MESSAGES FOR RETURN INFORMATION.
4944	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS GENDER.
4975	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
7500	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
P001	THE BILLING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THE SERVICES.
P002	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P003	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P005	THE PRIOR AUTHORIZATION CAN NOT BE END DATED. THE PRIOR AUTHORIZATION STATUS IS NOT APPROVED OR APPROVED WITH REVISIONS.
P006	PLEASE FURNISH THE PROCEDURE CODE AND CORRESPONDING DESCRIPTION.
P008	THE BILLING PROVIDER NUMBER IS INVALID.

Denial Code	Long Description
P009	THE BILLING PROVIDER NUMBER IS INVALID.
P010	THE REQUESTED END DATE IS INVALID.
P011	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P012	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P013	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P014	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P015	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P016	THE REQUESTED START DATE IS MISSING OR INVALID.
P019	THE REQUESTED START DATE IS MISSING OR INVALID.
P020	THE RENDERING PROVIDER NUMBER IS INVALID.
P021	THE RENDERING PROVIDER NUMBER IS INVALID.
P022	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P023	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P024	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P026	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P027	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P030	FIRST MODIFIER IS INVALID.
P031	FIRST MODIFIER IS INVALID.
P032	SECOND MODIFIER IS INVALID.
P033	SECOND MODIFIER IS INVALID.
P034	THIRD MODIFIER IS INVALID.
P035	THIRD MODIFIER IS INVALID.
P036	FOURTH MODIFIER IS INVALID.
P037	FOURTH MODIFIER IS INVALID.
P038	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P039	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P040	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P041	CLIENTS FIRST NAME IS MISSING.
P042	CLIENTS LAST NAME IS MISSING.
P043	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P044	BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES REQUESTED.
P045	FIRST MODIFIER IS INVALID.
P046	SECOND MODIFIER IS INVALID.
P047	THIRD MODIFIER IS INVALID.
P048	FOURTH MODIFIER IS INVALID.
P052	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P053	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P054	RENDERING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES FOR THE BENEFIT PLAN.
P055	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P058	PLEASE FURNISH THE INTERNATIONAL CLASSIFICATION OF DIAGNOSIS, NINTH REVISION, CLINICIAL MODIFICATION SURGICAL PROCEDURE CODE AND CORRESPONDING DESCRIPTION.
P061	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P062	THE CLIENT ID AND/OR NAME INDICATED ON THE PA REQUEST IS INCORRECT. THE CLIENT ID AND/OR NAME HAS BEEN UPDATED. PLEASE VERIFY THE ID AND/OR NAME IS CORRECT.
P064	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.

Denial Code	Long Description
P067	THE FREQUENCY OF HOURS REQUESTED ARE NOT APPROPRIATE FOR THIS CLIENT AND HAVE BEEN MODIFIED ACCORDINGLY.
P079	BILLING PROVIDER IS ON PAYMENT SUSPENSION DUE TO CREDIBLE ALLEGATION OF FRAUD.
P120	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAS BEEN REDUCED.
P121	THE SERVICE/ PROCEDURE REQUESTED IS NOT SUPPORTED BY SUBMITTED DOCUMENTATION.
P126	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
P128	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.
P138	SERVICE(S) DO NOT MEET COLORADO MEDICAID GUIDELINES.
P167	REQUESTED DOCUMENTATION HAS NOT BEEN SUBMITTED.
P178	THE SERVICE REQUESTED IS NOT MEDICALLY NECESSARY.
P179	THE MEDICAL NECESSITY FOR THIS SERVICE IS NOT SUPPORTED BY THE SUBMITTED DOCUMENTATION.
P233	THE DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE ADDITIONAL CARE.
P257	THIS CLIENTS FUNCTIONAL ASSESSMENT SCORES PLACE THIS CLIENT OUTSIDE ELIGIBILITY FOR DAY TREATMENT.
P274	OUR RECORDS INDICATE THIS CLIENT IS INVOLVED IN EFFECTIVE AND APPROPRIATE SERVICE ELSEWHERE.
P292	INTENSIVE REHABILITATION HOURS ARE NO LONGER APPROPRIATE AS INDICATED BY HISTORY, DIAGNOSIS, AND/ OR FUNCTIONAL ASSESSMENT SCORES.
P328	THE SERVICES REQUESTED INCLUDE NON-COVERED SERVICES, AND HOURS ARE REDUCED ACCORDINGLY.
P339	THE CLIENTS PAST HISTORY INDICATES REDUCED TREATMENT HOURS ARE WARRANTED.
P342	THE REQUEST DOES NOT MEET GENERALLY ACCEPTED CONDITIONS REQUIRING FLUORIDE TREATMENTS.
P346	SERVICES EXCEED COLORADO MEDICAID LIMITATION AND DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE MEDICAL NECESSITY OF THE SERVICE.
P349	THE SERVICE REQUESTED WAS PERFORMED LESS THAN FIVE YEARS AGO.
P353	THE EXISTING APPLIANCE HAS NOT BEEN WORN FOR THREE YEARS.
P367	THE CLIENT HAS BEEN TOTALLY WITHOUT TEETH AND AN APPLIANCE FOR FIVE YEARS.
P392	THE CLIENT IS MISSING AN ANTERIOR TOOTH AND/OR HAS TWO OR MORE POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P405	THE SERVICE(S) REQUESTED COULD ADEQUATELY BE PERFORMED IN THE DENTAL OFFICE.
P406	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE OF GOOD PERIODONTAL HEALTH (AMERICAN ACADEMY OF PERIODONTOLOGY PERIODONTAL CLASSIFICATION OF TYPE I OR II).
P407	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE VISIBLE ON RADIOGRAPHS THAT AT LEAST 50 PERCENT OF THE CLINICAL CROWN IS INTACT.
P409	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING SIX OR MORE TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED, INCLUDING THIRD MOLARS.
P410	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING ONE OR MORE ANTERIOR TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED.
P411	DOCUMENTATION DOES NOT SUPPORT THE NEED FOR PERIODONTIC SERVICES. POCKETS ARE LESS THAN 4MM AND/OR GREATER THAN 6MM FOR CLIENT AND/OR THE CLIENT IS UNDER THE AGE OF 13.
P412	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA.
P413	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA. THIS PA HAS BEEN GRANTED AS APPROVED NOT APPROVED WITH REVISIONS. THE DURATION REQUESTED MAY HAVE BEEN REDUCED TO REFLECT COVERAGE LIMITATIONS, PRESCRIBER ORDERS, CONFLICTI
P417	THE SERVICE(S) REQUESTED COULD BE ADEQUATELY PERFORMED WITH LOCAL ANESTHESIA.
P437	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO POOR ORAL HYGIENE.
P444	THIS LINE ITEM IS A DUPLICATE OF ANOTHER LINE ITEM ON THIS PRIOR AUTHORIZATION (PA) REQUEST. PLEASE CORRECT.
P446	THIS IS A DUPLICATE OF AN EXISTING PRIOR AUTHORIZATION (PA) REQUEST. YOU MAY CONTACT PROVIDER SERVICES IF YOU REQUIRE ASSISTANCE. DUPLICATE PA REQUEST
P448	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO DECAY HISTORY.
P449	QUESTIONABLE LONG TERM PROGNOSIS DUE TO GUM AND BONE DISEASE.
P456	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO APPARENT ROOT INFECTION.

Denial Code	Long Description
P457	OUR RECORDS INDICATE THIS CLIENT HAS EXCEEDED ESTABLISHED PROGRAM LIMITATIONS. COLORADO MEDICAID WILL NOT AUTHORIZE NEW DENTURES.
P458	DOCUMENTATION PROVIDED INDICATES A LESS ELABORATE PROCEDURE SHOULD BE CONSIDERED.
P502	RENTAL ONLY ALLOWED; MEDICAL NEED FOR PURCHASE HAS NOT BEEN DOCUMENTED.
P503	PURCHASE ONLY ALLOWED; MEDICAL NEED FOR RENTAL HAS NOT BEEN DOCUMENTED.
P504	OCCUPATIONAL THERAPY GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P505	THE SERVICE REQUESTED IS INCLUDED IN THE NURSING HOME RATE STRUCTURE.
P511	THIS NATIONAL DRUG CODE IS ONLY BILLABLE AS PART OF A COMPOUND DRUG.
P515	THE PRESENCE OF A HANDICAPPING MALOCCLUSION OR HANDICAPPING DENTOFACIAL DEFORMITY IS NOT SUPPORTED BY THE DOCUMENTATION SUBMITTED.
P521	THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVERED BY COLORADO MEDICAID.
P522	GASTRO-INTESTINAL SURGERY FOR THE PURPOSE OF WEIGHT CONTROL IS COVERED ONLY AS A LIFE THREATENING PROCEDURE.
P523	THE TREATMENT REQUEST IS NOT CONSISTENT WITH THE CLIENT'S DIAGNOSIS.
P524	PSYCHOTHERAPY PROVIDED IN THE CLIENTS HOME IS NOT A COVERED BENEFIT OF COLORADO MEDICAID.
P525	THE INFORMATION PROVIDED IS NOT CONSISTENT WITH THE INTENSITY OF SERVICES REQUESTED.
P526	INTENSIVE MULTIPLE MODALITY TREATMENT IS NOT CONSISTENT WITH THE INFORMATION PROVIDED.
P527	MULTIPLE PROVIDERS OF TREATMENT ARE NOT INDICATED FOR THIS CLIENT.
P528	THE DURATION OF TREATMENT SESSIONS EXCEED CURRENT COLORADO MEDICAID GUIDELINES.
P534	DOCUMENTATION OF POOR PHYSICAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P535	OTHER PHYSICAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P536	THE PHYSICAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P537	USE OF PHYSICAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P538	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF A PHYSICAL THERAPIST.
P539	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS AND LIVING ARRANGEMENT.
P540	GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P541	THE PROCEDURE(S) REQUESTED ARE NOT MEDICAL IN NATURE.
P542	DOCUMENTATION OF POOR OCCUPATIONAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P543	DOCUMENTATION OF POOR SPEECH THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P544	OTHER OCCUPATIONAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P546	THE OCCUPATIONAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P547	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF PHYSICAL THERAPY.
P548	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P549	ACTIVITIES TO PROMOTE DIVERSION OR GENERAL MOTIVATION ARE NONCOVERED COLORADO MEDICAID SERVICES.
P550	REVISIONS OF THE REQUEST IS NECESSITATED BY THE CLIENTS MINIMAL PROGRESS.
P551	RESTORATIVE NURSING INVOLVEMENT COULD BE INCREASED.
P552	CLIENTS DEMONSTRATED RESPONSE TO CURRENT THERAPY DOES NOT WARRANT THE INTENSE FREQUENCY REQUESTED.
P553	MAINTENANCE IS TWO TIMES PER WEEK OR LESS.
P554	THE SPEECH THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.

Denial Code	Long Description
P555	USE OF OCCUPATIONAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P556	USE OF SPEECH THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P557	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF AN OCCUPATIONAL THERAPIST.
P558	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
P559	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P560	THE MATERIALS/ SERVICES REQUESTED ARE PRINCIPALLY COSMETIC IN NATURE.
P561	THE LENS FORMULA DOES NOT JUSTIFY REPLACEMENT.
P562	THE CHANGE IN THE LENS FORMULA DOES NOT WARRANT MULTIPLE REPLACEMENTS.
P563	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P564	LENSES ONLY ARE APPROVED; PLEASE DISPENSE A CONTRACTED FRAME. THE NON-CONTRACTED FRAME IS NOT MEDICALLY JUSTIFIED.
P565	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P566	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P567	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF OCCUPATIONAL THERAPY.
P568	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF SPEECH THERAPY.
P569	LEVEL, INTENSITY, OR EXTENT OF SERVICE(S) REQUESTED HAS BEEN MODIFIED CONSISTENT WITH MEDICAL NEED AS DEFINED IN THE PLAN OF CARE.
P570	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P571	THE SERVICE ASKED FOR IS NOT COVERED BY COLORADO MEDICAID AS THESE TASKS CAN BE DONE BY NURSES OR ACTIVITY STAFF.
P572	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P573	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.
P574	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P575	MEDICAL NEED FOR EQUIPMENT/ SUPPLY REQUESTED IS NOT SUPPORTED BY DOCUMENTATION SUBMITTED.
P576	OTHER SPEECH THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P577	DOCUMENTATION SUBMITTED IDENTIFIES THAT THE CLIENT HAS FEWER THAN TWO POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P582	LESS EXPENSIVE ALTERNATIVE SERVICES ARE AVAILABLE FOR THIS CLIENT.
P634	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P711	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING PERIODONTAL SCALING AND ROOT PLANNING.
P712	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING GINGIVECTOMY.
P754	AN APPROVED SUBSTANCE ABUSE DAY TREATMENT PROGRAM CANNOT EXCEED A SIX WEEK PERIOD.
P761	THE CLIENT DOES NOT APPEAR TO BE ABLE OR WILLING TO ABSTAIN FROM ALCOHOL/DRUG USAGE WHILE IN TREATMENT. THEREFORE, SUBSTANCE ABUSE DAY TREATMENT SERVICES ARE NOT APPROVED.
P764	THIS CLIENT HAS COMPLETED INTENSIVE SUBSTANCE ABUSE TREATMENT WITHIN THE PAST 12 MONTHS. THE DOCUMENTATION PROVIDED IS NOT ADEQUATE TO JUSTIFY ADDITIONAL INTENSIVE TREATMENT AT THIS TIME.
P785	A LESS THAN SIX-WEEK HEALING PERIOD HAS BEEN SPECIFIED FOR THIS PRIOR AUTHORIZATION. THEREFORE IT IS NOT NECESSARY TO WAIT THE FULL SIX WEEKS AFTER EXTRACTIONS BEFORE TAKING DENTURE IMPRESSIONS.
P818	SIX-WEEK HEALING TIME IS REQUIRED BETWEEN EDENTULATION AND FINAL IMPRESSIONS. PAYMENT FOR DENTURES WILL BE DENIED OR RECOUPED IF HEALING PERIOD IS NOT OBSERVED.
P849	COLORADO MEDICAID HAS DETERMINED THERE WERE (ARE) SEVERAL HOME HEALTH AGENCIES WILLING TO PROVIDE MEDICALLY NECESSARY SKILLED NURSING SERVICES TO THIS CLIENT.

Denial Code	Long Description
P864	THE DOCUMENTATION YOU HAVE SUBMITTED DOES NOT MEET THE REQUIREMENTS OF COLORADO MEDICAID.
P873	THE MEDICAL NECESSITY FOR THE HOURS REQUESTED IS NOT SUPPORTED BY THE INFORMATION SUBMITTED.
P874	THE DOCUMENTATION SUBMITTED INDICATES THE TASKS SPECIFIED CAN BE COMPLETED DURING THE VISITS APPROVED.
P878	THE DOCUMENTATION SUBMITTED DOES NOT INDICATE THAT MEDICALLY ORIENTED TASKS ARE MEDICALLY NECESSARY; THEREFORE PERSONAL CARE SERVICES HAVE BEEN APPROVED.
P880	THE QUANTITY OF SERVICES AUTHORIZED FOR THIS CLIENTS PERSONAL CARE HAS BEEN AMENDED BASED ON INFORMATION RECEIVED FROM ONE OR MORE OF THESE SOURCES: THE CLIENT, THEIR PHYSICIAN, AND/OR THE IN-HOME VISIT BY STAFF OF THE OIG (OFFICE OF INSPECTOR GENERAL).
P885	THE USE OF THIS DRUG FOR THE INTENDED PURPOSE IS NOT COVERED BY COLORADO MEDICAID, CONSISTENT WITH COLORADO ADMINISTRATIVE CODE AND FEDERAL LAW.
P924	THE MEDICAL RECORDS SUBMITTED WITH THE CURRENT REQUEST CONFLICT OR DISAGREE WITH OUR MEDICAL RECORDS ON THIS CLIENT.
P950	INDEPENDENT NURSES, PLEASE NOTE PAYABLE SERVICES MAY NOT EXCEED 12 HOURS/DAY OR 60 HOURS/WEEK.
P951	SERVICES CAN ONLY BE AUTHORIZED THROUGH ONE YEAR FROM THE PRESCRIPTION DATE.
P952	LEAD INSPECTION IS A COVERED COLORADO MEDICAID SERVICE WHEN THE CHILD HAS BEEN SHOWN TO HAVE LEAD POISONING (E.G., CHILD HAS A BLOOD LEAD LEVEL > 19 UG/DL OR TWO CONSECUTIVE BLOOD LEAD LEVELS OF 15-19 UG/DL DONE AT LEAST 90 DAYS APART). THE INSPECTION MUS
P953	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P954	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P956	THE REQUEST CAN ONLY BE BACKDATED A MAXIMUM OF 14 DAYS FROM FIRST DATE RECEIVED BY COLORADO MEDICAID.
P957	COMPLETE PERIODONTAL CHARTING AT TIME OF SERVICE, AND SUBMIT CHARTING, COPY OF OPERATIVE REPORT, TOGETHER WITH A COPY OF THE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF), F-11035, TO PA UNIT ATTENTION DENTAL CONTSULTANT.
P958	NOTE THAT CODE D4341 HAS BEEN CHANGED. REFER TO THE DECISION NOTICE FOR AUTHORIZED QUANTITY.
P960	YOUR PA HAS BEEN APPROVED FOR 90 DAYS. THE 90 DAY APPROVAL DOES NOT IMPLY THE PA REQUEST MEETS PRIOR AUTHORIZATION CRITERIA. AFTER ADDITIONAL INFORMATION IS AVAILABLE IN INTERCHANGE, COLORADO MEDICAID WILL CREATE AN AMENDMENT REQUEST TO EXTEND THE PA FOR
P961	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P962	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
PA10	THE REQUESTED END DATE IS INVALID.
PA12	PLEASE FURNISH A WRITTEN DESCRIPTION OF THE CLIENTS DIAGNOSIS.
PA13	PROVIDE DIAGNOSES WITH DATES OF ONSET.
PA14	IDENTIFY PROBLEMS TO BE TREATED.
PA15	THE AUDIOLOGISTS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1), F-11020, AND PRIOR AUTHORIZATION REQUEST/HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2), F-11021.
PA16	THE PHYSICIANS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION/PHYSICIAN OTOLOGICAL REPORT (PA/POR), F-11019.
PA17	SUBMIT BRIEF HISTORY WITH REFERRAL INFORMATION, LIVING SITUATION, FUNCTIONAL STATUS, AND OTHER PERTINENT INFORMATION. WHAT CHANGE OF STATUS RESULTED IN REFERRAL AT THIS TIME?
PA18	PLEASE FURNISH THE CLIENTS HEIGHT AND WEIGHT.
PA19	PLEASE SUBMIT CLINICAL INFORMATION SUFFICIENT TO VERIFY THE NEED FOR THE REQUESTED SERVICE(S).

Denial Code	Long Description
PA20	PLEASE RESUBMIT WITH COMPLETE PERIODONTAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PA21	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL EDUCATIONAL PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA22	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL PROGRAM PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA23	REFER TO THE DURABLE MEDICAL EQUIPMENT INDEX FOR APPROPRIATE CODE AND DESCRIPTION. DO NOT USE AN "UNLISTED" CODE.
PA24	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUALIZED FAMILY SERVICE PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA25	INFORMATION ON THE REQUEST FORM IS ILLEGIBLE, AND THE REQUEST CANNOT BE PROCESSED.
PA26	RE-EVALUATE YOUR GOALS. EMPHASIS SHOULD BE ON FUNCTIONAL SELF-CARE. GOALS MUST BE RELATED TO FUNCTIONAL OUTCOME.
PA27	PLEASE CLARIFY THE NUMBER OF HOURS PER WEEK REQUESTED.
PA28	PLEASE CLARIFY THE NUMBER OF HOURS PER DAY REQUESTED.
PA29	PLEASE CLARIFY THE NUMBER OF VISITS PER DAY REQUESTED.
PA30	ATTACH SUPPORTIVE DOCUMENTATION; HOME EXERCISE PROGRAM AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA31	THE DIAGNOSIS CODE INDICATED ON THE REQUEST DOES NOT CORRESPOND TO THE DIAGNOSIS CODE DESCRIPTION.
PA32	PLEASE SUBMIT ADDITIONAL INFORMATION SUFFICIENT TO VERIFY APPROPRIATENESS AND NEED FOR TRANSPLANT.
PA33	PLEASE SUBMIT THE INITIAL AND PROGRESSIVE OBJECTIVE FINDINGS.
PA34	ATTACH SUPPORTIVE DOCUMENTATION, FACILITY PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA35	PLEASE SUBMIT THE CLIENTS ORIGINAL COMPLAINTS AND EXAMINATION FINDINGS.
PA36	ATTACH SUPPORTIVE DOCUMENTATION, IN-HOME AUTISM PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA37	PLEASE SUBMIT YOUR TREATMENT PLAN FOR THIS CLIENT.
PA38	ATTACH SUPPORTIVE DOCUMENTATION AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA39	INITIAL EVALUATIONS MUST BE PERFORMED BY AN OCCUPATIONAL THERAPIST REGISTERED (OTR), PER AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA) STANDARDS.
PA41	IDENTIFY THE PLACE OF SERVICE AND ITS EFFECT ON SUPPORTING THE DESIRED TREATMENT OUTCOME.
PA42	PLEASE INDICATE THE HOURS OF USE OF OXYGEN PER 24-HOUR PERIOD.
PA43	PROVIDE BASELINE DOCUMENTATION FOR THIS CLIENTS LIMITATIONS USING UNITS OF MEASUREMENT THAT ARE APPLIED CONSISTENTLY WHEN REPORTING STATUS.
PA44	IDENTIFY FUNCTIONAL LIMITATIONS AS THEY ARE RELATED TO IDENTIFIED CONDITIONS.
PA46	CORRELATE PLAN OF CARE TO REQUESTED PROCEDURE CODES.
PA47	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE FREQUENCY/DURATION REQUESTED.
PA48	PLEASE PROVIDE THE NAME AND CREDENTIALS OF THE RENDERING PROVIDER.
PA50	COLORADO MEDICAID RECORDS INDICATE THE CLIENT OWNS A WHEELCHAIR. DOCUMENT THE REASON AND NEED FOR REPLACEMENT AND COST TO REPAIR CURRENT WHEELCHAIR.
PA51	PLEASE DISTINGUISH PRIMARY AND SUPPORTIVE MODALITIES.
PA52	PLEASE SUBMIT A PROGRESS REPORT.
PA53	MULTIPLE FAMILY CLIENTS TREATMENT BY THE SAME PROVIDER REQUIRES FURTHER INFORMATION DOCUMENTING COORDINATION OF TREATMENT PLAN.
PA54	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE MINUTES REQUESTED.
PA55	MEDICAL NECESSITY OF TREATMENT REQUIRES ADDITIONAL DOCUMENTATION.
PA56	GIVEN AGE, DIAGNOSES, CURRENT LEVEL OF FUNCTION, PAST RESPONSE TO TREATMENT, AND LIVING SITUATION, EXPAND ON POTENTIAL FOR SIGNIFICANT FUNCTIONAL PROGRESS WITHIN THE NEXT SIX MONTHS. EMPHASIZE WHY PROGRESS IS EXPECTED WITH SERVICES AT THIS TIME.

Denial Code	Long Description
PA57	SUBMIT THE INITIAL FINDINGS. INCLUDE A COMPREHENSIVE EVALUATION.
PA58	SUBMIT PROGRESSIVE, OBJECTIVE FINDINGS. INCLUDE A PERTINENT RE-EVALUATION.
PA59	PLEASE SUPPLY INFORMATION REGARDING THE CLIENTS MEDICATION REQUIREMENTS, IF ANY.
PA60	PLEASE SPECIFY IF THE CLIENT IS IN AN EDUCATIONAL SETTING.
PA61	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA62	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
PA63	THE SKILLS OF A THERAPIST ARE PURPOSEFUL AND SKILLED INTERVENTIONS REQUIRED TO CONTINUALLY DESIGN, IMPLEMENT, REASSESS, MODIFY/GRADE, AND/OR DISCONTINUE A PLAN OF CARE IN A TIMELY MANNER, BASED ON THE COMPLEXITY OF THE CLIENTS MEDICAL CONDITION AND/OR CO
PA64	PLEASE SUBMIT A THERAPY PLAN OF CARE, INCLUDING A CURRENT, DATED EVALUATION.
PA65	A PLAN OF CARE SIGNED AND DATED BY THE PHYSICIAN IS REQUIRED.
PA66	THE SKILLS OF A THERAPIST ARE REQUIRED WHEN ONLY THE THERAPIST CAN SAFELY AND EFFECTIVELY DELIVER THE THERAPEUTIC PROCEDURES BECAUSE OF THEIR UNIQUE KNOWLEDGE, TRAINING, AND EXPERTISE. DESCRIBE THE REASON THAT SOMEONE OTHER THAN A THERAPIST CANNOT SAFELY
PA67	PLEASE SPECIFY IF THE CLIENTS WORK SITE DEMANDS GOOD BINAURAL HEARING.
PA68	DESCRIBE THE REASON, BASED ON THE CLIENTS COGNITIVE, PHYSICAL, COMMUNICATION, OR RESOURCE STATUS, THAT A HOME PROGRAM, EQUIPMENT, OR ENVIRONMENTAL ADAPTATIONS ALONE CANNOT MEET CLIENTS NEEDS.
PA69	PLEASE SPECIFY IF THE CLIENT HAS AN ACCOMPANYING DISABILITY THAT ADDS TO THE HEARING PROBLEM.
PA70	DISTINGUISH REQUESTED PROCEDURES AND GOALS FROM OTHER SERVICES THIS CLIENT RECEIVES. THEY MAY NOT BE DUPLICATIVE.
PA71	PLEASE INDICATE THE NUMBER OF DAYS REQUESTED.
PA73	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA74	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA75	PLEASE DOCUMENT CARRYOVER OF THE THERAPY PROGRAM TO NURSING.
PA76	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA79	PROVIDE EVIDENCE OF SIGNIFICANT FUNCTIONAL PROGRESS IN LAST SIX MONTHS.
PA84	THE GRANT DATE OF THIS REQUEST CANNOT BE PRIOR TO THE SIGNATURE DATE OF THE PRESCRIBING PHYSICIAN.
PA86	PROVIDE EVIDENCE OF SKILLS GAINED IN THERAPY CARRYING OVER TO OTHER SETTINGS WITHIN SIX MONTHS.
PA87	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE NUMBER OF SESSIONS REQUESTED.
PA88	THE REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL SCOPE OF PRACTICE.
PA89	PRIOR AUTHORIZATION IS NOT REQUIRED UNTIL LIMITATION OF SERVICE HAS BEEN REACHED.
PA91	PLEASE SUBMIT REQUIRED X-RAYS.
PA92	PLEASE PROVIDE AN EXPLANATION FOR THE MATERIAL SUBMITTED WITH THE REQUEST.
PA95	PLEASE DESCRIBE HOW THE PROVISION OF THIS SERVICE WOULD PREVENT INSTITUTIONALIZATION OF THE CLIENT.
PA96	COULD THE EXISTING DENTURE(S) BE RELINED OR REBASED? IF NOT, PLEASE EXPLAIN WHY NOT.
PA97	REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL STANDARDS OF PRACTICE.
PA98	PLEASE INDICATE IF THE CLIENT IS CURRENTLY BEING TUBE FED.
PB02	PLEASE PROVIDE THE REQUIRED DATED SIGNATURES ON THE ATTACHMENTS.
PB03	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING THE LOSS/DESTRUCTION/THEFT OF THE HEARING AID.
PB04	DESCRIBE THE CLIENTS ABILITY TO STAND OR AMBULATE SUFFICIENTLY TO ACCOMPLISH SELF-CARE ACTIVITIES.
PB07	PLEASE SUBMIT AN ORTHODONTIC STUDY MODEL OR DIAGNOSTIC CASTS.
PB09	PLEASE PROVIDE A PHOTOGRAPH OF THE INVOLVED AREA(S).

Denial Code	Long Description
PB10	PLEASE PROVIDE AN ESTIMATION (IN GRAMS) OF THE TOTAL AMOUNT OF TISSUE TO BE RESECTED.
PB11	PLEASE SUBMIT THE PLAN OF CARE FOR CO-TREATMENT.
PB12	FURNISH A DETAILED DESCRIPTION FOR THE PROCEDURE CODE REQUESTED.
PB13	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB15	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB18	PLEASE COMPLETE THE ATTACHED OUT-OF-STATE PROVIDER DATA SHEET, F-11001, AND RESUBMIT.
PB20	A SIGNED AND DATED PRESCRIPTION IS REQUIRED WITHIN THREE MONTHS OF RECEIPT BY COLORADO MEDICAID FOR INITIAL REQUESTS AND WITHIN 12 MONTHS OF RECEIPT BY COLORADO MEDICAID FOR SUBSEQUENT REQUESTS.
PB21	PLEASE COMPLETE THE APPROPRIATE PRIOR AUTHORIZATION ATTACHMENT. CONTACT PROVIDER SERVICES OR THE PRIOR AUTHORIZATION UNIT FOR ASSISTANCE.
PB23	PHYSICAL THERAPY ASSISTANT NOTES AND ALL FORMS SUBMITTED MUST BE COSIGNED BY A REGISTERED PHYSICAL THERAPIST.
PB31	ARE YOU REQUESTING A COMPLETE APPLIANCE, OR REPLACEMENT PARTS?
PB32	THE PROCEDURE CODE INDICATED ON THE REQUEST DOES NOT MATCH THE DESCRIPTION OF SERVICE; PLEASE CORRECT AND RESUBMIT.
PB35	THE SERVICE REQUESTED DOES NOT REQUIRE PRIOR AUTHORIZATION.
PB41	PLEASE FURNISH A CURRENT MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT, F-11090 (DATED WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID).
PB45	THE CERTIFICATION PERIOD ON THE PLAN OF CARE (POC) DOES NOT COVER THE REQUESTED GRANT/START DATE. PLEASE RESUBMIT YOUR REQUEST WITH A NEW POC.
PB49	A CERTIFIED OCCUPATIONAL THERAPY ASSISTANTS NOTES MUST BE COSIGNED BY AN OCCUPATIONAL THERAPIST REGISTERED.
PB51	ADDITIONAL INFORMATION IS REQUIRED ON PRIOR AUTHORIZATION TO ENABLE PRICING.
PB54	REQUESTED SERVICES DO NOT MATCH SERVICES ON THE PHYSICIANS ORDERS.
PB59	PLEASE PROVIDE AN INDIVIDUAL EDUCATIONAL PLAN (IEP), WHICH HAS BEEN SIGNED BY THE PROVIDER NO EARLIER THAN NINE MONTHS PRIOR TO RECEIPT AT COLORADO MEDICAID; OTHERWISE, DOCUMENT WHY NO IEP EXISTS.
PB65	PLEASE FURNISH THE ANTICIPATED TOTAL CHARGES FOR THIS REQUEST.
PB66	A PHOTOCOPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED; THE DATE MUST BE WITHIN SIX MONTHS OF RECEIPT BY COLORADO MEDICAID.
PB67	THE PRESCRIPTION DATE MUST INCLUDE MONTH, DAY, AND YEAR.
PB68	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID.
PB73	THE SERVICES IDENTIFIED ON THE PLAN OF CARE DO NOT APPEAR APPROPRIATE FOR THE PROCEDURE CODE(S) REQUESTED ON THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018.
PB74	THE CLIENT/PROVIDER DOES NOT HAVE RETROACTIVE ENROLLMENT.
PB75	THE REQUESTED START DATE IS MORE THAN 14 DAYS BEFORE OR 62 DAYS AFTER RECEIPT.
PB82	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
PB83	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A HOME HEALTH AIDE. PLEASE RESUBMIT AS A PERSONAL CARE WORKER OR PROVIDE ADDITIONAL DOCUMENTATION.
PB86	THE SERVICES REQUESTED ARE NOT BEING PROVIDED IN THE CLIENTS RESIDENCE. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL.
PB87	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A NURSE. PLEASE RESUBMIT AS A HOME HEALTH AIDE OR PROVIDE ADDITIONAL DOCUMENTATION.
PB92	PLEASE FURNISH THE CLIENTS COMPLETE ADDRESS.
PB94	IF THE CLIENT IS A RESIDENT OF A NURSING HOME, SUPPLY THE COMPLETE NAME AND ADDRESS OF THE NURSING HOME.
PB99	THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018, MUST BE SIGNED AND DATED.
PC01	PLEASE SUPPLY THE RENDERING PROVIDERS PROVIDER NUMBER.
PC03	THE DRUG ENFORCEMENT ADMINISTRATION NUMBER IS MISSING OR INVALID.
PC06	PLEASE DESCRIBE YOUR PROGRAM; INCLUDE ENTRY DATE, TERMINATION DATE, HOURS PER WEEK, AND NUMBER OF WEEKS OF PRIMARY INTENSIVE SERVICE REQUESTED.

Denial Code	Long Description
PC07	PLEASE DESCRIBE YOUR "AFTERCARE/FOLLOW-UP" PLANS FOR THIS CLIENT.
PC08	PLEASE SUPPLY DOCUMENTATION OF PREVIOUS SUBSTANCE ABUSE SERVICES WITH DATE(S) AND OUTCOME.
PC09	PLEASE DESCRIBE IN DETAIL THE TREATMENT OBJECTIVES/GOALS FOR THIS CLIENT.
PC10	PLEASE DESCRIBE THE FAMILY SITUATION/DYNAMICS. EXPLAIN HOW THE FAMILY WILL BE INCORPORATED INTO THE CLIENTS PLAN OF CARE.
PC12	PLEASE EXPLAIN IF YOUR SERVICE ENCOURAGES THE CLIENT TO ATTEND SELF-HELP GROUPS.
PC13	PLEASE SUPPLY A SPECIFIC SCHEDULE OF ACTIVITIES, INCLUDING DAY, TIME OF DAY, LENGTH OF SESSION, AND SERVICE TO BE RENDERED DURING THAT TIME.
PC15	PLEASE FURNISH DIAGNOSTIC RATIONALE.
PC17	PLEASE DOCUMENT IF THE CLIENT EVER RECEIVED SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT.
PC19	PLEASE FURNISH MORE EXTENSIVE AND IN-DEPTH HISTORICAL AND PSYCHOSOCIAL DATA.
PC20	PLEASE SUPPLY THE DATE THE CLIENT BECAME TOTALLY ENDENTULOUS.
PC23	PLEASE SUBMIT A PHYSICIANS STATEMENT REGARDING THE MEDICAL NECESSITY OF DENTURES FOR THIS CLIENT. THE PHYSICIANS STATEMENT MUST DOCUMENT THE MEDICAL NEED FOR DENTURES.
PC24	THE SERVICE REQUESTED WAS PREVIOUSLY AUTHORIZED. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT INDICATING THIS FACT IS REQUIRED.
PC25	PLEASE SUPPLY SUFFICIENT MITIGATING CIRCUMSTANCES TO WARRANT THE CONSTRUCTION OF NEW DENTURES(S).
PC26	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
PC28	PLEASE SUBMIT A PHYSICIANS STATEMENT INDICATING DENTURES ARE NECESSARY FOR THIS NURSING HOME CLIENT.
PC29	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING LOSS OR DESTRUCTION OF DENTURE(S). INCLUDE SIGNED STATEMENT FROM CLIENT OR FACILITY DIRECTOR REGARDING HOW, WHEN AND WHERE LOST.
PC30	PLEASE PROVIDE COMPLETE INTRAORAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PC31	PLEASE DESCRIBE ANY RELATED DEFORMITIES OF THE FEET.
PC34	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD WITH REQUESTED DME ITEM(S) AND DOCUMENT IF THE CLIENT CAN USE SAFELY AND INDEPENDENTLY.
PC35	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD AND DESCRIBE THE RESULTS AND EFFECTIVENESS OF THE SERVICE REQUESTED.
PC39	PLEASE INDICATE LITER FLOW PER MINUTE, HOURS OF USE PER 24 HOUR PERIOD, AND THE EXPECTED DURATION OF NEED.
PC40	THE ITEM DOES NOT REQUIRE PRIOR AUTHORIZATION UNTIL THE LIFE EXPECTANCY HAS BEEN REACHED.
PC41	PLEASE SUPPLY INFORMATION INDICATING THE NECESSITY OF POSITIONING THE CLIENT'S BODY IN MULTIPLE POSITIONS.
PC42	PLEASE INDICATE IF THE BED HEIGHT MUST BE CHANGED TO ALLOW FOR SAFE TRANSFER OR ADEQUATE BED CARE.
PC43	SUPPLY A PHYSICIANS STATEMENT INDICATING TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR UNIT HAS REDUCED PAIN, IMPROVED/INCREASED THE CLIENTS ACTIVITY LEVEL, AND/OR REDUCED CLIENTS USE OF PAIN MEDICATION.
PC44	A CURRENT AUTHORIZATION FOR THIS SERVICE IS ON FILE FOR ANOTHER PROVIDER. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT OF THAT FACT IS REQUIRED BY THE CLIENT OF FIRST PROVIDER.
PC59	DOCUMENT DECLINE OR PROGRESS IN SPECIFIC, MEASURABLE, OBJECTIVE TERMS.
PC60	DOCUMENT IF CLIENT HAS DEMONSTRATED A GOOD APPOINTMENT COMPLIANCE RECORD.
PC61	THE PHYSICIANS SIGNATURE DATE MUST NOT EXCEED 90 DAYS FROM THE DATE OF RECEIPT BY COLORADO MEDICAID.
PC62	REQUESTS FOR A CONTINUATION OF THERAPY SHOULD NOT BE SUBMITTED MORE THAN FOUR WEEKS PRIOR TO THE EXPIRATION DATE OF THE CURRENT AUTHORIZATION.
PC63	PLEASE FURNISH THE STYLE AND MANUFACTURER OF THE FRAME.
PC64	PLEASE FURNISH THE CLIENTS LENS FORMULA.
PC66	ALL REQUESTS FOR TINTS REQUIRE DOCUMENTATION OF THE VISUAL OR MEDICAL CONDITION RELATED TO PHOTOPHOBIA.

Denial Code	Long Description
PC67	PLEASE DOCUMENT THE REASON AND JUSTIFICATION FOR REPLACEMENT BEYOND THE FIRST LENS/FRAME.
PC68	DOCUMENT IF ALL REMAINING MAXILLARY AND/OR MANDIBULAR TEETH ARE DECAY-FREE, PROPERLY RESTORED, AND PERIODONTICALLY SOUND.
PC72	SUPPLY MORE DETAIL REGARDING PROGRESS (ATTACHMENT OF GOALS, ETC.). CORRELATE PROGRESS TO PREVIOUS GOALS AND IDENTIFIED LIMITATIONS.
PC77	PLEASE SUBMIT A PLAN OF CARE DESCRIBING THE SERVICES THAT WOULD BE PROVIDED.
PC78	PLEASE DOCUMENT SPECIFIC, MEASURABLE GOALS.
PC82	THE PRIOR AUTHORIZATION (PA) SYSTEM CAN PROCESS ONLY 26 DETAILS PER PA REQUEST. PLEASE RESUBMIT YOUR REQUEST WITH NO MORE THAN 26 DETAILS.
PC83	PLEASE SUPPLY A PHYSICIANS PRESCRIPTION DATED WITHIN ONE MONTH OF REQUESTED SUBSTANCE ABUSE DAY TREATMENT.
PC84	PLEASE PROVIDE INFORMATION INDICATING THIS CLIENT IS APPROPRIATELY DETOXIFIED FROM ALCOHOL AND/OR OTHER DRUGS.
PC85	PLEASE PROVIDE INFORMATION TO INDICATE THE CLIENTS ABILITY TO ABSTAIN FROM ALCOHOL OR DRUGS WHILE IN THE SUBSTANCE ABUSE DAY TREATMENT PROGRAM.
PC86	PLEASE INDICATE IF THIS CLIENT IS WILLING TO PARTICIPATE IN AFTERCARE OR CONTINUING CARE SERVICES.
PC87	PROVIDE MORE INFORMATION ON TREATMENT HISTORY; INCLUDE SERVICE PROVIDED, DATES, AND OUTCOME. PROVIDE DETAIL OF PREVIOUS TREATMENT.
PC88	PLEASE PROVIDE MORE RATIONALE FOR THE APPROPRIATENESS AND MEDICAL NECESSITY OF SUBSTANCE ABUSE DAY TREATMENT.
PC89	PROVIDE A TREATMENT PLAN THAT CONTAINS MEASURABLE GOALS AND OBJECTIVES CORRESPONDING TO THE IDENTIFIED DEFICIT.
PC91	PLEASE PROVIDE MORE INFORMATION ON FAMILY INVOLVEMENT TREATMENT.
PC92	PLEASE PROVIDE MORE HISTORY AND EXPLANATION ABOUT THE ISSUE OF ABSTINENCE FOR THIS CLIENT.
PC94	PLEASE PROVIDE THE ANTICIPATED BEGINNING DATE AND/OR THE ESTIMATED SUBSTANCE ABUSE DAY TREATMENT DISCHARGE DATE.
PC95	PLEASE SUPPLY JUSTIFICATION FOR BEGINNING CLIENT IN SERVICE PRIOR TO AUTHORIZATION BEING OBTAINED.
PC96	THE INITIAL THREE HOURS OF SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IN A CALENDAR YEAR DO NOT REQUIRE PRIOR AUTHORIZATION.
PC97	REIMBURSEMENT FOR INITIAL SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IS LIMITED TO THREE HOURS IN A CALENDAR YEAR AND DOES NOT REQUIRE PRIOR AUTHORIZATION.
PC98	THIS DRUG IS CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE BILL USING THE APPROPRIATE NATIONAL DRUG CODE (NDC) OR SUBMIT A COMPLETED DRUG ADDITION REQUEST FORM IF THE NDC IS NOT LISTED IN THE DRUG INDEX.
PC99	THIS DRUG IS NOT CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL, CURRENT ADMINISTRATIVE RULE, OR COLORADO DRUG INDEX FOR COVERAGE LIMITATIONS.
PD01	DOCUMENT THAT CLIENT HAS ACHIEVED GOOD ORAL HYGIENE, PERIODONTAL CASE TYPE 1 OR 2, AND IS MOTIVATED TO MAINTAIN SAME.
PD03	PLEASE PROVIDE AN ARTERIAL BLOOD GAS READING OR PULSE OXIMETRY RESULTS DONE ON ROOM AIR SIGNED AND DATED BY A MEDICAL DOCTOR. THIS SHOULD BE DONE WITHIN 60 DAYS OF REQUESTED SERVICE.
PD04	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 30 DAYS OF RECEIPT BY COLORADO MEDICAID.
PD07	SUBMIT A PHOTOCOPY OF A VALID PRESCRIPTION, ISSUED WITHIN THE PAST YEAR, OR COMPLETE SECTION B OF THE PRIOR AUTHORIZATION/DRUG ATTACHMENT (PA/DGA), F-11049.
PD10	BRAND MEDICALLY NECESSARY MUST BE IN THE PRESCRIBERS OWN HANDWRITING AND WRITTEN DIRECTLY ON THE PRESCRIPTION OR A SEPARATE ORDER ATTACHED TO THE ORIGINAL PRESCRIPTION.
PD12	COMPLETE DENTURES, PARTIAL DENTURES, DENTURE RELINES, AND FIXED PROSTHODONTIC SERVICES ARE NOT COVERED SERVICES FOR ADULTS FOR DATES OF SERVICE ON AND AFTER OCTOBER 1, 1995.
PD22	PLEASE COMPLETE ALL REQUIRED ELEMENTS ON THE PERSONAL CARE SCREENING TOOL (PCST), F-11133.

Denial Code	Long Description
PD24	THIS PRIOR AUTHORIZATION REQUEST IS UNABLE TO BE PROCESSED. PLEASE RESUBMIT WITH ADDITIONAL REQUIRED FORMS, INCLUDING THE ENTIRE PERSONAL CARE SCREENING TOOL (PCST), F-11133; PERSONAL CARE ADDENDUM, F-11136; AND SUPPORTING DOCUMENTATION, AS DIRECTED.
PD25	THERE IS A PERSONAL CARE SCREENING TOOL (PCST), F-11133, COMPLETED BY ANOTHER AGENCY. CONTACT THE AGENCY TO TRANSFER SCREEN.
PD26	THERE IS A LIMITED TERM CARE FUNCTIONAL SCREEN (LTC-FS) COMPLETED BY ANOTHER AGENCY. THE PERSONAL CARE SCREENING TOOL (PCST), F-11133, INFORMATION IS IN CONFLICT WITH LTC-FS.
PD27	ONLY ONE LEVEL OF FUNCTION MAY BE SELECTED FOR ALL ELEMENTS EXCEPT TOILETING. COLORADO MEDICAID IS UNABLE TO PROCESS THE PRIOR AUTHORIZATION REQUEST.
PD28	NO UNITS MAY BE REQUESTED USING THIS PRIOR AUTHORIZATION PROCESS. PLEASE SUBMIT WITH THE APPROPRIATE ATTACHMENTS FOR REQUESTING SPECIFIC PERSONAL CARE WORKER UNITS.
PD29	CLIENT IS NOT ELIGIBLE FOR THE REQUESTED SERVICE(S) AS OF THE REQUESTED START DATE.
PD30	NO TRAVEL TIME MAY BE AUTHORIZED WHEN NO PERSONAL CARE WORKER SERVICE IS AUTHORIZED.
PD32	PROVIDER NOT CERTIFIED TO RENDER THE SERVICE(S) REQUESTED.
PD34	BASED ON THE DOCUMENTATION SUBMITTED, THIS REQUEST CAN NOT BE PRIOR AUTHORIZED. REFER TO THE PA MESSAGES FROM THE CONSULTANT FOR COMPLETE EXPLANATION.
PD98	PLEASE DOCUMENT HOW AND WHEN EACH PREVIOUSLY AUTHORIZED PRO RE NATA VISIT WAS USED.

Transportation

Denial Code	Long Description
0201	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
0233	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0235	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0237	CLIENT IDENTIFICATION NUMBER DOES NOT MATCH CLIENTS FIRST NAME.
0238	THE CLIENT IDENTIFICATION NUMBER DOES NOT MATCH THE CLIENTS LAST NAME.
0242	SECONDARY DIAGNOSIS CODE IS INVALID.
0248	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0249	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0251	PROCEDURE CODE MODIFIER IN FIRST POSITION IS INVALID.
0252	THE PROCEDURE CODE MODIFIER IN SECOND POSITION IS INVALID FOR REQUESTED START DATE OR DATE OF RECEIPT.
0253	THE PROCEDURE CODE MODIFIER IN THIRD POSITION IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
0258	THE PRIMARY DIAGNOSIS CODE IS REQUIRED.
0272	THE PRIMARY DIAGNSOSIS CODE IS INVALID.
0400	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0853	HCPCS - ANNUAL UPDATE
0885	NEVER EVENTS MODIFIERS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
0886	NEVER EVENTS DIAGNOSIS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
1000	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
1002	RENDERING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1003	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1007	RENDERING PROVIDER ID IS NOT ON FILE.
1047	THE RENDERING PROVIDERS CERTIFICATION HAS BEEN CANCELLED.
1048	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1801	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.

Denial Code	Long Description
1804	A CERTIFIED SUBSTANCE ABUSE DAY TREATMENT PROVIDER MUST SUBMIT A SUBSTANCE ABUSE DAY TREATMENT PROCEDURE CODE.
1806	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
1808	THE BILLING PROVIDER DOES NOT HAVE THE REQUIRED CERTIFICATION ADDENDUM ON FILE.
1900	THE BILLING PROVIDERS TAXONOMY CODE IS INVALID.
1901	THE RENDERING PROVIDERS TAXONOMY CODE IS INVALID.
1927	A NATIONAL PROVIDER IDENTIFIER IS REQUIRED FOR THE BILLING PROVIDER.
1934	A NATIONAL PROVIDER INDENTIFIER IS REQUIRED FOR THE RENDERING PROVIDER.
1936	THE BILLING PROVIDER NUMBER IS INVALID.
1937	THE RENDERING PROVIDER NUMBER IS INVALID.
1960	INTERNAL PROCESSING IS REQUIRED.
1963	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.
1964	THE BILLING PROVIDER INDICATED IS NOT ALLOWABLE AS A BILLING PROVIDER.
1965	RENDERING PROVIDER NUMBER IS MISSING/INVALID FOR THIS PROCEDURE PROVIDER.
1974	PRESCRIBING/REFERRING/ORDERING PROVIDER INDICATED IS NOT CERTIFIED AS A PRESCRIBING/REFERRING/ORDERING PROVIDER.
1975	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
1976	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
2001	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2003	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2017	THE CLIENT IS ENROLLED IN A MEDICAID OR OTHER MANAGED CARE PROGRAM.
2037	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2603	CLIENT LOCKED-IN TO A PROVIDER OR ENROLLED IN A HOSPICE. CONTACT CLIENTS HOSPICE FOR PAYMENT OF SERVICES OR RESUBMIT WITH DOCUMENTATION OF UNRELATED NATURE OF CARE.
3324	THE MODIFIER HAS BEEN DISCONTINUED BY THE CENTERS OF MEDICARE AND MEDICAID SERVICES OR THE AMERICAN MEDICAL ASSOCIATION FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
3337	THE PROCEDURE CODE HAS BEEN TERMINATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AMERICAN MEDICAL ASSOCIATION, OR AMERICAN DENTAL ASSOCIATION FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT. RESUBMIT WITH VALID A PROCEDURE CODE.
3339	THE PROCEDURE BILLED IS NOT PAYABLE ACCORDING TO DEFICIT REDUCTION ACT (DEFRA) GUIDELINES.
3351	THE PROCEDURE IS NOT COVERED FOR CLIENTS WITH A NURSING HOME AUTHORIZATION ON THE REQUESTED START DATE OR DATE OF RECEIPT.
3353	THE PROCEDURE IS NOT A COVERED SERVICE FOR HOME AND COMMUNITY-BASED WAIVER CLIENTS.
4021	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4027	THE DIAGNOSIS CODE IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
4031	THE PROCEDURE SUBMITTED IS NOT APPROPRIATE FOR CLIENTS GENDER.
4032	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4034	THE PROCEDURE CODE HAS AN AGE RESTRICTION.
4036	THE PLACE OF SERVICE CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4040	THE PRIMARY DIAGNOSIS CODE IS NOT ON FILE.
4041	THE SECONDARY DIAGNOSIS IS NOT ON FILE.
4046	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4127	INTERNAL PROCESSING IS REQUIRED.
4131	INTERNAL PROCESSING IS REQUIRED.
4141	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4149	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4150	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4236	ETIOLOGY DIAGNOSIS CODE(S) (E-CODES) ARE INVALID AS THE PRIMARY DIAGNOSIS.
4244	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4245	THE FOURTH POSITION MODIFIER IS INVALID FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT.
4256	THE PROCEDURE CODE AND MODIFIER COMBINATION IS NOT PAYABLE FOR THE CLIENTS BENEFIT PLAN.
4257	THE MODIFIERS SUBMITTED ARE EITHER INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT OR THE MODIFIERS ARE MISSING.

Denial Code	Long Description
4311	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4315	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4316	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4371	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4372	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4711	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR CLIENTS AGE.
4714	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS AGE.
4731	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS DIAGNOSIS.
4742	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4743	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4744	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4745	DIAGNOSIS AND/OR PROCEDURE AND/OR PLACE OF SERVICE (POS) CODE IS NOT COVERED FOR EXPRESS ENROLLMENT CLIENTS.
4746	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4801	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4802	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
4821	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
4871	PLEASE REFER TO PA MESSAGES FOR RETURN INFORMATION.
4963	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS GENDER.
4990	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
7500	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
7509	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
P001	THE BILLING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THE SERVICES.
P002	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P003	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P005	THE PRIOR AUTHORIZATION CAN NOT BE END DATED. THE PRIOR AUTHORIZATION STATUS IS NOT APPROVED OR APPROVED WITH REVISIONS.
P006	PLEASE FURNISH THE PROCEDURE CODE AND CORRESPONDING DESCRIPTION.
P008	THE BILLING PROVIDER NUMBER IS INVALID.
P009	THE BILLING PROVIDER NUMBER IS INVALID.
P010	THE REQUESTED END DATE IS INVALID.
P011	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P012	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P013	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P014	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P015	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P016	THE REQUESTED START DATE IS MISSING OR INVALID.
P019	THE REQUESTED START DATE IS MISSING OR INVALID.
P020	THE RENDERING PROVIDER NUMBER IS INVALID.
P021	THE RENDERING PROVIDER NUMBER IS INVALID.
P022	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P023	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P024	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P026	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P027	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.

Denial Code	Long Description
P030	FIRST MODIFIER IS INVALID.
P031	FIRST MODIFIER IS INVALID.
P032	SECOND MODIFIER IS INVALID.
P033	SECOND MODIFIER IS INVALID.
P034	THIRD MODIFIER IS INVALID.
P035	THIRD MODIFIER IS INVALID.
P036	FOURTH MODIFIER IS INVALID.
P037	FOURTH MODIFIER IS INVALID.
P038	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P039	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P040	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P041	CLIENTS FIRST NAME IS MISSING.
P042	CLIENTS LAST NAME IS MISSING.
P043	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P044	BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES REQUESTED.
P045	FIRST MODIFIER IS INVALID.
P046	SECOND MODIFIER IS INVALID.
P047	THIRD MODIFIER IS INVALID.
P048	FOURTH MODIFIER IS INVALID.
P052	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P053	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P054	RENDERING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES FOR THE BENEFIT PLAN.
P055	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P061	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P062	THE CLIENT ID AND/OR NAME INDICATED ON THE PA REQUEST IS INCORRECT. THE CLIENT ID AND/OR NAME HAS BEEN UPDATED. PLEASE VERIFY THE ID AND/OR NAME IS CORRECT.
P064	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
P067	THE FREQUENCY OF HOURS REQUESTED ARE NOT APPROPRIATE FOR THIS CLIENT AND HAVE BEEN MODIFIED ACCORDINGLY.
P079	BILLING PROVIDER IS ON PAYMENT SUSPENSION DUE TO CREDIBLE ALLEGATION OF FRAUD.
P120	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAS BEEN REDUCED.
P121	THE SERVICE/ PROCEDURE REQUESTED IS NOT SUPPORTED BY SUBMITTED DOCUMENTATION.
P126	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
P128	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.
P138	SERVICE(S) DO NOT MEET COLORADO MEDICAID GUIDELINES.
P167	REQUESTED DOCUMENTATION HAS NOT BEEN SUBMITTED.
P178	THE SERVICE REQUESTED IS NOT MEDICALLY NECESSARY.
P179	THE MEDICAL NECESSITY FOR THIS SERVICE IS NOT SUPPORTED BY THE SUBMITTED DOCUMENTATION.
P233	THE DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE ADDITIONAL CARE.
P257	THIS CLIENTS FUNCTIONAL ASSESSMENT SCORES PLACE THIS CLIENT OUTSIDE ELIGIBILITY FOR DAY TREATMENT.
P274	OUR RECORDS INDICATE THIS CLIENT IS INVOLVED IN EFFECTIVE AND APPROPRIATE SERVICE ELSEWHERE.
P292	INTENSIVE REHABILITATION HOURS ARE NO LONGER APPROPRIATE AS INDICATED BY HISTORY, DIAGNOSIS, AND/ OR FUNCTIONAL ASSESSMENT SCORES.
P328	THE SERVICES REQUESTED INCLUDE NON-COVERED SERVICES, AND HOURS ARE REDUCED ACCORDINGLY.
P339	THE CLIENTS PAST HISTORY INDICATES REDUCED TREATMENT HOURS ARE WARRANTED.
P342	THE REQUEST DOES NOT MEET GENERALLY ACCEPTED CONDITIONS REQUIRING FLUORIDE TREATMENTS.

Denial Code	Long Description
P346	SERVICES EXCEED COLORADO MEDICAID LIMITATION AND DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE MEDICAL NECESSITY OF THE SERVICE.
P349	THE SERVICE REQUESTED WAS PERFORMED LESS THAN FIVE YEARS AGO.
P353	THE EXISTING APPLIANCE HAS NOT BEEN WORN FOR THREE YEARS.
P367	THE CLIENT HAS BEEN TOTALLY WITHOUT TEETH AND AN APPLIANCE FOR FIVE YEARS.
P392	THE CLIENT IS MISSING AN ANTERIOR TOOTH AND/OR HAS TWO OR MORE POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P405	THE SERVICE(S) REQUESTED COULD ADEQUATELY BE PERFORMED IN THE DENTAL OFFICE.
P406	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE OF GOOD PERIODONTAL HEALTH (AMERICAN ACADEMY OF PERIODONTOLOGY PERIODONTAL CLASSIFICATION OF TYPE I OR II).
P407	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE VISIBLE ON RADIOGRAPHS THAT AT LEAST 50 PERCENT OF THE CLINICAL CROWN IS INTACT.
P409	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING SIX OR MORE TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED, INCLUDING THIRD MOLARS.
P410	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING ONE OR MORE ANTERIOR TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED.
P411	DOCUMENTATION DOES NOT SUPPORT THE NEED FOR PERIODONTIC SERVICES. POCKETS ARE LESS THAN 4MM AND/OR GREATER THAN 6MM FOR CLIENT AND/OR THE CLIENT IS UNDER THE AGE OF 13.
P412	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA.
P413	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA. THIS PA HAS BEEN GRANTED AS APPROVED NOT APPROVED WITH REVISIONS. THE DURATION REQUESTED MAY HAVE BEEN REDUCED TO REFLECT COVERAGE LIMITATIONS, PRESCRIBER ORDERS, CONFLICTI
P417	THE SERVICE(S) REQUESTED COULD BE ADEQUATELY PERFORMED WITH LOCAL ANESTHESIA.
P437	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO POOR ORAL HYGIENE.
P444	THIS LINE ITEM IS A DUPLICATE OF ANOTHER LINE ITEM ON THIS PRIOR AUTHORIZATION (PA) REQUEST. PLEASE CORRECT.
P446	THIS IS A DUPLICATE OF AN EXISTING PRIOR AUTHORIZATION (PA) REQUEST. YOU MAY CONTACT PROVIDER SERVICES IF YOU REQUIRE ASSISTANCE. DUPLICATE PA REQUEST
P448	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO DECAY HISTORY.
P449	QUESTIONABLE LONG TERM PROGNOSIS DUE TO GUM AND BONE DISEASE.
P456	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO APPARENT ROOT INFECTION.
P457	OUR RECORDS INDICATE THIS CLIENT HAS EXCEEDED ESTABLISHED PROGRAM LIMITATIONS. COLORADO MEDICAID WILL NOT AUTHORIZE NEW DENTURES.
P458	DOCUMENTATION PROVIDED INDICATES A LESS ELABORATE PROCEDURE SHOULD BE CONSIDERED.
P502	RENTAL ONLY ALLOWED; MEDICAL NEED FOR PURCHASE HAS NOT BEEN DOCUMENTED.
P503	PURCHASE ONLY ALLOWED; MEDICAL NEED FOR RENTAL HAS NOT BEEN DOCUMENTED.
P504	OCCUPATIONAL THERAPY GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P505	THE SERVICE REQUESTED IS INCLUDED IN THE NURSING HOME RATE STRUCTURE.
P511	THIS NATIONAL DRUG CODE IS ONLY BILLABLE AS PART OF A COMPOUND DRUG.
P515	THE PRESENCE OF A HANDICAPPING MALOCCLUSION OR HANDICAPPING DENTOFACIAL DEFORMITY IS NOT SUPPORTED BY THE DOCUMENTATION SUBMITTED.
P521	THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVERED BY COLORADO MEDICAID.
P522	GASTRO-INTESTINAL SURGERY FOR THE PURPOSE OF WEIGHT CONTROL IS COVERED ONLY AS A LIFE THREATENING PROCEDURE.
P523	THE TREATMENT REQUEST IS NOT CONSISTENT WITH THE CLIENT'S DIAGNOSIS.
P524	PSYCHOTHERAPY PROVIDED IN THE CLIENTS HOME IS NOT A COVERED BENEFIT OF COLORADO MEDICAID.
P525	THE INFORMATION PROVIDED IS NOT CONSISTENT WITH THE INTENSITY OF SERVICES REQUESTED.
P526	INTENSIVE MULTIPLE MODALITY TREATMENT IS NOT CONSISTENT WITH THE INFORMATION PROVIDED.
P527	MULTIPLE PROVIDERS OF TREATMENT ARE NOT INDICATED FOR THIS CLIENT.
P528	THE DURATION OF TREATMENT SESSIONS EXCEED CURRENT COLORADO MEDICAID GUIDELINES.

Denial Code	Long Description
P534	DOCUMENTATION OF POOR PHYSICAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P535	OTHER PHYSICAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P536	THE PHYSICAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P537	USE OF PHYSICAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P538	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF A PHYSICAL THERAPIST.
P539	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS AND LIVING ARRANGEMENT.
P540	GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P541	THE PROCEDURE(S) REQUESTED ARE NOT MEDICAL IN NATURE.
P542	DOCUMENTATION OF POOR OCCUPATIONAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P543	DOCUMENTATION OF POOR SPEECH THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P544	OTHER OCCUPATIONAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P546	THE OCCUPATIONAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P547	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF PHYSICAL THERAPY.
P548	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P549	ACTIVITIES TO PROMOTE DIVERSION OR GENERAL MOTIVATION ARE NONCOVERED COLORADO MEDICAID SERVICES.
P550	REVISIONS OF THE REQUEST IS NECESSITATED BY THE CLIENTS MINIMAL PROGRESS.
P551	RESTORATIVE NURSING INVOLVEMENT COULD BE INCREASED.
P552	CLIENTS DEMONSTRATED RESPONSE TO CURRENT THERAPY DOES NOT WARRANT THE INTENSE FREQUENCY REQUESTED.
P553	MAINTENANCE IS TWO TIMES PER WEEK OR LESS.
P554	THE SPEECH THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P555	USE OF OCCUPATIONAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P556	USE OF SPEECH THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P557	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF AN OCCUPATIONAL THERAPIST.
P558	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
P559	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P560	THE MATERIALS/ SERVICES REQUESTED ARE PRINCIPALLY COSMETIC IN NATURE.
P561	THE LENS FORMULA DOES NOT JUSTIFY REPLACEMENT.
P562	THE CHANGE IN THE LENS FORMULA DOES NOT WARRANT MULTIPLE REPLACEMENTS.
P563	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P564	LENSES ONLY ARE APPROVED; PLEASE DISPENSE A CONTRACTED FRAME. THE NON-CONTRACTED FRAME IS NOT MEDICALLY JUSTIFIED.
P565	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P566	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P567	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF OCCUPATIONAL THERAPY.
P568	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF SPEECH THERAPY.
P569	LEVEL, INTENSITY, OR EXTENT OF SERVICE(S) REQUESTED HAS BEEN MODIFIED CONSISTENT WITH MEDICAL NEED AS DEFINED IN THE PLAN OF CARE.

Denial Code	Long Description
P570	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P571	THE SERVICE ASKED FOR IS NOT COVERED BY COLORADO MEDICAID AS THESE TASKS CAN BE DONE BY NURSES OR ACTIVITY STAFF.
P572	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P573	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.
P574	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P575	MEDICAL NEED FOR EQUIPMENT/ SUPPLY REQUESTED IS NOT SUPPORTED BY DOCUMENTATION SUBMITTED.
P576	OTHER SPEECH THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P577	DOCUMENTATION SUBMITTED IDENTIFIES THAT THE CLIENT HAS FEWER THAN TWO POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P582	LESS EXPENSIVE ALTERNATIVE SERVICES ARE AVAILABLE FOR THIS CLIENT.
P634	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P711	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING PERIODONTAL SCALING AND ROOT PLANNING.
P712	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING GINGIVECTOMY.
P754	AN APPROVED SUBSTANCE ABUSE DAY TREATMENT PROGRAM CANNOT EXCEED A SIX WEEK PERIOD.
P761	THE CLIENT DOES NOT APPEAR TO BE ABLE OR WILLING TO ABSTAIN FROM ALCOHOL/DRUG USAGE WHILE IN TREATMENT. THEREFORE, SUBSTANCE ABUSE DAY TREATMENT SERVICES ARE NOT APPROVED.
P764	THIS CLIENT HAS COMPLETED INTENSIVE SUBSTANCE ABUSE TREATMENT WITHIN THE PAST 12 MONTHS. THE DOCUMENTATION PROVIDED IS NOT ADEQUATE TO JUSTIFY ADDITIONAL INTENSIVE TREATMENT AT THIS TIME.
P785	A LESS THAN SIX-WEEK HEALING PERIOD HAS BEEN SPECIFIED FOR THIS PRIOR AUTHORIZATION. THEREFORE IT IS NOT NECESSARY TO WAIT THE FULL SIX WEEKS AFTER EXTRACTIONS BEFORE TAKING DENTURE IMPRESSIONS.
P818	SIX-WEEK HEALING TIME IS REQUIRED BETWEEN EDENTULATION AND FINAL IMPRESSIONS. PAYMENT FOR DENTURES WILL BE DENIED OR RECOUPED IF HEALING PERIOD IS NOT OBSERVED.
P849	COLORADO MEDICAID HAS DETERMINED THERE WERE (ARE) SEVERAL HOME HEALTH AGENCIES WILLING TO PROVIDE MEDICALLY NECESSARY SKILLED NURSING SERVICES TO THIS CLIENT.
P864	THE DOCUMENTATION YOU HAVE SUBMITTED DOES NOT MEET THE REQUIREMENTS OF COLORADO MEDICAID.
P873	THE MEDICAL NECESSITY FOR THE HOURS REQUESTED IS NOT SUPPORTED BY THE INFORMATION SUBMITTED.
P874	THE DOCUMENTATION SUBMITTED INDICATES THE TASKS SPECIFIED CAN BE COMPLETED DURING THE VISITS APPROVED.
P878	THE DOCUMENTATION SUBMITTED DOES NOT INDICATE THAT MEDICALLY ORIENTED TASKS ARE MEDICALLY NECESSARY; THEREFORE PERSONAL CARE SERVICES HAVE BEEN APPROVED.
P880	THE QUANTITY OF SERVICES AUTHORIZED FOR THIS CLIENTS PERSONAL CARE HAS BEEN AMENDED BASED ON INFORMATION RECEIVED FROM ONE OR MORE OF THESE SOURCES: THE CLIENT, THEIR PHYSICIAN, AND/OR THE IN-HOME VISIT BY STAFF OF THE OIG (OFFICE OF INSPECTOR GENERAL).
P885	THE USE OF THIS DRUG FOR THE INTENDED PURPOSE IS NOT COVERED BY COLORADO MEDICAID, CONSISTENT WITH COLORADO ADMINISTRATIVE CODE AND FEDERAL LAW.
P924	THE MEDICAL RECORDS SUBMITTED WITH THE CURRENT REQUEST CONFLICT OR DISAGREE WITH OUR MEDICAL RECORDS ON THIS CLIENT.
P950	INDEPENDENT NURSES, PLEASE NOTE PAYABLE SERVICES MAY NOT EXCEED 12 HOURS/DAY OR 60 HOURS/WEEK.
P951	SERVICES CAN ONLY BE AUTHORIZED THROUGH ONE YEAR FROM THE PRESCRIPTION DATE.
P952	LEAD INSPECTION IS A COVERED COLORADO MEDICAID SERVICE WHEN THE CHILD HAS BEEN SHOWN TO HAVE LEAD POISONING (E.G., CHILD HAS A BLOOD LEAD LEVEL > 19 UG/DL OR TWO CONSECUTIVE BLOOD LEAD LEVELS OF 15-19 UG/DL DONE AT LEAST 90 DAYS APART). THE INSPECTION MUS

Denial Code	Long Description
P953	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P954	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P956	THE REQUEST CAN ONLY BE BACKDATED A MAXIMUM OF 14 DAYS FROM FIRST DATE RECEIVED BY COLORADO MEDICAID.
P957	COMPLETE PERIODONTAL CHARTING AT TIME OF SERVICE, AND SUBMIT CHARTING, COPY OF OPERATIVE REPORT, TOGETHER WITH A COPY OF THE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF), F-11035, TO PA UNIT ATTENTION DENTAL CONTSULTANT.
P958	NOTE THAT CODE D4341 HAS BEEN CHANGED. REFER TO THE DECISION NOTICE FOR AUTHORIZED QUANTITY.
P960	YOUR PA HAS BEEN APPROVED FOR 90 DAYS. THE 90 DAY APPROVAL DOES NOT IMPLY THE PA REQUEST MEETS PRIOR AUTHORIZATION CRITERIA. AFTER ADDITIONAL INFORMATION IS AVAILABLE IN INTERCHANGE, COLORADO MEDICAID WILL CREATE AN AMENDMENT REQUEST TO EXTEND THE PA FOR
P961	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P962	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
PA10	THE REQUESTED END DATE IS INVALID.
PA12	PLEASE FURNISH A WRITTEN DESCRIPTION OF THE CLIENTS DIAGNOSIS.
PA13	PROVIDE DIAGNOSES WITH DATES OF ONSET.
PA14	IDENTIFY PROBLEMS TO BE TREATED.
PA15	THE AUDIOLOGISTS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1), F-11020, AND PRIOR AUTHORIZATION REQUEST/HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2), F-11021.
PA16	THE PHYSICIANS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION/PHYSICIAN OTOLOGICAL REPORT (PA/POR), F-11019.
PA17	SUBMIT BRIEF HISTORY WITH REFERRAL INFORMATION, LIVING SITUATION, FUNCTIONAL STATUS, AND OTHER PERTINENT INFORMATION. WHAT CHANGE OF STATUS RESULTED IN REFERRAL AT THIS TIME?
PA18	PLEASE FURNISH THE CLIENTS HEIGHT AND WEIGHT.
PA19	PLEASE SUBMIT CLINICAL INFORMATION SUFFICIENT TO VERIFY THE NEED FOR THE REQUESTED SERVICE(S).
PA20	PLEASE RESUBMIT WITH COMPLETE PERIODONTAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PA21	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL EDUCATIONAL PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA22	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL PROGRAM PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA23	REFER TO THE DURABLE MEDICAL EQUIPMENT INDEX FOR APPROPRIATE CODE AND DESCRIPTION. DO NOT USE AN "UNLISTED" CODE.
PA24	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUALIZED FAMILY SERVICE PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA25	INFORMATION ON THE REQUEST FORM IS ILLEGIBLE, AND THE REQUEST CANNOT BE PROCESSED.
PA26	RE-EVALUATE YOUR GOALS. EMPHASIS SHOULD BE ON FUNCTIONAL SELF-CARE. GOALS MUST BE RELATED TO FUNCTIONAL OUTCOME.
PA27	PLEASE CLARIFY THE NUMBER OF HOURS PER WEEK REQUESTED.
PA28	PLEASE CLARIFY THE NUMBER OF HOURS PER DAY REQUESTED.
PA29	PLEASE CLARIFY THE NUMBER OF VISITS PER DAY REQUESTED.
PA30	ATTACH SUPPORTIVE DOCUMENTATION; HOME EXERCISE PROGRAM AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA31	THE DIAGNOSIS CODE INDICATED ON THE REQUEST DOES NOT CORRESPOND TO THE DIAGNOSIS CODE DESCRIPTION.

Denial Code	Long Description
PA32	PLEASE SUBMIT ADDITIONAL INFORMATION SUFFICIENT TO VERIFY APPROPRIATENESS AND NEED FOR TRANSPLANT.
PA33	PLEASE SUBMIT THE INITIAL AND PROGRESSIVE OBJECTIVE FINDINGS.
PA34	ATTACH SUPPORTIVE DOCUMENTATION, FACILITY PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA35	PLEASE SUBMIT THE CLIENTS ORIGINAL COMPLAINTS AND EXAMINATION FINDINGS.
PA36	ATTACH SUPPORTIVE DOCUMENTATION, IN-HOME AUTISM PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA37	PLEASE SUBMIT YOUR TREATMENT PLAN FOR THIS CLIENT.
PA38	ATTACH SUPPORTIVE DOCUMENTATION AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA39	INITIAL EVALUATIONS MUST BE PERFORMED BY AN OCCUPATIONAL THERAPIST REGISTERED (OTR), PER AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA) STANDARDS.
PA41	IDENTIFY THE PLACE OF SERVICE AND ITS EFFECT ON SUPPORTING THE DESIRED TREATMENT OUTCOME.
PA42	PLEASE INDICATE THE HOURS OF USE OF OXYGEN PER 24-HOUR PERIOD.
PA43	PROVIDE BASELINE DOCUMENTATION FOR THIS CLIENTS LIMITATIONS USING UNITS OF MEASUREMENT THAT ARE APPLIED CONSISTENTLY WHEN REPORTING STATUS.
PA44	IDENTIFY FUNCTIONAL LIMITATIONS AS THEY ARE RELATED TO IDENTIFIED CONDITIONS.
PA46	CORRELATE PLAN OF CARE TO REQUESTED PROCEDURE CODES.
PA47	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE FREQUENCY/DURATION REQUESTED.
PA48	PLEASE PROVIDE THE NAME AND CREDENTIALS OF THE RENDERING PROVIDER.
PA50	COLORADO MEDICAID RECORDS INDICATE THE CLIENT OWNS A WHEELCHAIR. DOCUMENT THE REASON AND NEED FOR REPLACEMENT AND COST TO REPAIR CURRENT WHEELCHAIR.
PA51	PLEASE DISTINGUISH PRIMARY AND SUPPORTIVE MODALITIES.
PA52	PLEASE SUBMIT A PROGRESS REPORT.
PA53	MULTIPLE FAMILY CLIENTS TREATMENT BY THE SAME PROVIDER REQUIRES FURTHER INFORMATION DOCUMENTING COORDINATION OF TREATMENT PLAN.
PA54	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE MINUTES REQUESTED.
PA55	MEDICAL NECESSITY OF TREATMENT REQUIRES ADDITIONAL DOCUMENTATION.
PA56	GIVEN AGE, DIAGNOSES, CURRENT LEVEL OF FUNCTION, PAST RESPONSE TO TREATMENT, AND LIVING SITUATION, EXPAND ON POTENTIAL FOR SIGNIFICANT FUNCTIONAL PROGRESS WITHIN THE NEXT SIX MONTHS. EMPHASIZE WHY PROGRESS IS EXPECTED WITH SERVICES AT THIS TIME.
PA57	SUBMIT THE INITIAL FINDINGS. INCLUDE A COMPREHENSIVE EVALUATION.
PA58	SUBMIT PROGRESSIVE, OBJECTIVE FINDINGS. INCLUDE A PERTINENT RE-EVALUATION.
PA59	PLEASE SUPPLY INFORMATION REGARDING THE CLIENTS MEDICATION REQUIREMENTS, IF ANY.
PA60	PLEASE SPECIFY IF THE CLIENT IS IN AN EDUCATIONAL SETTING.
PA61	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA62	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
PA63	THE SKILLS OF A THERAPIST ARE PURPOSEFUL AND SKILLED INTERVENTIONS REQUIRED TO CONTINUALLY DESIGN, IMPLEMENT, REASSESS, MODIFY/GRADE, AND/OR DISCONTINUE A PLAN OF CARE IN A TIMELY MANNER, BASED ON THE COMPLEXITY OF THE CLIENTS MEDICAL CONDITION AND/OR CO
PA64	PLEASE SUBMIT A THERAPY PLAN OF CARE, INCLUDING A CURRENT, DATED EVALUATION.
PA65	A PLAN OF CARE SIGNED AND DATED BY THE PHYSICIAN IS REQUIRED.
PA66	THE SKILLS OF A THERAPIST ARE REQUIRED WHEN ONLY THE THERAPIST CAN SAFELY AND EFFECTIVELY DELIVER THE THERAPEUTIC PROCEDURES BECAUSE OF THEIR UNIQUE KNOWLEDGE, TRAINING, AND EXPERTISE. DESCRIBE THE REASON THAT SOMEONE OTHER THAN A THERAPIST CANNOT SAFELY
PA67	PLEASE SPECIFY IF THE CLIENTS WORK SITE DEMANDS GOOD BINAURAL HEARING.
PA68	DESCRIBE THE REASON, BASED ON THE CLIENTS COGNITIVE, PHYSICAL, COMMUNICATION, OR RESOURCE STATUS, THAT A HOME PROGRAM, EQUIPMENT, OR ENVIRONMENTAL ADAPTATIONS ALONE CANNOT MEET CLIENTS NEEDS.

Denial Code	Long Description
PA69	PLEASE SPECIFY IF THE CLIENT HAS AN ACCOMPANYING DISABILITY THAT ADDS TO THE HEARING PROBLEM.
PA70	DISTINGUISH REQUESTED PROCEDURES AND GOALS FROM OTHER SERVICES THIS CLIENT RECEIVES. THEY MAY NOT BE DUPLICATIVE.
PA71	PLEASE INDICATE THE NUMBER OF DAYS REQUESTED.
PA73	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA74	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA75	PLEASE DOCUMENT CARRYOVER OF THE THERAPY PROGRAM TO NURSING.
PA76	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA79	PROVIDE EVIDENCE OF SIGNIFICANT FUNCTIONAL PROGRESS IN LAST SIX MONTHS.
PA84	THE GRANT DATE OF THIS REQUEST CANNOT BE PRIOR TO THE SIGNATURE DATE OF THE PRESCRIBING PHYSICIAN.
PA86	PROVIDE EVIDENCE OF SKILLS GAINED IN THERAPY CARRYING OVER TO OTHER SETTINGS WITHIN SIX MONTHS.
PA87	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE NUMBER OF SESSIONS REQUESTED.
PA88	THE REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL SCOPE OF PRACTICE.
PA89	PRIOR AUTHORIZATION IS NOT REQUIRED UNTIL LIMITATION OF SERVICE HAS BEEN REACHED.
PA91	PLEASE SUBMIT REQUIRED X-RAYS.
PA92	PLEASE PROVIDE AN EXPLANATION FOR THE MATERIAL SUBMITTED WITH THE REQUEST.
PA95	PLEASE DESCRIBE HOW THE PROVISION OF THIS SERVICE WOULD PREVENT INSTITUTIONALIZATION OF THE CLIENT.
PA96	COULD THE EXISTING DENTURE(S) BE RELINED OR REBASED? IF NOT, PLEASE EXPLAIN WHY NOT.
PA97	REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL STANDARDS OF PRACTICE.
PA98	PLEASE INDICATE IF THE CLIENT IS CURRENTLY BEING TUBE FED.
PB02	PLEASE PROVIDE THE REQUIRED DATED SIGNATURES ON THE ATTACHMENTS.
PB03	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING THE LOSS/DESTRUCTION/THEFT OF THE HEARING AID.
PB04	DESCRIBE THE CLIENTS ABILITY TO STAND OR AMBULATE SUFFICIENTLY TO ACCOMPLISH SELF-CARE ACTIVITIES.
PB07	PLEASE SUBMIT AN ORTHODONTIC STUDY MODEL OR DIAGNOSTIC CASTS.
PB09	PLEASE PROVIDE A PHOTOGRAPH OF THE INVOLVED AREA(S).
PB10	PLEASE PROVIDE AN ESTIMATION (IN GRAMS) OF THE TOTAL AMOUNT OF TISSUE TO BE RESECTED.
PB11	PLEASE SUBMIT THE PLAN OF CARE FOR CO-TREATMENT.
PB12	FURNISH A DETAILED DESCRIPTION FOR THE PROCEDURE CODE REQUESTED.
PB13	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB15	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB18	PLEASE COMPLETE THE ATTACHED OUT-OF-STATE PROVIDER DATA SHEET, F-11001, AND RESUBMIT.
PB20	A SIGNED AND DATED PRESCRIPTION IS REQUIRED WITHIN THREE MONTHS OF RECEIPT BY COLORADO MEDICAID FOR INITIAL REQUESTS AND WITHIN 12 MONTHS OF RECEIPT BY COLORADO MEDICAID FOR SUBSEQUENT REQUESTS.
PB21	PLEASE COMPLETE THE APPROPRIATE PRIOR AUTHORIZATION ATTACHMENT. CONTACT PROVIDER SERVICES OR THE PRIOR AUTHORIZATION UNIT FOR ASSISTANCE.
PB23	PHYSICAL THERAPY ASSISTANT NOTES AND ALL FORMS SUBMITTED MUST BE COSIGNED BY A REGISTERED PHYSICAL THERAPIST.
PB31	ARE YOU REQUESTING A COMPLETE APPLIANCE, OR REPLACEMENT PARTS?
PB32	THE PROCEDURE CODE INDICATED ON THE REQUEST DOES NOT MATCH THE DESCRIPTION OF SERVICE; PLEASE CORRECT AND RESUBMIT.
PB35	THE SERVICE REQUESTED DOES NOT REQUIRE PRIOR AUTHORIZATION.
PB41	PLEASE FURNISH A CURRENT MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT, F-11090 (DATED WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID).

Denial Code	Long Description
PB45	THE CERTIFICATION PERIOD ON THE PLAN OF CARE (POC) DOES NOT COVER THE REQUESTED GRANT/START DATE. PLEASE RESUBMIT YOUR REQUEST WITH A NEW POC.
PB49	A CERTIFIED OCCUPATIONAL THERAPY ASSISTANTS NOTES MUST BE COSIGNED BY AN OCCUPATIONAL THERAPIST REGISTERED.
PB51	ADDITIONAL INFORMATION IS REQUIRED ON PRIOR AUTHORIZATION TO ENABLE PRICING.
PB54	REQUESTED SERVICES DO NOT MATCH SERVICES ON THE PHYSICIANS ORDERS.
PB59	PLEASE PROVIDE AN INDIVIDUAL EDUCATIONAL PLAN (IEP), WHICH HAS BEEN SIGNED BY THE PROVIDER NO EARLIER THAN NINE MONTHS PRIOR TO RECEIPT AT COLORADO MEDICAID; OTHERWISE, DOCUMENT WHY NO IEP EXISTS.
PB65	PLEASE FURNISH THE ANTICIPATED TOTAL CHARGES FOR THIS REQUEST.
PB66	A PHOTOCOPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED; THE DATE MUST BE WITHIN SIX MONTHS OF RECEIPT BY COLORADO MEDICAID.
PB67	THE PRESCRIPTION DATE MUST INCLUDE MONTH, DAY, AND YEAR.
PB68	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID.
PB73	THE SERVICES IDENTIFIED ON THE PLAN OF CARE DO NOT APPEAR APPROPRIATE FOR THE PROCEDURE CODE(S) REQUESTED ON THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018.
PB74	THE CLIENT/PROVIDER DOES NOT HAVE RETROACTIVE ENROLLMENT.
PB75	THE REQUESTED START DATE IS MORE THAN 14 DAYS BEFORE OR 62 DAYS AFTER RECEIPT.
PB82	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
PB83	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A HOME HEALTH AIDE. PLEASE RESUBMIT AS A PERSONAL CARE WORKER OR PROVIDE ADDITIONAL DOCUMENTATION.
PB86	THE SERVICES REQUESTED ARE NOT BEING PROVIDED IN THE CLIENTS RESIDENCE. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL.
PB87	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A NURSE. PLEASE RESUBMIT AS A HOME HEALTH AIDE OR PROVIDE ADDITIONAL DOCUMENTATION.
PB92	PLEASE FURNISH THE CLIENTS COMPLETE ADDRESS.
PB94	IF THE CLIENT IS A RESIDENT OF A NURSING HOME, SUPPLY THE COMPLETE NAME AND ADDRESS OF THE NURSING HOME.
PB99	THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018, MUST BE SIGNED AND DATED.
PC01	PLEASE SUPPLY THE RENDERING PROVIDERS PROVIDER NUMBER.
PC03	THE DRUG ENFORCEMENT ADMINISTRATION NUMBER IS MISSING OR INVALID.
PC06	PLEASE DESCRIBE YOUR PROGRAM; INCLUDE ENTRY DATE, TERMINATION DATE, HOURS PER WEEK, AND NUMBER OF WEEKS OF PRIMARY INTENSIVE SERVICE REQUESTED.
PC07	PLEASE DESCRIBE YOUR "AFTERCARE/FOLLOW-UP" PLANS FOR THIS CLIENT.
PC08	PLEASE SUPPLY DOCUMENTATION OF PREVIOUS SUBSTANCE ABUSE SERVICES WITH DATE(S) AND OUTCOME.
PC09	PLEASE DESCRIBE IN DETAIL THE TREATMENT OBJECTIVES/GOALS FOR THIS CLIENT.
PC10	PLEASE DESCRIBE THE FAMILY SITUATION/DYNAMICS. EXPLAIN HOW THE FAMILY WILL BE INCORPORATED INTO THE CLIENTS PLAN OF CARE.
PC12	PLEASE EXPLAIN IF YOUR SERVICE ENCOURAGES THE CLIENT TO ATTEND SELF-HELP GROUPS.
PC13	PLEASE SUPPLY A SPECIFIC SCHEDULE OF ACTIVITIES, INCLUDING DAY, TIME OF DAY, LENGTH OF SESSION, AND SERVICE TO BE RENDERED DURING THAT TIME.
PC15	PLEASE FURNISH DIAGNOSTIC RATIONALE.
PC17	PLEASE DOCUMENT IF THE CLIENT EVER RECEIVED SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT.
PC19	PLEASE FURNISH MORE EXTENSIVE AND IN-DEPTH HISTORICAL AND PSYCHOSOCIAL DATA.
PC20	PLEASE SUPPLY THE DATE THE CLIENT BECAME TOTALLY ENDENTULOUS.
PC23	PLEASE SUBMIT A PHYSICIANS STATEMENT REGARDING THE MEDICAL NECESSITY OF DENTURES FOR THIS CLIENT. THE PHYSICIANS STATEMENT MUST DOCUMENT THE MEDICAL NEED FOR DENTURES.
PC24	THE SERVICE REQUESTED WAS PREVIOUSLY AUTHORIZED. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT INDICATING THIS FACT IS REQUIRED.
PC25	PLEASE SUPPLY SUFFICIENT MITIGATING CIRCUMSTANCES TO WARRANT THE CONSTRUCTION OF NEW DENTURES(S).

Denial Code	Long Description
PC26	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
PC28	PLEASE SUBMIT A PHYSICIANS STATEMENT INDICATING DENTURES ARE NECESSARY FOR THIS NURSING HOME CLIENT.
PC29	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING LOSS OR DESTRUCTION OF DENTURE(S). INCLUDE SIGNED STATEMENT FROM CLIENT OR FACILITY DIRECTOR REGARDING HOW, WHEN AND WHERE LOST.
PC30	PLEASE PROVIDE COMPLETE INTRAORAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PC31	PLEASE DESCRIBE ANY RELATED DEFORMITIES OF THE FEET.
PC34	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD WITH REQUESTED DME ITEM(S) AND DOCUMENT IF THE CLIENT CAN USE SAFELY AND INDEPENDENTLY.
PC35	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD AND DESCRIBE THE RESULTS AND EFFECTIVENESS OF THE SERVICE REQUESTED.
PC39	PLEASE INDICATE LITER FLOW PER MINUTE, HOURS OF USE PER 24 HOUR PERIOD, AND THE EXPECTED DURATION OF NEED.
PC40	THE ITEM DOES NOT REQUIRE PRIOR AUTHORIZATION UNTIL THE LIFE EXPECTANCY HAS BEEN REACHED.
PC41	PLEASE SUPPLY INFORMATION INDICATING THE NECESSITY OF POSITIONING THE CLIENT'S BODY IN MULTIPLE POSITIONS.
PC42	PLEASE INDICATE IF THE BED HEIGHT MUST BE CHANGED TO ALLOW FOR SAFE TRANSFER OR ADEQUATE BED CARE.
PC43	SUPPLY A PHYSICIANS STATEMENT INDICATING TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR UNIT HAS REDUCED PAIN, IMPROVED/INCREASED THE CLIENTS ACTIVITY LEVEL, AND/OR REDUCED CLIENTS USE OF PAIN MEDICATION.
PC44	A CURRENT AUTHORIZATION FOR THIS SERVICE IS ON FILE FOR ANOTHER PROVIDER. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT OF THAT FACT IS REQUIRED BY THE CLIENT OF FIRST PROVIDER.
PC59	DOCUMENT DECLINE OR PROGRESS IN SPECIFIC, MEASURABLE, OBJECTIVE TERMS.
PC60	DOCUMENT IF CLIENT HAS DEMONSTRATED A GOOD APPOINTMENT COMPLIANCE RECORD.
PC61	THE PHYSICIANS SIGNATURE DATE MUST NOT EXCEED 90 DAYS FROM THE DATE OF RECEIPT BY COLORADO MEDICAID.
PC62	REQUESTS FOR A CONTINUATION OF THERAPY SHOULD NOT BE SUBMITTED MORE THAN FOUR WEEKS PRIOR TO THE EXPIRATION DATE OF THE CURRENT AUTHORIZATION.
PC63	PLEASE FURNISH THE STYLE AND MANUFACTURER OF THE FRAME.
PC64	PLEASE FURNISH THE CLIENTS LENS FORMULA.
PC66	ALL REQUESTS FOR TINTS REQUIRE DOCUMENTATION OF THE VISUAL OR MEDICAL CONDITION RELATED TO PHOTOPHOBIA.
PC67	PLEASE DOCUMENT THE REASON AND JUSTIFICATION FOR REPLACEMENT BEYOND THE FIRST LENS/FRAME.
PC68	DOCUMENT IF ALL REMAINING MAXILLARY AND/OR MANDIBULAR TEETH ARE DECAY-FREE, PROPERLY RESTORED, AND PERIODONTICALLY SOUND.
PC72	SUPPLY MORE DETAIL REGARDING PROGRESS (ATTACHMENT OF GOALS, ETC.). CORRELATE PROGRESS TO PREVIOUS GOALS AND IDENTIFIED LIMITATIONS.
PC77	PLEASE SUBMIT A PLAN OF CARE DESCRIBING THE SERVICES THAT WOULD BE PROVIDED.
PC78	PLEASE DOCUMENT SPECIFIC, MEASURABLE GOALS.
PC82	THE PRIOR AUTHORIZATION (PA) SYSTEM CAN PROCESS ONLY 26 DETAILS PER PA REQUEST. PLEASE RESUBMIT YOUR REQUEST WITH NO MORE THAN 26 DETAILS.
PC83	PLEASE SUPPLY A PHYSICIANS PRESCRIPTION DATED WITHIN ONE MONTH OF REQUESTED SUBSTANCE ABUSE DAY TREATMENT.
PC84	PLEASE PROVIDE INFORMATION INDICATING THIS CLIENT IS APPROPRIATELY DETOXIFIED FROM ALCOHOL AND/OR OTHER DRUGS.
PC85	PLEASE PROVIDE INFORMATION TO INDICATE THE CLIENTS ABILITY TO ABSTAIN FROM ALCOHOL OR DRUGS WHILE IN THE SUBSTANCE ABUSE DAY TREATMENT PROGRAM.
PC86	PLEASE INDICATE IF THIS CLIENT IS WILLING TO PARTICIPATE IN AFTERCARE OR CONTINUING CARE SERVICES.

Denial Code	Long Description
PC87	PROVIDE MORE INFORMATION ON TREATMENT HISTORY; INCLUDE SERVICE PROVIDED, DATES, AND OUTCOME. PROVIDE DETAIL OF PREVIOUS TREATMENT.
PC88	PLEASE PROVIDE MORE RATIONALE FOR THE APPROPRIATENESS AND MEDICAL NECESSITY OF SUBSTANCE ABUSE DAY TREATMENT.
PC89	PROVIDE A TREATMENT PLAN THAT CONTAINS MEASURABLE GOALS AND OBJECTIVES CORRESPONDING TO THE IDENTIFIED DEFICIT.
PC91	PLEASE PROVIDE MORE INFORMATION ON FAMILY INVOLVEMENT TREATMENT.
PC92	PLEASE PROVIDE MORE HISTORY AND EXPLANATION ABOUT THE ISSUE OF ABSTINENCE FOR THIS CLIENT.
PC94	PLEASE PROVIDE THE ANTICIPATED BEGINNING DATE AND/OR THE ESTIMATED SUBSTANCE ABUSE DAY TREATMENT DISCHARGE DATE.
PC95	PLEASE SUPPLY JUSTIFICATION FOR BEGINNING CLIENT IN SERVICE PRIOR TO AUTHORIZATION BEING OBTAINED.
PC96	THE INITIAL THREE HOURS OF SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IN A CALENDAR YEAR DO NOT REQUIRE PRIOR AUTHORIZATION.
PC97	REIMBURSEMENT FOR INITIAL SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IS LIMITED TO THREE HOURS IN A CALENDAR YEAR AND DOES NOT REQUIRE PRIOR AUTHORIZATION.
PC98	THIS DRUG IS CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE BILL USING THE APPROPRIATE NATIONAL DRUG CODE (NDC) OR SUBMIT A COMPLETED DRUG ADDITION REQUEST FORM IF THE NDC IS NOT LISTED IN THE DRUG INDEX.
PC99	THIS DRUG IS NOT CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL, CURRENT ADMINISTRATIVE RULE, OR COLORADO DRUG INDEX FOR COVERAGE LIMITATIONS.
PD01	DOCUMENT THAT CLIENT HAS ACHIEVED GOOD ORAL HYGIENE, PERIODONTAL CASE TYPE 1 OR 2, AND IS MOTIVATED TO MAINTAIN SAME.
PD03	PLEASE PROVIDE AN ARTERIAL BLOOD GAS READING OR PULSE OXIMETRY RESULTS DONE ON ROOM AIR SIGNED AND DATED BY A MEDICAL DOCTOR. THIS SHOULD BE DONE WITHIN 60 DAYS OF REQUESTED SERVICE.
PD04	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 30 DAYS OF RECEIPT BY COLORADO MEDICAID.
PD07	SUBMIT A PHOTOCOPY OF A VALID PRESCRIPTION, ISSUED WITHIN THE PAST YEAR, OR COMPLETE SECTION B OF THE PRIOR AUTHORIZATION/DRUG ATTACHMENT (PA/DGA), F-11049.
PD10	BRAND MEDICALLY NECESSARY MUST BE IN THE PRESCRIBERS OWN HANDWRITING AND WRITTEN DIRECTLY ON THE PRESCRIPTION OR A SEPARATE ORDER ATTACHED TO THE ORIGINAL PRESCRIPTION.
PD12	COMPLETE DENTURES, PARTIAL DENTURES, DENTURE RELINES, AND FIXED PROSTHODONTIC SERVICES ARE NOT COVERED SERVICES FOR ADULTS FOR DATES OF SERVICE ON AND AFTER OCTOBER 1, 1995.
PD22	PLEASE COMPLETE ALL REQUIRED ELEMENTS ON THE PERSONAL CARE SCREENING TOOL (PCST), F-11133.
PD24	THIS PRIOR AUTHORIZATION REQUEST IS UNABLE TO BE PROCESSED. PLEASE RESUBMIT WITH ADDITIONAL REQUIRED FORMS, INCLUDING THE ENTIRE PERSONAL CARE SCREENING TOOL (PCST), F-11133; PERSONAL CARE ADDENDUM, F-11136; AND SUPPORTING DOCUMENTATION, AS DIRECTED.
PD25	THERE IS A PERSONAL CARE SCREENING TOOL (PCST), F-11133, COMPLETED BY ANOTHER AGENCY. CONTACT THE AGENCY TO TRANSFER SCREEN.
PD26	THERE IS A LIMITED TERM CARE FUNCTIONAL SCREEN (LTC-FS) COMPLETED BY ANOTHER AGENCY. THE PERSONAL CARE SCREENING TOOL (PCST), F-11133, INFORMATION IS IN CONFLICT WITH LTC-FS.
PD27	ONLY ONE LEVEL OF FUNCTION MAY BE SELECTED FOR ALL ELEMENTS EXCEPT TOILETING. COLORADO MEDICAID IS UNABLE TO PROCESS THE PRIOR AUTHORIZATION REQUEST.
PD28	NO UNITS MAY BE REQUESTED USING THIS PRIOR AUTHORIZATION PROCESS. PLEASE SUBMIT WITH THE APPROPRIATE ATTACHMENTS FOR REQUESTING SPECIFIC PERSONAL CARE WORKER UNITS.
PD29	CLIENT IS NOT ELIGIBLE FOR THE REQUESTED SERVICE(S) AS OF THE REQUESTED START DATE.
PD30	NO TRAVEL TIME MAY BE AUTHORIZED WHEN NO PERSONAL CARE WORKER SERVICE IS AUTHORIZED.
PD32	PROVIDER NOT CERTIFIED TO RENDER THE SERVICE(S) REQUESTED.
PD34	BASED ON THE DOCUMENTATION SUBMITTED, THIS REQUEST CAN NOT BE PRIOR AUTHORIZED. REFER TO THE PA MESSAGES FROM THE CONSULTANT FOR COMPLETE EXPLANATION.
PD98	PLEASE DOCUMENT HOW AND WHEN EACH PREVIOUSLY AUTHORIZED PRO RE NATA VISIT WAS USED.

Trapeze, Traction, Fracture Frame

Denial Code	Long Description
0201	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
0233	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0235	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0237	CLIENT IDENTIFICATION NUMBER DOES NOT MATCH CLIENTS FIRST NAME.
0238	THE CLIENT IDENTIFICATION NUMBER DOES NOT MATCH THE CLIENTS LAST NAME.
0242	SECONDARY DIAGNOSIS CODE IS INVALID.
0248	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0249	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0251	PROCEDURE CODE MODIFIER IN FIRST POSITION IS INVALID.
0252	THE PROCEDURE CODE MODIFIER IN SECOND POSITION IS INVALID FOR REQUESTED START DATE OR DATE OF RECEIPT.
0253	THE PROCEDURE CODE MODIFIER IN THIRD POSITION IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
0258	THE PRIMARY DIAGNOSIS CODE IS REQUIRED.
0272	THE PRIMARY DIAGNSOSIS CODE IS INVALID.
0400	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0853	HCPCS - ANNUAL UPDATE
0885	NEVER EVENTS MODIFIERS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
0886	NEVER EVENTS DIAGNOSIS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
1000	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
1002	RENDERING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1003	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1007	RENDERING PROVIDER ID IS NOT ON FILE.
1047	THE RENDERING PROVIDERS CERTIFICATION HAS BEEN CANCELLED.
1048	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1801	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
1804	A CERTIFIED SUBSTANCE ABUSE DAY TREATMENT PROVIDER MUST SUBMIT A SUBSTANCE ABUSE DAY TREATMENT PROCEDURE CODE.
1806	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
1808	THE BILLING PROVIDER DOES NOT HAVE THE REQUIRED CERTIFICATION ADDENDUM ON FILE.
1900	THE BILLING PROVIDERS TAXONOMY CODE IS INVALID.
1901	THE RENDERING PROVIDERS TAXONOMY CODE IS INVALID.
1927	A NATIONAL PROVIDER IDENTIFIER IS REQUIRED FOR THE BILLING PROVIDER.
1934	A NATIONAL PROVIDER INDENTIFIER IS REQUIRED FOR THE RENDERING PROVIDER.
1936	THE BILLING PROVIDER NUMBER IS INVALID.
1937	THE RENDERING PROVIDER NUMBER IS INVALID.
1960	INTERNAL PROCESSING IS REQUIRED.
1963	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.
1964	THE BILLING PROVIDER INDICATED IS NOT ALLOWABLE AS A BILLING PROVIDER.
1965	RENDERING PROVIDER NUMBER IS MISSING/INVALID FOR THIS PROCEDURE PROVIDER.
1974	PRESCRIBING/REFERRING/ORDERING PROVIDER INDICATED IS NOT CERTIFIED AS A PRESCRIBING/REFERRING/ORDERING PROVIDER.
1975	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
1976	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
2001	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.

Denial Code	Long Description
2003	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2017	THE CLIENT IS ENROLLED IN A MEDICAID OR OTHER MANAGED CARE PROGRAM.
2037	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2603	CLIENT LOCKED-IN TO A PROVIDER OR ENROLLED IN A HOSPICE. CONTACT CLIENTS HOSPICE FOR PAYMENT OF SERVICES OR RESUBMIT WITH DOCUMENTATION OF UNRELATED NATURE OF CARE.
3324	THE MODIFIER HAS BEEN DISCONTINUED BY THE CENTERS OF MEDICARE AND MEDICAID SERVICES OR THE AMERICAN MEDICAL ASSOCIATION FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
3337	THE PROCEDURE CODE HAS BEEN TERMINATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AMERICAN MEDICAL ASSOCIATION, OR AMERICAN DENTAL ASSOCIATION FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT. RESUBMIT WITH VALID A PROCEDURE CODE.
3339	THE PROCEDURE BILLED IS NOT PAYABLE ACCORDING TO DEFICIT REDUCTION ACT (DEFRA) GUIDELINES.
3351	THE PROCEDURE IS NOT COVERED FOR CLIENTS WITH A NURSING HOME AUTHORIZATION ON THE REQUESTED START DATE OR DATE OF RECEIPT.
3353	THE PROCEDURE IS NOT A COVERED SERVICE FOR HOME AND COMMUNITY-BASED WAIVER CLIENTS.
4021	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4027	THE DIAGNOSIS CODE IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
4031	THE PROCEDURE SUBMITTED IS NOT APPROPRIATE FOR CLIENTS GENDER.
4032	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4034	THE PROCEDURE CODE HAS AN AGE RESTRICTION.
4036	THE PLACE OF SERVICE CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4040	THE PRIMARY DIAGNOSIS CODE IS NOT ON FILE.
4041	THE SECONDARY DIAGNOSIS IS NOT ON FILE.
4046	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4127	INTERNAL PROCESSING IS REQUIRED.
4131	INTERNAL PROCESSING IS REQUIRED.
4141	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4149	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4150	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4236	ETIOLOGY DIAGNOSIS CODE(S) (E-CODES) ARE INVALID AS THE PRIMARY DIAGNOSIS.
4244	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4245	THE FOURTH POSITION MODIFIER IS INVALID FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT.
4256	THE PROCEDURE CODE AND MODIFIER COMBINATION IS NOT PAYABLE FOR THE CLIENTS BENEFIT PLAN.
4257	THE MODIFIERS SUBMITTED ARE EITHER INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT OR THE MODIFIERS ARE MISSING.
4311	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4315	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4316	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4371	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4372	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4711	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR CLIENTS AGE.
4714	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS AGE.
4731	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS DIAGNOSIS.
4742	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4743	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4744	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4745	DIAGNOSIS AND/OR PROCEDURE AND/OR PLACE OF SERVICE (POS) CODE IS NOT COVERED FOR EXPRESS ENROLLMENT CLIENTS.
4746	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4801	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4802	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.

Denial Code	Long Description
4821	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
4871	PLEASE REFER TO PA MESSAGES FOR RETURN INFORMATION.
4963	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS GENDER.
4990	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
7500	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
7509	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
P001	THE BILLING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THE SERVICES.
P002	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P003	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P005	THE PRIOR AUTHORIZATION CAN NOT BE END DATED. THE PRIOR AUTHORIZATION STATUS IS NOT APPROVED OR APPROVED WITH REVISIONS.
P006	PLEASE FURNISH THE PROCEDURE CODE AND CORRESPONDING DESCRIPTION.
P008	THE BILLING PROVIDER NUMBER IS INVALID.
P009	THE BILLING PROVIDER NUMBER IS INVALID.
P010	THE REQUESTED END DATE IS INVALID.
P011	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P012	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P013	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P014	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P015	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P016	THE REQUESTED START DATE IS MISSING OR INVALID.
P019	THE REQUESTED START DATE IS MISSING OR INVALID.
P020	THE RENDERING PROVIDER NUMBER IS INVALID.
P021	THE RENDERING PROVIDER NUMBER IS INVALID.
P022	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P023	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P024	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P026	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P027	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P030	FIRST MODIFIER IS INVALID.
P031	FIRST MODIFIER IS INVALID.
P032	SECOND MODIFIER IS INVALID.
P033	SECOND MODIFIER IS INVALID.
P034	THIRD MODIFIER IS INVALID.
P035	THIRD MODIFIER IS INVALID.
P036	FOURTH MODIFIER IS INVALID.
P037	FOURTH MODIFIER IS INVALID.
P038	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P039	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P040	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P041	CLIENTS FIRST NAME IS MISSING.
P042	CLIENTS LAST NAME IS MISSING.
P043	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P044	BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES REQUESTED.
P045	FIRST MODIFIER IS INVALID.

Denial Code	Long Description
P046	SECOND MODIFIER IS INVALID.
P047	THIRD MODIFIER IS INVALID.
P048	FOURTH MODIFIER IS INVALID.
P052	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P053	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P054	RENDERING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES FOR THE BENEFIT PLAN.
P055	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P061	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P062	THE CLIENT ID AND/OR NAME INDICATED ON THE PA REQUEST IS INCORRECT. THE CLIENT ID AND/OR NAME HAS BEEN UPDATED. PLEASE VERIFY THE ID AND/OR NAME IS CORRECT.
P064	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
P067	THE FREQUENCY OF HOURS REQUESTED ARE NOT APPROPRIATE FOR THIS CLIENT AND HAVE BEEN MODIFIED ACCORDINGLY.
P079	BILLING PROVIDER IS ON PAYMENT SUSPENSION DUE TO CREDIBLE ALLEGATION OF FRAUD.
P120	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAS BEEN REDUCED.
P121	THE SERVICE/ PROCEDURE REQUESTED IS NOT SUPPORTED BY SUBMITTED DOCUMENTATION.
P126	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
P128	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.
P138	SERVICE(S) DO NOT MEET COLORADO MEDICAID GUIDELINES.
P167	REQUESTED DOCUMENTATION HAS NOT BEEN SUBMITTED.
P178	THE SERVICE REQUESTED IS NOT MEDICALLY NECESSARY.
P179	THE MEDICAL NECESSITY FOR THIS SERVICE IS NOT SUPPORTED BY THE SUBMITTED DOCUMENTATION.
P233	THE DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE ADDITIONAL CARE.
P257	THIS CLIENTS FUNCTIONAL ASSESSMENT SCORES PLACE THIS CLIENT OUTSIDE ELIGIBILITY FOR DAY TREATMENT.
P274	OUR RECORDS INDICATE THIS CLIENT IS INVOLVED IN EFFECTIVE AND APPROPRIATE SERVICE ELSEWHERE.
P292	INTENSIVE REHABILITATION HOURS ARE NO LONGER APPROPRIATE AS INDICATED BY HISTORY, DIAGNOSIS, AND/ OR FUNCTIONAL ASSESSMENT SCORES.
P328	THE SERVICES REQUESTED INCLUDE NON-COVERED SERVICES, AND HOURS ARE REDUCED ACCORDINGLY.
P339	THE CLIENTS PAST HISTORY INDICATES REDUCED TREATMENT HOURS ARE WARRANTED.
P342	THE REQUEST DOES NOT MEET GENERALLY ACCEPTED CONDITIONS REQUIRING FLUORIDE TREATMENTS.
P346	SERVICES EXCEED COLORADO MEDICAID LIMITATION AND DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE MEDICAL NECESSITY OF THE SERVICE.
P349	THE SERVICE REQUESTED WAS PERFORMED LESS THAN FIVE YEARS AGO.
P353	THE EXISTING APPLIANCE HAS NOT BEEN WORN FOR THREE YEARS.
P367	THE CLIENT HAS BEEN TOTALLY WITHOUT TEETH AND AN APPLIANCE FOR FIVE YEARS.
P392	THE CLIENT IS MISSING AN ANTERIOR TOOTH AND/OR HAS TWO OR MORE POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P405	THE SERVICE(S) REQUESTED COULD ADEQUATELY BE PERFORMED IN THE DENTAL OFFICE.
P406	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE OF GOOD PERIODONTAL HEALTH (AMERICAN ACADEMY OF PERIODONTOLOGY PERIODONTAL CLASSIFICATION OF TYPE I OR II).
P407	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE VISIBLE ON RADIOGRAPHS THAT AT LEAST 50 PERCENT OF THE CLINICAL CROWN IS INTACT.
P409	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING SIX OR MORE TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED, INCLUDING THIRD MOLARS.
P410	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING ONE OR MORE ANTERIOR TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED.
P411	DOCUMENTATION DOES NOT SUPPORT THE NEED FOR PERIODONTIC SERVICES. POCKETS ARE LESS THAN 4MM AND/OR GREATER THAN 6MM FOR CLIENT AND/OR THE CLIENT IS UNDER THE AGE OF 13.

Denial Code	Long Description
P412	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA.
P413	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA. THIS PA HAS BEEN GRANTED AS APPROVED NOT APPROVED WITH REVISIONS. THE DURATION REQUESTED MAY HAVE BEEN REDUCED TO REFLECT COVERAGE LIMITATIONS, PRESCRIBER ORDERS, CONFLICTI
P417	THE SERVICE(S) REQUESTED COULD BE ADEQUATELY PERFORMED WITH LOCAL ANESTHESIA.
P437	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO POOR ORAL HYGIENE.
P444	THIS LINE ITEM IS A DUPLICATE OF ANOTHER LINE ITEM ON THIS PRIOR AUTHORIZATION (PA) REQUEST. PLEASE CORRECT.
P446	THIS IS A DUPLICATE OF AN EXISTING PRIOR AUTHORIZATION (PA) REQUEST. YOU MAY CONTACT PROVIDER SERVICES IF YOU REQUIRE ASSISTANCE. DUPLICATE PA REQUEST
P448	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO DECAY HISTORY.
P449	QUESTIONABLE LONG TERM PROGNOSIS DUE TO GUM AND BONE DISEASE.
P456	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO APPARENT ROOT INFECTION.
P457	OUR RECORDS INDICATE THIS CLIENT HAS EXCEEDED ESTABLISHED PROGRAM LIMITATIONS. COLORADO MEDICAID WILL NOT AUTHORIZE NEW DENTURES.
P458	DOCUMENTATION PROVIDED INDICATES A LESS ELABORATE PROCEDURE SHOULD BE CONSIDERED.
P502	RENTAL ONLY ALLOWED; MEDICAL NEED FOR PURCHASE HAS NOT BEEN DOCUMENTED.
P503	PURCHASE ONLY ALLOWED; MEDICAL NEED FOR RENTAL HAS NOT BEEN DOCUMENTED.
P504	OCCUPATIONAL THERAPY GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P505	THE SERVICE REQUESTED IS INCLUDED IN THE NURSING HOME RATE STRUCTURE.
P511	THIS NATIONAL DRUG CODE IS ONLY BILLABLE AS PART OF A COMPOUND DRUG.
P515	THE PRESENCE OF A HANDICAPPING MALOCCLUSION OR HANDICAPPING DENTOFACIAL DEFORMITY IS NOT SUPPORTED BY THE DOCUMENTATION SUBMITTED.
P521	THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVERED BY COLORADO MEDICAID.
P522	GASTRO-INTESTINAL SURGERY FOR THE PURPOSE OF WEIGHT CONTROL IS COVERED ONLY AS A LIFE THREATENING PROCEDURE.
P523	THE TREATMENT REQUEST IS NOT CONSISTENT WITH THE CLIENT'S DIAGNOSIS.
P524	PSYCHOTHERAPY PROVIDED IN THE CLIENTS HOME IS NOT A COVERED BENEFIT OF COLORADO MEDICAID.
P525	THE INFORMATION PROVIDED IS NOT CONSISTENT WITH THE INTENSITY OF SERVICES REQUESTED.
P526	INTENSIVE MULTIPLE MODALITY TREATMENT IS NOT CONSISTENT WITH THE INFORMATION PROVIDED.
P527	MULTIPLE PROVIDERS OF TREATMENT ARE NOT INDICATED FOR THIS CLIENT.
P528	THE DURATION OF TREATMENT SESSIONS EXCEED CURRENT COLORADO MEDICAID GUIDELINES.
P534	DOCUMENTATION OF POOR PHYSICAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P535	OTHER PHYSICAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P536	THE PHYSICAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P537	USE OF PHYSICAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P538	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF A PHYSICAL THERAPIST.
P539	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS AND LIVING ARRANGEMENT.
P540	GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P541	THE PROCEDURE(S) REQUESTED ARE NOT MEDICAL IN NATURE.
P542	DOCUMENTATION OF POOR OCCUPATIONAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P543	DOCUMENTATION OF POOR SPEECH THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P544	OTHER OCCUPATIONAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.

Denial Code	Long Description
P546	THE OCCUPATIONAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P547	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF PHYSICAL THERAPY.
P548	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P549	ACTIVITIES TO PROMOTE DIVERSION OR GENERAL MOTIVATION ARE NONCOVERED COLORADO MEDICAID SERVICES.
P550	REVISIONS OF THE REQUEST IS NECESSITATED BY THE CLIENTS MINIMAL PROGRESS.
P551	RESTORATIVE NURSING INVOLVEMENT COULD BE INCREASED.
P552	CLIENTS DEMONSTRATED RESPONSE TO CURRENT THERAPY DOES NOT WARRANT THE INTENSE FREQUENCY REQUESTED.
P553	MAINTENANCE IS TWO TIMES PER WEEK OR LESS.
P554	THE SPEECH THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P555	USE OF OCCUPATIONAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P556	USE OF SPEECH THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P557	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF AN OCCUPATIONAL THERAPIST.
P558	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
P559	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P560	THE MATERIALS/ SERVICES REQUESTED ARE PRINCIPALLY COSMETIC IN NATURE.
P561	THE LENS FORMULA DOES NOT JUSTIFY REPLACEMENT.
P562	THE CHANGE IN THE LENS FORMULA DOES NOT WARRANT MULTIPLE REPLACEMENTS.
P563	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P564	LENSES ONLY ARE APPROVED; PLEASE DISPENSE A CONTRACTED FRAME. THE NON-CONTRACTED FRAME IS NOT MEDICALLY JUSTIFIED.
P565	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P566	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P567	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF OCCUPATIONAL THERAPY.
P568	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF SPEECH THERAPY.
P569	LEVEL, INTENSITY, OR EXTENT OF SERVICE(S) REQUESTED HAS BEEN MODIFIED CONSISTENT WITH MEDICAL NEED AS DEFINED IN THE PLAN OF CARE.
P570	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P571	THE SERVICE ASKED FOR IS NOT COVERED BY COLORADO MEDICAID AS THESE TASKS CAN BE DONE BY NURSES OR ACTIVITY STAFF.
P572	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P573	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.
P574	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P575	MEDICAL NEED FOR EQUIPMENT/ SUPPLY REQUESTED IS NOT SUPPORTED BY DOCUMENTATION SUBMITTED.
P576	OTHER SPEECH THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P577	DOCUMENTATION SUBMITTED IDENTIFIES THAT THE CLIENT HAS FEWER THAN TWO POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P582	LESS EXPENSIVE ALTERNATIVE SERVICES ARE AVAILABLE FOR THIS CLIENT.
P634	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P711	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING PERIODONTAL SCALING AND ROOT PLANNING.
P712	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING GINGIVECTOMY.
P754	AN APPROVED SUBSTANCE ABUSE DAY TREATMENT PROGRAM CANNOT EXCEED A SIX WEEK PERIOD.

Denial Code	Long Description
P761	THE CLIENT DOES NOT APPEAR TO BE ABLE OR WILLING TO ABSTAIN FROM ALCOHOL/DRUG USAGE WHILE IN TREATMENT. THEREFORE, SUBSTANCE ABUSE DAY TREATMENT SERVICES ARE NOT APPROVED.
P764	THIS CLIENT HAS COMPLETED INTENSIVE SUBSTANCE ABUSE TREATMENT WITHIN THE PAST 12 MONTHS. THE DOCUMENTATION PROVIDED IS NOT ADEQUATE TO JUSTIFY ADDITIONAL INTENSIVE TREATMENT AT THIS TIME.
P785	A LESS THAN SIX-WEEK HEALING PERIOD HAS BEEN SPECIFIED FOR THIS PRIOR AUTHORIZATION. THEREFORE IT IS NOT NECESSARY TO WAIT THE FULL SIX WEEKS AFTER EXTRACTIONS BEFORE TAKING DENTURE IMPRESSIONS.
P818	SIX-WEEK HEALING TIME IS REQUIRED BETWEEN EDENTULATION AND FINAL IMPRESSIONS. PAYMENT FOR DENTURES WILL BE DENIED OR RECOUPED IF HEALING PERIOD IS NOT OBSERVED.
P849	COLORADO MEDICAID HAS DETERMINED THERE WERE (ARE) SEVERAL HOME HEALTH AGENCIES WILLING TO PROVIDE MEDICALLY NECESSARY SKILLED NURSING SERVICES TO THIS CLIENT.
P864	THE DOCUMENTATION YOU HAVE SUBMITTED DOES NOT MEET THE REQUIREMENTS OF COLORADO MEDICAID.
P873	THE MEDICAL NECESSITY FOR THE HOURS REQUESTED IS NOT SUPPORTED BY THE INFORMATION SUBMITTED.
P874	THE DOCUMENTATION SUBMITTED INDICATES THE TASKS SPECIFIED CAN BE COMPLETED DURING THE VISITS APPROVED.
P878	THE DOCUMENTATION SUBMITTED DOES NOT INDICATE THAT MEDICALLY ORIENTED TASKS ARE MEDICALLY NECESSARY; THEREFORE PERSONAL CARE SERVICES HAVE BEEN APPROVED.
P880	THE QUANTITY OF SERVICES AUTHORIZED FOR THIS CLIENTS PERSONAL CARE HAS BEEN AMENDED BASED ON INFORMATION RECEIVED FROM ONE OR MORE OF THESE SOURCES: THE CLIENT, THEIR PHYSICIAN, AND/OR THE IN-HOME VISIT BY STAFF OF THE OIG (OFFICE OF INSPECTOR GENERAL).
P885	THE USE OF THIS DRUG FOR THE INTENDED PURPOSE IS NOT COVERED BY COLORADO MEDICAID, CONSISTENT WITH COLORADO ADMINISTRATIVE CODE AND FEDERAL LAW.
P924	THE MEDICAL RECORDS SUBMITTED WITH THE CURRENT REQUEST CONFLICT OR DISAGREE WITH OUR MEDICAL RECORDS ON THIS CLIENT.
P950	INDEPENDENT NURSES, PLEASE NOTE PAYABLE SERVICES MAY NOT EXCEED 12 HOURS/DAY OR 60 HOURS/WEEK.
P951	SERVICES CAN ONLY BE AUTHORIZED THROUGH ONE YEAR FROM THE PRESCRIPTION DATE.
P952	LEAD INSPECTION IS A COVERED COLORADO MEDICAID SERVICE WHEN THE CHILD HAS BEEN SHOWN TO HAVE LEAD POISONING (E.G., CHILD HAS A BLOOD LEAD LEVEL > 19 UG/DL OR TWO CONSECUTIVE BLOOD LEAD LEVELS OF 15-19 UG/DL DONE AT LEAST 90 DAYS APART). THE INSPECTION MUS
P953	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P954	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P956	THE REQUEST CAN ONLY BE BACKDATED A MAXIMUM OF 14 DAYS FROM FIRST DATE RECEIVED BY COLORADO MEDICAID.
P957	COMPLETE PERIODONTAL CHARTING AT TIME OF SERVICE, AND SUBMIT CHARTING, COPY OF OPERATIVE REPORT, TOGETHER WITH A COPY OF THE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF), F-11035, TO PA UNIT ATTENTION DENTAL CONTSULTANT.
P958	NOTE THAT CODE D4341 HAS BEEN CHANGED. REFER TO THE DECISION NOTICE FOR AUTHORIZED QUANTITY.
P960	YOUR PA HAS BEEN APPROVED FOR 90 DAYS. THE 90 DAY APPROVAL DOES NOT IMPLY THE PA REQUEST MEETS PRIOR AUTHORIZATION CRITERIA. AFTER ADDITIONAL INFORMATION IS AVAILABLE IN INTERCHANGE, COLORADO MEDICAID WILL CREATE AN AMENDMENT REQUEST TO EXTEND THE PA FOR
P961	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P962	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
PA10	THE REQUESTED END DATE IS INVALID.
PA12	PLEASE FURNISH A WRITTEN DESCRIPTION OF THE CLIENTS DIAGNOSIS.

Denial Code	Long Description
PA13	PROVIDE DIAGNOSES WITH DATES OF ONSET.
PA14	IDENTIFY PROBLEMS TO BE TREATED.
PA15	THE AUDIOLOGISTS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1), F-11020, AND PRIOR AUTHORIZATION REQUEST/HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2), F-11021.
PA16	THE PHYSICIANS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION/PHYSICIAN OTOLOGICAL REPORT (PA/POR), F-11019.
PA17	SUBMIT BRIEF HISTORY WITH REFERRAL INFORMATION, LIVING SITUATION, FUNCTIONAL STATUS, AND OTHER PERTINENT INFORMATION. WHAT CHANGE OF STATUS RESULTED IN REFERRAL AT THIS TIME?
PA18	PLEASE FURNISH THE CLIENTS HEIGHT AND WEIGHT.
PA19	PLEASE SUBMIT CLINICAL INFORMATION SUFFICIENT TO VERIFY THE NEED FOR THE REQUESTED SERVICE(S).
PA20	PLEASE RESUBMIT WITH COMPLETE PERIODONTAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PA21	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL EDUCATIONAL PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA22	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL PROGRAM PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA23	REFER TO THE DURABLE MEDICAL EQUIPMENT INDEX FOR APPROPRIATE CODE AND DESCRIPTION. DO NOT USE AN "UNLISTED" CODE.
PA24	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUALIZED FAMILY SERVICE PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA25	INFORMATION ON THE REQUEST FORM IS ILLEGIBLE, AND THE REQUEST CANNOT BE PROCESSED.
PA26	RE-EVALUATE YOUR GOALS. EMPHASIS SHOULD BE ON FUNCTIONAL SELF-CARE. GOALS MUST BE RELATED TO FUNCTIONAL OUTCOME.
PA27	PLEASE CLARIFY THE NUMBER OF HOURS PER WEEK REQUESTED.
PA28	PLEASE CLARIFY THE NUMBER OF HOURS PER DAY REQUESTED.
PA29	PLEASE CLARIFY THE NUMBER OF VISITS PER DAY REQUESTED.
PA30	ATTACH SUPPORTIVE DOCUMENTATION; HOME EXERCISE PROGRAM AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA31	THE DIAGNOSIS CODE INDICATED ON THE REQUEST DOES NOT CORRESPOND TO THE DIAGNOSIS CODE DESCRIPTION.
PA32	PLEASE SUBMIT ADDITIONAL INFORMATION SUFFICIENT TO VERIFY APPROPRIATENESS AND NEED FOR TRANSPLANT.
PA33	PLEASE SUBMIT THE INITIAL AND PROGRESSIVE OBJECTIVE FINDINGS.
PA34	ATTACH SUPPORTIVE DOCUMENTATION, FACILITY PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA35	PLEASE SUBMIT THE CLIENTS ORIGINAL COMPLAINTS AND EXAMINATION FINDINGS.
PA36	ATTACH SUPPORTIVE DOCUMENTATION, IN-HOME AUTISM PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA37	PLEASE SUBMIT YOUR TREATMENT PLAN FOR THIS CLIENT.
PA38	ATTACH SUPPORTIVE DOCUMENTATION AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA39	INITIAL EVALUATIONS MUST BE PERFORMED BY AN OCCUPATIONAL THERAPIST REGISTERED (OTR), PER AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA) STANDARDS.
PA41	IDENTIFY THE PLACE OF SERVICE AND ITS EFFECT ON SUPPORTING THE DESIRED TREATMENT OUTCOME.
PA42	PLEASE INDICATE THE HOURS OF USE OF OXYGEN PER 24-HOUR PERIOD.
PA43	PROVIDE BASELINE DOCUMENTATION FOR THIS CLIENTS LIMITATIONS USING UNITS OF MEASUREMENT THAT ARE APPLIED CONSISTENTLY WHEN REPORTING STATUS.
PA44	IDENTIFY FUNCTIONAL LIMITATIONS AS THEY ARE RELATED TO IDENTIFIED CONDITIONS.
PA46	CORRELATE PLAN OF CARE TO REQUESTED PROCEDURE CODES.
PA47	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE FREQUENCY/DURATION REQUESTED.

Denial Code	Long Description
PA48	PLEASE PROVIDE THE NAME AND CREDENTIALS OF THE RENDERING PROVIDER.
PA50	COLORADO MEDICAID RECORDS INDICATE THE CLIENT OWNS A WHEELCHAIR. DOCUMENT THE REASON AND NEED FOR REPLACEMENT AND COST TO REPAIR CURRENT WHEELCHAIR.
PA51	PLEASE DISTINGUISH PRIMARY AND SUPPORTIVE MODALITIES.
PA52	PLEASE SUBMIT A PROGRESS REPORT.
PA53	MULTIPLE FAMILY CLIENTS TREATMENT BY THE SAME PROVIDER REQUIRES FURTHER INFORMATION DOCUMENTING COORDINATION OF TREATMENT PLAN.
PA54	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE MINUTES REQUESTED.
PA55	MEDICAL NECESSITY OF TREATMENT REQUIRES ADDITIONAL DOCUMENTATION.
PA56	GIVEN AGE, DIAGNOSES, CURRENT LEVEL OF FUNCTION, PAST RESPONSE TO TREATMENT, AND LIVING SITUATION, EXPAND ON POTENTIAL FOR SIGNIFICANT FUNCTIONAL PROGRESS WITHIN THE NEXT SIX MONTHS. EMPHASIZE WHY PROGRESS IS EXPECTED WITH SERVICES AT THIS TIME.
PA57	SUBMIT THE INITIAL FINDINGS. INCLUDE A COMPREHENSIVE EVALUATION.
PA58	SUBMIT PROGRESSIVE, OBJECTIVE FINDINGS. INCLUDE A PERTINENT RE-EVALUATION.
PA59	PLEASE SUPPLY INFORMATION REGARDING THE CLIENTS MEDICATION REQUIREMENTS, IF ANY.
PA60	PLEASE SPECIFY IF THE CLIENT IS IN AN EDUCATIONAL SETTING.
PA61	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA62	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
PA63	THE SKILLS OF A THERAPIST ARE PURPOSEFUL AND SKILLED INTERVENTIONS REQUIRED TO CONTINUALLY DESIGN, IMPLEMENT, REASSESS, MODIFY/GRADE, AND/OR DISCONTINUE A PLAN OF CARE IN A TIMELY MANNER, BASED ON THE COMPLEXITY OF THE CLIENTS MEDICAL CONDITION AND/OR CO
PA64	PLEASE SUBMIT A THERAPY PLAN OF CARE, INCLUDING A CURRENT, DATED EVALUATION.
PA65	A PLAN OF CARE SIGNED AND DATED BY THE PHYSICIAN IS REQUIRED.
PA66	THE SKILLS OF A THERAPIST ARE REQUIRED WHEN ONLY THE THERAPIST CAN SAFELY AND EFFECTIVELY DELIVER THE THERAPEUTIC PROCEDURES BECAUSE OF THEIR UNIQUE KNOWLEDGE, TRAINING, AND EXPERTISE. DESCRIBE THE REASON THAT SOMEONE OTHER THAN A THERAPIST CANNOT SAFELY
PA67	PLEASE SPECIFY IF THE CLIENTS WORK SITE DEMANDS GOOD BINAURAL HEARING.
PA68	DESCRIBE THE REASON, BASED ON THE CLIENTS COGNITIVE, PHYSICAL, COMMUNICATION, OR RESOURCE STATUS, THAT A HOME PROGRAM, EQUIPMENT, OR ENVIRONMENTAL ADAPTATIONS ALONE CANNOT MEET CLIENTS NEEDS.
PA69	PLEASE SPECIFY IF THE CLIENT HAS AN ACCOMPANYING DISABILITY THAT ADDS TO THE HEARING PROBLEM.
PA70	DISTINGUISH REQUESTED PROCEDURES AND GOALS FROM OTHER SERVICES THIS CLIENT RECEIVES. THEY MAY NOT BE DUPLICATIVE.
PA71	PLEASE INDICATE THE NUMBER OF DAYS REQUESTED.
PA73	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA74	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA75	PLEASE DOCUMENT CARRYOVER OF THE THERAPY PROGRAM TO NURSING.
PA76	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA79	PROVIDE EVIDENCE OF SIGNIFICANT FUNCTIONAL PROGRESS IN LAST SIX MONTHS.
PA84	THE GRANT DATE OF THIS REQUEST CANNOT BE PRIOR TO THE SIGNATURE DATE OF THE PRESCRIBING PHYSICIAN.
PA86	PROVIDE EVIDENCE OF SKILLS GAINED IN THERAPY CARRYING OVER TO OTHER SETTINGS WITHIN SIX MONTHS.
PA87	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE NUMBER OF SESSIONS REQUESTED.
PA88	THE REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL SCOPE OF PRACTICE.
PA89	PRIOR AUTHORIZATION IS NOT REQUIRED UNTIL LIMITATION OF SERVICE HAS BEEN REACHED.
PA91	PLEASE SUBMIT REQUIRED X-RAYS.

Denial Code	Long Description
PA92	PLEASE PROVIDE AN EXPLANATION FOR THE MATERIAL SUBMITTED WITH THE REQUEST.
PA95	PLEASE DESCRIBE HOW THE PROVISION OF THIS SERVICE WOULD PREVENT INSTITUTIONALIZATION OF THE CLIENT.
PA96	COULD THE EXISTING DENTURE(S) BE RELINED OR REBASED? IF NOT, PLEASE EXPLAIN WHY NOT.
PA97	REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL STANDARDS OF PRACTICE.
PA98	PLEASE INDICATE IF THE CLIENT IS CURRENTLY BEING TUBE FED.
PB02	PLEASE PROVIDE THE REQUIRED DATED SIGNATURES ON THE ATTACHMENTS.
PB03	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING THE LOSS/DESTRUCTION/THEFT OF THE HEARING AID.
PB04	DESCRIBE THE CLIENTS ABILITY TO STAND OR AMBULATE SUFFICIENTLY TO ACCOMPLISH SELF-CARE ACTIVITIES.
PB07	PLEASE SUBMIT AN ORTHODONTIC STUDY MODEL OR DIAGNOSTIC CASTS.
PB09	PLEASE PROVIDE A PHOTOGRAPH OF THE INVOLVED AREA(S).
PB10	PLEASE PROVIDE AN ESTIMATION (IN GRAMS) OF THE TOTAL AMOUNT OF TISSUE TO BE RESECTED.
PB11	PLEASE SUBMIT THE PLAN OF CARE FOR CO-TREATMENT.
PB12	FURNISH A DETAILED DESCRIPTION FOR THE PROCEDURE CODE REQUESTED.
PB13	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB15	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB18	PLEASE COMPLETE THE ATTACHED OUT-OF-STATE PROVIDER DATA SHEET, F-11001, AND RESUBMIT.
PB20	A SIGNED AND DATED PRESCRIPTION IS REQUIRED WITHIN THREE MONTHS OF RECEIPT BY COLORADO MEDICAID FOR INITIAL REQUESTS AND WITHIN 12 MONTHS OF RECEIPT BY COLORADO MEDICAID FOR SUBSEQUENT REQUESTS.
PB21	PLEASE COMPLETE THE APPROPRIATE PRIOR AUTHORIZATION ATTACHMENT. CONTACT PROVIDER SERVICES OR THE PRIOR AUTHORIZATION UNIT FOR ASSISTANCE.
PB23	PHYSICAL THERAPY ASSISTANT NOTES AND ALL FORMS SUBMITTED MUST BE COSIGNED BY A REGISTERED PHYSICAL THERAPIST.
PB31	ARE YOU REQUESTING A COMPLETE APPLIANCE, OR REPLACEMENT PARTS?
PB32	THE PROCEDURE CODE INDICATED ON THE REQUEST DOES NOT MATCH THE DESCRIPTION OF SERVICE; PLEASE CORRECT AND RESUBMIT.
PB35	THE SERVICE REQUESTED DOES NOT REQUIRE PRIOR AUTHORIZATION.
PB41	PLEASE FURNISH A CURRENT MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT, F-11090 (DATED WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID).
PB45	THE CERTIFICATION PERIOD ON THE PLAN OF CARE (POC) DOES NOT COVER THE REQUESTED GRANT/START DATE. PLEASE RESUBMIT YOUR REQUEST WITH A NEW POC.
PB49	A CERTIFIED OCCUPATIONAL THERAPY ASSISTANTS NOTES MUST BE COSIGNED BY AN OCCUPATIONAL THERAPIST REGISTERED.
PB51	ADDITIONAL INFORMATION IS REQUIRED ON PRIOR AUTHORIZATION TO ENABLE PRICING.
PB54	REQUESTED SERVICES DO NOT MATCH SERVICES ON THE PHYSICIANS ORDERS.
PB59	PLEASE PROVIDE AN INDIVIDUAL EDUCATIONAL PLAN (IEP), WHICH HAS BEEN SIGNED BY THE PROVIDER NO EARLIER THAN NINE MONTHS PRIOR TO RECEIPT AT COLORADO MEDICAID; OTHERWISE, DOCUMENT WHY NO IEP EXISTS.
PB65	PLEASE FURNISH THE ANTICIPATED TOTAL CHARGES FOR THIS REQUEST.
PB66	A PHOTOCOPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED; THE DATE MUST BE WITHIN SIX MONTHS OF RECEIPT BY COLORADO MEDICAID.
PB67	THE PRESCRIPTION DATE MUST INCLUDE MONTH, DAY, AND YEAR.
PB68	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID.
PB73	THE SERVICES IDENTIFIED ON THE PLAN OF CARE DO NOT APPEAR APPROPRIATE FOR THE PROCEDURE CODE(S) REQUESTED ON THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018.
PB74	THE CLIENT/PROVIDER DOES NOT HAVE RETROACTIVE ENROLLMENT.
PB75	THE REQUESTED START DATE IS MORE THAN 14 DAYS BEFORE OR 62 DAYS AFTER RECEIPT.
PB82	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
PB83	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A HOME HEALTH AIDE. PLEASE RESUBMIT AS A PERSONAL CARE WORKER OR PROVIDE ADDITIONAL DOCUMENTATION.

Denial Code	Long Description
PB86	THE SERVICES REQUESTED ARE NOT BEING PROVIDED IN THE CLIENTS RESIDENCE. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL.
PB87	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A NURSE. PLEASE RESUBMIT AS A HOME HEALTH AIDE OR PROVIDE ADDITIONAL DOCUMENTATION.
PB92	PLEASE FURNISH THE CLIENTS COMPLETE ADDRESS.
PB94	IF THE CLIENT IS A RESIDENT OF A NURSING HOME, SUPPLY THE COMPLETE NAME AND ADDRESS OF THE NURSING HOME.
PB99	THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018, MUST BE SIGNED AND DATED.
PC01	PLEASE SUPPLY THE RENDERING PROVIDERS PROVIDER NUMBER.
PC03	THE DRUG ENFORCEMENT ADMINISTRATION NUMBER IS MISSING OR INVALID.
PC06	PLEASE DESCRIBE YOUR PROGRAM; INCLUDE ENTRY DATE, TERMINATION DATE, HOURS PER WEEK, AND NUMBER OF WEEKS OF PRIMARY INTENSIVE SERVICE REQUESTED.
PC07	PLEASE DESCRIBE YOUR "AFTERCARE/FOLLOW-UP" PLANS FOR THIS CLIENT.
PC08	PLEASE SUPPLY DOCUMENTATION OF PREVIOUS SUBSTANCE ABUSE SERVICES WITH DATE(S) AND OUTCOME.
PC09	PLEASE DESCRIBE IN DETAIL THE TREATMENT OBJECTIVES/GOALS FOR THIS CLIENT.
PC10	PLEASE DESCRIBE THE FAMILY SITUATION/DYNAMICS. EXPLAIN HOW THE FAMILY WILL BE INCORPORATED INTO THE CLIENTS PLAN OF CARE.
PC12	PLEASE EXPLAIN IF YOUR SERVICE ENCOURAGES THE CLIENT TO ATTEND SELF-HELP GROUPS.
PC13	PLEASE SUPPLY A SPECIFIC SCHEDULE OF ACTIVITIES, INCLUDING DAY, TIME OF DAY, LENGTH OF SESSION, AND SERVICE TO BE RENDERED DURING THAT TIME.
PC15	PLEASE FURNISH DIAGNOSTIC RATIONALE.
PC17	PLEASE DOCUMENT IF THE CLIENT EVER RECEIVED SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT.
PC19	PLEASE FURNISH MORE EXTENSIVE AND IN-DEPTH HISTORICAL AND PSYCHOSOCIAL DATA.
PC20	PLEASE SUPPLY THE DATE THE CLIENT BECAME TOTALLY ENDENTULOUS.
PC23	PLEASE SUBMIT A PHYSICIANS STATEMENT REGARDING THE MEDICAL NECESSITY OF DENTURES FOR THIS CLIENT. THE PHYSICIANS STATEMENT MUST DOCUMENT THE MEDICAL NEED FOR DENTURES.
PC24	THE SERVICE REQUESTED WAS PREVIOUSLY AUTHORIZED. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT INDICATING THIS FACT IS REQUIRED.
PC25	PLEASE SUPPLY SUFFICIENT MITIGATING CIRCUMSTANCES TO WARRANT THE CONSTRUCTION OF NEW DENTURES(S).
PC26	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
PC28	PLEASE SUBMIT A PHYSICIANS STATEMENT INDICATING DENTURES ARE NECESSARY FOR THIS NURSING HOME CLIENT.
PC29	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING LOSS OR DESTRUCTION OF DENTURE(S). INCLUDE SIGNED STATEMENT FROM CLIENT OR FACILITY DIRECTOR REGARDING HOW, WHEN AND WHERE LOST.
PC30	PLEASE PROVIDE COMPLETE INTRAORAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PC31	PLEASE DESCRIBE ANY RELATED DEFORMITIES OF THE FEET.
PC34	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD WITH REQUESTED DME ITEM(S) AND DOCUMENT IF THE CLIENT CAN USE SAFELY AND INDEPENDENTLY.
PC35	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD AND DESCRIBE THE RESULTS AND EFFECTIVENESS OF THE SERVICE REQUESTED.
PC39	PLEASE INDICATE LITER FLOW PER MINUTE, HOURS OF USE PER 24 HOUR PERIOD, AND THE EXPECTED DURATION OF NEED.
PC40	THE ITEM DOES NOT REQUIRE PRIOR AUTHORIZATION UNTIL THE LIFE EXPECTANCY HAS BEEN REACHED.
PC41	PLEASE SUPPLY INFORMATION INDICATING THE NECESSITY OF POSITIONING THE CLIENT'S BODY IN MULTIPLE POSITIONS.
PC42	PLEASE INDICATE IF THE BED HEIGHT MUST BE CHANGED TO ALLOW FOR SAFE TRANSFER OR ADEQUATE BED CARE.
PC43	SUPPLY A PHYSICIANS STATEMENT INDICATING TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR UNIT HAS REDUCED PAIN, IMPROVED/INCREASED THE CLIENTS ACTIVITY LEVEL, AND/OR REDUCED CLIENTS USE OF PAIN MEDICATION.

Denial Code	Long Description
PC44	A CURRENT AUTHORIZATION FOR THIS SERVICE IS ON FILE FOR ANOTHER PROVIDER. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT OF THAT FACT IS REQUIRED BY THE CLIENT OF FIRST PROVIDER.
PC59	DOCUMENT DECLINE OR PROGRESS IN SPECIFIC, MEASURABLE, OBJECTIVE TERMS.
PC60	DOCUMENT IF CLIENT HAS DEMONSTRATED A GOOD APPOINTMENT COMPLIANCE RECORD.
PC61	THE PHYSICIANS SIGNATURE DATE MUST NOT EXCEED 90 DAYS FROM THE DATE OF RECEIPT BY COLORADO MEDICAID.
PC62	REQUESTS FOR A CONTINUATION OF THERAPY SHOULD NOT BE SUBMITTED MORE THAN FOUR WEEKS PRIOR TO THE EXPIRATION DATE OF THE CURRENT AUTHORIZATION.
PC63	PLEASE FURNISH THE STYLE AND MANUFACTURER OF THE FRAME.
PC64	PLEASE FURNISH THE CLIENTS LENS FORMULA.
PC66	ALL REQUESTS FOR TINTS REQUIRE DOCUMENTATION OF THE VISUAL OR MEDICAL CONDITION RELATED TO PHOTOPHOBIA.
PC67	PLEASE DOCUMENT THE REASON AND JUSTIFICATION FOR REPLACEMENT BEYOND THE FIRST LENS/FRAME.
PC68	DOCUMENT IF ALL REMAINING MAXILLARY AND/OR MANDIBULAR TEETH ARE DECAY-FREE, PROPERLY RESTORED, AND PERIODONTICALLY SOUND.
PC72	SUPPLY MORE DETAIL REGARDING PROGRESS (ATTACHMENT OF GOALS, ETC.). CORRELATE PROGRESS TO PREVIOUS GOALS AND IDENTIFIED LIMITATIONS.
PC77	PLEASE SUBMIT A PLAN OF CARE DESCRIBING THE SERVICES THAT WOULD BE PROVIDED.
PC78	PLEASE DOCUMENT SPECIFIC, MEASURABLE GOALS.
PC82	THE PRIOR AUTHORIZATION (PA) SYSTEM CAN PROCESS ONLY 26 DETAILS PER PA REQUEST. PLEASE RESUBMIT YOUR REQUEST WITH NO MORE THAN 26 DETAILS.
PC83	PLEASE SUPPLY A PHYSICIANS PRESCRIPTION DATED WITHIN ONE MONTH OF REQUESTED SUBSTANCE ABUSE DAY TREATMENT.
PC84	PLEASE PROVIDE INFORMATION INDICATING THIS CLIENT IS APPROPRIATELY DETOXIFIED FROM ALCOHOL AND/OR OTHER DRUGS.
PC85	PLEASE PROVIDE INFORMATION TO INDICATE THE CLIENTS ABILITY TO ABSTAIN FROM ALCOHOL OR DRUGS WHILE IN THE SUBSTANCE ABUSE DAY TREATMENT PROGRAM.
PC86	PLEASE INDICATE IF THIS CLIENT IS WILLING TO PARTICIPATE IN AFTERCARE OR CONTINUING CARE SERVICES.
PC87	PROVIDE MORE INFORMATION ON TREATMENT HISTORY; INCLUDE SERVICE PROVIDED, DATES, AND OUTCOME. PROVIDE DETAIL OF PREVIOUS TREATMENT.
PC88	PLEASE PROVIDE MORE RATIONALE FOR THE APPROPRIATENESS AND MEDICAL NECESSITY OF SUBSTANCE ABUSE DAY TREATMENT.
PC89	PROVIDE A TREATMENT PLAN THAT CONTAINS MEASURABLE GOALS AND OBJECTIVES CORRESPONDING TO THE IDENTIFIED DEFICIT.
PC91	PLEASE PROVIDE MORE INFORMATION ON FAMILY INVOLVEMENT TREATMENT.
PC92	PLEASE PROVIDE MORE HISTORY AND EXPLANATION ABOUT THE ISSUE OF ABSTINENCE FOR THIS CLIENT.
PC94	PLEASE PROVIDE THE ANTICIPATED BEGINNING DATE AND/OR THE ESTIMATED SUBSTANCE ABUSE DAY TREATMENT DISCHARGE DATE.
PC95	PLEASE SUPPLY JUSTIFICATION FOR BEGINNING CLIENT IN SERVICE PRIOR TO AUTHORIZATION BEING OBTAINED.
PC96	THE INITIAL THREE HOURS OF SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IN A CALENDAR YEAR DO NOT REQUIRE PRIOR AUTHORIZATION.
PC97	REIMBURSEMENT FOR INITIAL SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IS LIMITED TO THREE HOURS IN A CALENDAR YEAR AND DOES NOT REQUIRE PRIOR AUTHORIZATION.
PC98	THIS DRUG IS CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE BILL USING THE APPROPRIATE NATIONAL DRUG CODE (NDC) OR SUBMIT A COMPLETED DRUG ADDITION REQUEST FORM IF THE NDC IS NOT LISTED IN THE DRUG INDEX.
PC99	THIS DRUG IS NOT CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL, CURRENT ADMINISTRATIVE RULE, OR COLORADO DRUG INDEX FOR COVERAGE LIMITATIONS.
PD01	DOCUMENT THAT CLIENT HAS ACHIEVED GOOD ORAL HYGIENE, PERIODONTAL CASE TYPE 1 OR 2, AND IS MOTIVATED TO MAINTAIN SAME.

Denial Code	Long Description
PD03	PLEASE PROVIDE AN ARTERIAL BLOOD GAS READING OR PULSE OXIMETRY RESULTS DONE ON ROOM AIR SIGNED AND DATED BY A MEDICAL DOCTOR. THIS SHOULD BE DONE WITHIN 60 DAYS OF REQUESTED SERVICE.
PD04	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 30 DAYS OF RECEIPT BY COLORADO MEDICAID.
PD07	SUBMIT A PHOTOCOPY OF A VALID PRESCRIPTION, ISSUED WITHIN THE PAST YEAR, OR COMPLETE SECTION B OF THE PRIOR AUTHORIZATION/DRUG ATTACHMENT (PA/DGA), F-11049.
PD10	BRAND MEDICALLY NECESSARY MUST BE IN THE PRESCRIBERS OWN HANDWRITING AND WRITTEN DIRECTLY ON THE PRESCRIPTION OR A SEPARATE ORDER ATTACHED TO THE ORIGINAL PRESCRIPTION.
PD12	COMPLETE DENTURES, PARTIAL DENTURES, DENTURE RELINES, AND FIXED PROSTHODONTIC SERVICES ARE NOT COVERED SERVICES FOR ADULTS FOR DATES OF SERVICE ON AND AFTER OCTOBER 1, 1995.
PD22	PLEASE COMPLETE ALL REQUIRED ELEMENTS ON THE PERSONAL CARE SCREENING TOOL (PCST), F-11133.
PD24	THIS PRIOR AUTHORIZATION REQUEST IS UNABLE TO BE PROCESSED. PLEASE RESUBMIT WITH ADDITIONAL REQUIRED FORMS, INCLUDING THE ENTIRE PERSONAL CARE SCREENING TOOL (PCST), F-11133; PERSONAL CARE ADDENDUM, F-11136; AND SUPPORTING DOCUMENTATION, AS DIRECTED.
PD25	THERE IS A PERSONAL CARE SCREENING TOOL (PCST), F-11133, COMPLETED BY ANOTHER AGENCY. CONTACT THE AGENCY TO TRANSFER SCREEN.
PD26	THERE IS A LIMITED TERM CARE FUNCTIONAL SCREEN (LTC-FS) COMPLETED BY ANOTHER AGENCY. THE PERSONAL CARE SCREENING TOOL (PCST), F-11133, INFORMATION IS IN CONFLICT WITH LTC-FS.
PD27	ONLY ONE LEVEL OF FUNCTION MAY BE SELECTED FOR ALL ELEMENTS EXCEPT TOILETING. COLORADO MEDICAID IS UNABLE TO PROCESS THE PRIOR AUTHORIZATION REQUEST.
PD28	NO UNITS MAY BE REQUESTED USING THIS PRIOR AUTHORIZATION PROCESS. PLEASE SUBMIT WITH THE APPROPRIATE ATTACHMENTS FOR REQUESTING SPECIFIC PERSONAL CARE WORKER UNITS.
PD29	CLIENT IS NOT ELIGIBLE FOR THE REQUESTED SERVICE(S) AS OF THE REQUESTED START DATE.
PD30	NO TRAVEL TIME MAY BE AUTHORIZED WHEN NO PERSONAL CARE WORKER SERVICE IS AUTHORIZED.
PD32	PROVIDER NOT CERTIFIED TO RENDER THE SERVICE(S) REQUESTED.
PD34	BASED ON THE DOCUMENTATION SUBMITTED, THIS REQUEST CAN NOT BE PRIOR AUTHORIZED. REFER TO THE PA MESSAGES FROM THE CONSULTANT FOR COMPLETE EXPLANATION.
PD98	PLEASE DOCUMENT HOW AND WHEN EACH PREVIOUSLY AUTHORIZED PRO RE NATA VISIT WAS USED.

Denial Code	Long Description

Denial Code	Long Description

Denial Code	Long Description

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Denial Code	Long Description

Denial Code	Long Description

Denial Code	Long Description

Vision

Denial Code	Long Description
0201	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
0233	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0235	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
0237	CLIENT IDENTIFICATION NUMBER DOES NOT MATCH CLIENTS FIRST NAME.
0238	THE CLIENT IDENTIFICATION NUMBER DOES NOT MATCH THE CLIENTS LAST NAME.
0242	SECONDARY DIAGNOSIS CODE IS INVALID.
0248	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0249	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
0251	PROCEDURE CODE MODIFIER IN FIRST POSITION IS INVALID.
0252	THE PROCEDURE CODE MODIFIER IN SECOND POSITION IS INVALID FOR REQUESTED START DATE OR DATE OF RECEIPT.
0253	THE PROCEDURE CODE MODIFIER IN THIRD POSITION IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
0258	THE PRIMARY DIAGNOSIS CODE IS REQUIRED.
0272	THE PRIMARY DIAGNSOSIS CODE IS INVALID.
0400	PLEASE INDICATE THE QUANTITY REQUESTED FOR EACH SERVICE REQUESTED.
0853	HCPCS - ANNUAL UPDATE
0885	NEVER EVENTS MODIFIERS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
0886	NEVER EVENTS DIAGNOSIS MUST BE SUBMITTED SEPARATELY FROM NON-NEVER EVENTS.
1000	THE BILLING PROVIDER NUMBER IS MISSING OR UNIDENTIFIABLE. INDICATE A BILLING PROVIDER NUMBER IN THE APPROPRIATE ELEMENT.
1002	RENDERING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1003	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE.
1007	RENDERING PROVIDER ID IS NOT ON FILE.
1047	THE RENDERING PROVIDERS CERTIFICATION HAS BEEN CANCELLED.
1048	BILLING PROVIDER CERTIFICATION HAS BEEN CANCELLED.
1801	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
1804	A CERTIFIED SUBSTANCE ABUSE DAY TREATMENT PROVIDER MUST SUBMIT A SUBSTANCE ABUSE DAY TREATMENT PROCEDURE CODE.
1806	BILLING PROVIDER IS NOT CERTIFIED FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
1808	THE BILLING PROVIDER DOES NOT HAVE THE REQUIRED CERTIFICATION ADDENDUM ON FILE.
1900	THE BILLING PROVIDERS TAXONOMY CODE IS INVALID.
1901	THE RENDERING PROVIDERS TAXONOMY CODE IS INVALID.
1927	A NATIONAL PROVIDER IDENTIFIER IS REQUIRED FOR THE BILLING PROVIDER.
1934	A NATIONAL PROVIDER INDENTIFIER IS REQUIRED FOR THE RENDERING PROVIDER.
1936	THE BILLING PROVIDER NUMBER IS INVALID.
1937	THE RENDERING PROVIDER NUMBER IS INVALID.

Denial Code	Long Description
1960	INTERNAL PROCESSING IS REQUIRED.
1963	RENDERING PROVIDER INDICATED IS NOT CERTIFIED AS A RENDERING PROVIDER.
1964	THE BILLING PROVIDER INDICATED IS NOT ALLOWABLE AS A BILLING PROVIDER.
1965	RENDERING PROVIDER NUMBER IS MISSING/INVALID FOR THIS PROCEDURE PROVIDER.
1974	PRESCRIBING/REFERRING/ORDERING PROVIDER INDICATED IS NOT CERTIFIED AS A PRESCRIBING/REFERRING/ORDERING PROVIDER.
1975	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
1976	A VALID PRESCRIBING/REFERRING/ORDERING PROVIDER ID IS REQUIRED.
2001	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2003	THE CLIENT IS NOT ELIGIBLE ON THE REQUESTED START DATE.
2017	THE CLIENT IS ENROLLED IN A MEDICAID OR OTHER MANAGED CARE PROGRAM.
2037	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
2603	CLIENT LOCKED-IN TO A PROVIDER OR ENROLLED IN A HOSPICE. CONTACT CLIENTS HOSPICE FOR PAYMENT OF SERVICES OR RESUBMIT WITH DOCUMENTATION OF UNRELATED NATURE OF CARE.
3324	THE MODIFIER HAS BEEN DISCONTINUED BY THE CENTERS OF MEDICARE AND MEDICAID SERVICES OR THE AMERICAN MEDICAL ASSOCIATION FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
3337	THE PROCEDURE CODE HAS BEEN TERMINATED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, AMERICAN MEDICAL ASSOCIATION, OR AMERICAN DENTAL ASSOCIATION FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT. RESUBMIT WITH VALID A PROCEDURE CODE.
3339	THE PROCEDURE BILLED IS NOT PAYABLE ACCORDING TO DEFICIT REDUCTION ACT (DEFRA) GUIDELINES.
3351	THE PROCEDURE IS NOT COVERED FOR CLIENTS WITH A NURSING HOME AUTHORIZATION ON THE REQUESTED START DATE OR DATE OF RECEIPT.
3353	THE PROCEDURE IS NOT A COVERED SERVICE FOR HOME AND COMMUNITY-BASED WAIVER CLIENTS.
4021	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4027	THE DIAGNOSIS CODE IS INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT.
4031	THE PROCEDURE SUBMITTED IS NOT APPROPRIATE FOR CLIENTS GENDER.
4032	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4034	THE PROCEDURE CODE HAS AN AGE RESTRICTION.
4036	THE PLACE OF SERVICE CODE IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4040	THE PRIMARY DIAGNOSIS CODE IS NOT ON FILE.
4041	THE SECONDARY DIAGNOSIS IS NOT ON FILE.
4046	AN INCORRECT OR INVALID NATIONAL DRUG CODE/PROCEDURE CODE/REVENUE CODE WAS SUBMITTED.
4127	INTERNAL PROCESSING IS REQUIRED.
4131	INTERNAL PROCESSING IS REQUIRED.
4141	THE RENDERING PROVIDER TYPE AND SPECIALTY IS INAPPROPRIATE FOR THE PROCEDURE CODE.
4149	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4150	THE PROCEDURE SUBMITTED IS NOT APPLICABLE TO THE PROVIDER SPECIALTY.
4236	ETIOLOGY DIAGNOSIS CODE(S) (E-CODES) ARE INVALID AS THE PRIMARY DIAGNOSIS.
4244	THE CLIENT IS NOT ELIGIBLE FOR COLORADO MEDICAID BENEFITS.
4245	THE FOURTH POSITION MODIFIER IS INVALID FOR THE REQUESTED START DATE OR THE DATE OF RECEIPT.
4256	THE PROCEDURE CODE AND MODIFIER COMBINATION IS NOT PAYABLE FOR THE CLIENTS BENEFIT PLAN.
4257	THE MODIFIERS SUBMITTED ARE EITHER INVALID FOR THE REQUESTED START DATE OR DATE OF RECEIPT OR THE MODIFIERS ARE MISSING.
4311	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4315	DIAGNOSIS SUBMITTED DOES NOT INDICATE MEDICAL NECESSITY OR IS NOT APPROPRIATE FOR THE SERVICE SUBMITTED.
4316	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4371	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
4372	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4711	THE DIAGNOSIS CODE IS INAPPROPRIATE FOR CLIENTS AGE.
4714	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS AGE.
4731	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS DIAGNOSIS.
4742	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.

Denial Code	Long Description
4743	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4744	THE SECONDARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4745	DIAGNOSIS AND/OR PROCEDURE AND/OR PLACE OF SERVICE (POS) CODE IS NOT COVERED FOR EXPRESS ENROLLMENT CLIENTS.
4746	THE PRIMARY DIAGNOSIS CODE IS INAPPROPRIATE FOR THE SERVICE REQUESTED.
4801	PROCEDURE, DRUG, OR REVENUE CODE IS NOT A COVERED SERVICEON THE REQUESTED START DATE OR DATE OF RECEIPT.
4802	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
4821	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
4871	PLEASE REFER TO PA MESSAGES FOR RETURN INFORMATION.
4963	THE SERVICE REQUESTED IS INAPPROPRIATE FOR THE CLIENTS GENDER.
4990	THE CLIENT IS NOT ELIGIBLE FOR THE SERVICE REQUESTED.
7509	THE PROVIDER IS NOT AUTHORIZED TO PERFORM OR PROVIDE THE SERVICE REQUESTED.
P001	THE BILLING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THE SERVICES.
P002	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P003	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P005	THE PRIOR AUTHORIZATION CAN NOT BE END DATED. THE PRIOR AUTHORIZATION STATUS IS NOT APPROVED OR APPROVED WITH REVISIONS.
P006	PLEASE FURNISH THE PROCEDURE CODE AND CORRESPONDING DESCRIPTION.
P008	THE BILLING PROVIDER NUMBER IS INVALID.
P009	THE BILLING PROVIDER NUMBER IS INVALID.
P010	THE REQUESTED END DATE IS INVALID.
P011	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P012	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P013	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P014	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P015	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P016	THE REQUESTED START DATE IS MISSING OR INVALID.
P019	THE REQUESTED START DATE IS MISSING OR INVALID.
P020	THE RENDERING PROVIDER NUMBER IS INVALID.
P021	THE RENDERING PROVIDER NUMBER IS INVALID.
P022	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P023	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P024	CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P026	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P027	THE PRESCRIBING/REFERRING/ORDERING PROVIDER NAME AND/OR NUMBER IS MISSING OR INVALID.
P030	FIRST MODIFIER IS INVALID.
P031	FIRST MODIFIER IS INVALID.
P032	SECOND MODIFIER IS INVALID.
P033	SECOND MODIFIER IS INVALID.
P034	THIRD MODIFIER IS INVALID.
P035	THIRD MODIFIER IS INVALID.
P036	FOURTH MODIFIER IS INVALID.
P037	FOURTH MODIFIER IS INVALID.
P038	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.

Denial Code	Long Description
P039	THE PROCEDURE IS NOT COVERED FOR THE PLACE OF SERVICE (POS) OR THE TWO DIGIT POS CODE IS INVALID OR BLANK.
P040	THE CLIENT IDENTIFICATION NUMBER IS MISSING OR INVALID.
P041	CLIENTS FIRST NAME IS MISSING.
P042	CLIENTS LAST NAME IS MISSING.
P043	THE BILLING PROVIDERS NAME IS MISSING OR INVALID.
P044	BILLING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES REQUESTED.
P045	FIRST MODIFIER IS INVALID.
P046	SECOND MODIFIER IS INVALID.
P047	THIRD MODIFIER IS INVALID.
P048	FOURTH MODIFIER IS INVALID.
P052	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P053	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
P054	RENDERING PROVIDER IS NOT AUTHORIZED TO PROVIDE SERVICES FOR THE BENEFIT PLAN.
P055	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P061	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
P062	THE CLIENT ID AND/OR NAME INDICATED ON THE PA REQUEST IS INCORRECT. THE CLIENT ID AND/OR NAME HAS BEEN UPDATED. PLEASE VERIFY THE ID AND/OR NAME IS CORRECT.
P064	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
P067	THE FREQUENCY OF HOURS REQUESTED ARE NOT APPROPRIATE FOR THIS CLIENT AND HAVE BEEN MODIFIED ACCORDINGLY.
P079	BILLING PROVIDER IS ON PAYMENT SUSPENSION DUE TO CREDIBLE ALLEGATION OF FRAUD.
P120	CONSISTENT WITH DOCUMENTED MEDICAL NEED, THE NUMBER OF SERVICES REQUESTED HAS BEEN REDUCED.
P121	THE SERVICE/ PROCEDURE REQUESTED IS NOT SUPPORTED BY SUBMITTED DOCUMENTATION.
P126	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
P128	SERVICE PROVIDED BEFORE PRIOR AUTHORIZATION WAS OBTAINED IS NOT ALLOWABLE.
P138	SERVICE(S) DO NOT MEET COLORADO MEDICAID GUIDELINES.
P167	REQUESTED DOCUMENTATION HAS NOT BEEN SUBMITTED.
P178	THE SERVICE REQUESTED IS NOT MEDICALLY NECESSARY.
P179	THE MEDICAL NECESSITY FOR THIS SERVICE IS NOT SUPPORTED BY THE SUBMITTED DOCUMENTATION.
P233	THE DOCUMENTATION SUBMITTED DOES NOT SUBSTANTIATE ADDITIONAL CARE.
P257	THIS CLIENTS FUNCTIONAL ASSESSMENT SCORES PLACE THIS CLIENT OUTSIDE ELIGIBILITY FOR DAY TREATMENT.
P274	OUR RECORDS INDICATE THIS CLIENT IS INVOLVED IN EFFECTIVE AND APPROPRIATE SERVICE ELSEWHERE.
P292	INTENSIVE REHABILITATION HOURS ARE NO LONGER APPROPRIATE AS INDICATED BY HISTORY, DIAGNOSIS, AND/ OR FUNCTIONAL ASSESSMENT SCORES.
P328	THE SERVICES REQUESTED INCLUDE NON-COVERED SERVICES, AND HOURS ARE REDUCED ACCORDINGLY.
P339	THE CLIENTS PAST HISTORY INDICATES REDUCED TREATMENT HOURS ARE WARRANTED.
P342	THE REQUEST DOES NOT MEET GENERALLY ACCEPTED CONDITIONS REQUIRING FLUORIDE TREATMENTS.
P346	SERVICES EXCEED COLORADO MEDICAID LIMITATION AND DOCUMENTATION SUBMITTED DOES NOT SUPPORT THE MEDICAL NECESSITY OF THE SERVICE.
P349	THE SERVICE REQUESTED WAS PERFORMED LESS THAN FIVE YEARS AGO.
P353	THE EXISTING APPLIANCE HAS NOT BEEN WORN FOR THREE YEARS.
P367	THE CLIENT HAS BEEN TOTALLY WITHOUT TEETH AND AN APPLIANCE FOR FIVE YEARS.
P392	THE CLIENT IS MISSING AN ANTERIOR TOOTH AND/OR HAS TWO OR MORE POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P405	THE SERVICE(S) REQUESTED COULD ADEQUATELY BE PERFORMED IN THE DENTAL OFFICE.
P406	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE OF GOOD PERIODONTAL HEALTH (AMERICAN ACADEMY OF PERIODONTOLOGY PERIODONTAL CLASSIFICATION OF TYPE I OR II).

Denial Code	Long Description
P407	DOCUMENTATION SUBMITTED DOES NOT SUPPORT EVIDENCE VISIBLE ON RADIOGRAPHS THAT AT LEAST 50 PERCENT OF THE CLINICAL CROWN IS INTACT.
P409	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING SIX OR MORE TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED, INCLUDING THIRD MOLARS.
P410	DOCUMENTATION SUBMITTED IDENTIFIES THE CLIENT IS MISSING ONE OR MORE ANTERIOR TEETH IN THE ARCH WHERE THE ROOT CANAL IS TO BE PERFORMED.
P411	DOCUMENTATION DOES NOT SUPPORT THE NEED FOR PERIODONTIC SERVICES. POCKETS ARE LESS THAN 4MM AND/OR GREATER THAN 6MM FOR CLIENT AND/OR THE CLIENT IS UNDER THE AGE OF 13.
P412	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA.
P413	SERVICES REQUESTED DO NOT MEET THE COLORADO MEDICAID DEPARTMENTAL REVIEW CRITERIA. THIS PA HAS BEEN GRANTED AS APPROVED NOT APPROVED WITH REVISIONS. THE DURATION REQUESTED MAY HAVE BEEN REDUCED TO REFLECT COVERAGE LIMITATIONS, PRESCRIBER ORDERS, CONFLICTI
P417	THE SERVICE(S) REQUESTED COULD BE ADEQUATELY PERFORMED WITH LOCAL ANESTHESIA.
P437	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO POOR ORAL HYGIENE.
P444	THIS LINE ITEM IS A DUPLICATE OF ANOTHER LINE ITEM ON THIS PRIOR AUTHORIZATION (PA) REQUEST. PLEASE CORRECT.
P446	THIS IS A DUPLICATE OF AN EXISTING PRIOR AUTHORIZATION (PA) REQUEST. YOU MAY CONTACT PROVIDER SERVICES IF YOU REQUIRE ASSISTANCE. DUPLICATE PA REQUEST
P448	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO DECAY HISTORY.
P449	QUESTIONABLE LONG TERM PROGNOSIS DUE TO GUM AND BONE DISEASE.
P456	QUESTIONABLE LONG-TERM PROGNOSIS DUE TO APPARENT ROOT INFECTION.
P457	OUR RECORDS INDICATE THIS CLIENT HAS EXCEEDED ESTABLISHED PROGRAM LIMITATIONS. COLORADO MEDICAID WILL NOT AUTHORIZE NEW DENTURES.
P458	DOCUMENTATION PROVIDED INDICATES A LESS ELABORATE PROCEDURE SHOULD BE CONSIDERED.
P502	RENTAL ONLY ALLOWED; MEDICAL NEED FOR PURCHASE HAS NOT BEEN DOCUMENTED.
P503	PURCHASE ONLY ALLOWED; MEDICAL NEED FOR RENTAL HAS NOT BEEN DOCUMENTED.
P504	OCCUPATIONAL THERAPY GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P505	THE SERVICE REQUESTED IS INCLUDED IN THE NURSING HOME RATE STRUCTURE.
P511	THIS NATIONAL DRUG CODE IS ONLY BILLABLE AS PART OF A COMPOUND DRUG.
P515	THE PRESENCE OF A HANDICAPPING MALOCCLUSION OR HANDICAPPING DENTOFACIAL DEFORMITY IS NOT SUPPORTED BY THE DOCUMENTATION SUBMITTED.
P521	THE REQUESTED PROCEDURE IS COSMETIC IN NATURE, THEREFORE NOT COVERED BY COLORADO MEDICAID.
P522	GASTRO-INTESTINAL SURGERY FOR THE PURPOSE OF WEIGHT CONTROL IS COVERED ONLY AS A LIFE THREATENING PROCEDURE.
P523	THE TREATMENT REQUEST IS NOT CONSISTENT WITH THE CLIENT'S DIAGNOSIS.
P524	PSYCHOTHERAPY PROVIDED IN THE CLIENTS HOME IS NOT A COVERED BENEFIT OF COLORADO MEDICAID.
P525	THE INFORMATION PROVIDED IS NOT CONSISTENT WITH THE INTENSITY OF SERVICES REQUESTED.
P526	INTENSIVE MULTIPLE MODALITY TREATMENT IS NOT CONSISTENT WITH THE INFORMATION PROVIDED.
P527	MULTIPLE PROVIDERS OF TREATMENT ARE NOT INDICATED FOR THIS CLIENT.
P528	THE DURATION OF TREATMENT SESSIONS EXCEED CURRENT COLORADO MEDICAID GUIDELINES.
P534	DOCUMENTATION OF POOR PHYSICAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P535	OTHER PHYSICAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P536	THE PHYSICAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P537	USE OF PHYSICAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P538	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF A PHYSICAL THERAPIST.
P539	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS AND LIVING ARRANGEMENT.
P540	GOALS ARE NOT REALISTIC TO THE CLIENTS WAY OF LIFE OR HOME SITUATION AND SERVE NO FUNCTIONAL OR MAINTENANCE SERVICE.
P541	THE PROCEDURE(S) REQUESTED ARE NOT MEDICAL IN NATURE.

Denial Code	Long Description
P542	DOCUMENTATION OF POOR OCCUPATIONAL THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P543	DOCUMENTATION OF POOR SPEECH THERAPY MOTIVATION, LACK OF PROGRESS, AND/OR LONG STANDING INABILITY TO CARRY-OVER ABILITIES FROM TREATMENT TO THE HOME ENVIRONMENT DOES NOT SUPPORT THE SERVICE/PROCEDURE REQUESTED.
P544	OTHER OCCUPATIONAL THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.
P546	THE OCCUPATIONAL THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P547	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF PHYSICAL THERAPY.
P548	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P549	ACTIVITIES TO PROMOTE DIVERSION OR GENERAL MOTIVATION ARE NONCOVERED COLORADO MEDICAID SERVICES.
P550	REVISIONS OF THE REQUEST IS NECESSITATED BY THE CLIENTS MINIMAL PROGRESS.
P551	RESTORATIVE NURSING INVOLVEMENT COULD BE INCREASED.
P552	CLIENTS DEMONSTRATED RESPONSE TO CURRENT THERAPY DOES NOT WARRANT THE INTENSE FREQUENCY REQUESTED.
P553	MAINTENANCE IS TWO TIMES PER WEEK OR LESS.
P554	THE SPEECH THERAPY SKILLS OF A THERAPIST ARE NOT REQUIRED TO MAINTAIN THE CLIENT.
P555	USE OF OCCUPATIONAL THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P556	USE OF SPEECH THERAPY EQUIPMENT ALONE IS NOT SUFFICIENT TO JUSTIFY MAINTENANCE THERAPY.
P557	ENDURANCE ACTIVITIES DO NOT REQUIRE THE SKILLS OF AN OCCUPATIONAL THERAPIST.
P558	THE SERVICE REQUESTED IS NOT ALLOWABLE FOR THE DIAGNOSIS INDICATED.
P559	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P560	THE MATERIALS/ SERVICES REQUESTED ARE PRINCIPALLY COSMETIC IN NATURE.
P561	THE LENS FORMULA DOES NOT JUSTIFY REPLACEMENT.
P562	THE CHANGE IN THE LENS FORMULA DOES NOT WARRANT MULTIPLE REPLACEMENTS.
P563	THE CLIENT APPEARS TO BE AT A MAXIMUM LEVEL FOR AGE, DIAGNOSIS, AND LIVING ARRANGEMENT.
P564	LENSES ONLY ARE APPROVED; PLEASE DISPENSE A CONTRACTED FRAME. THE NON-CONTRACTED FRAME IS NOT MEDICALLY JUSTIFIED.
P565	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P566	THE PROCEDURE(S) REQUESTED IS NOT MEDICAL IN NATURE.
P567	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF OCCUPATIONAL THERAPY.
P568	RESTORATIVE NURSING CAN PROVIDE FOLLOW-THROUGH BASED ON DIAGNOSIS OF LONG-STANDING NATURE AND THE AMOUNT OF SPEECH THERAPY.
P569	LEVEL, INTENSITY, OR EXTENT OF SERVICE(S) REQUESTED HAS BEEN MODIFIED CONSISTENT WITH MEDICAL NEED AS DEFINED IN THE PLAN OF CARE.
P570	GENERAL EXERCISE TO PROMOTE OVERALL FITNESS AND FLEXIBILITY ARE NONCOVERED COLORADO MEDICAID SERVICES.
P571	THE SERVICE ASKED FOR IS NOT COVERED BY COLORADO MEDICAID AS THESE TASKS CAN BE DONE BY NURSES OR ACTIVITY STAFF.
P572	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P573	INSUFFICIENT DOCUMENTATION TO SUPPORT THE REQUEST.
P574	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P575	MEDICAL NEED FOR EQUIPMENT/ SUPPLY REQUESTED IS NOT SUPPORTED BY DOCUMENTATION SUBMITTED.
P576	OTHER SPEECH THERAPIES CURRENTLY PROVIDE SUFFICIENT SERVICES TO MEET THE CLIENTS NEEDS.

Denial Code	Long Description
P577	DOCUMENTATION SUBMITTED IDENTIFIES THAT THE CLIENT HAS FEWER THAN TWO POSTERIOR TEETH BILATERALLY IN OCCLUSION WITH THE OPPOSING ARCH.
P582	LESS EXPENSIVE ALTERNATIVE SERVICES ARE AVAILABLE FOR THIS CLIENT.
P634	THE CLIENT HAS SHOWN NO SIGNIFICANT FUNCTIONAL PROGRESS TOWARD MEETING OR MAINTAINING ESTABLISHED AND MEASURABLE TREATMENT GOALS OVER A SIX-MONTH PERIOD.
P711	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING PERIODONTAL SCALING AND ROOT PLANNING.
P712	NONE OF THE TEETH REQUESTED MEET GENERALLY ACCEPTED CRITERIA REQUIRING GINGIVECTOMY.
P754	AN APPROVED SUBSTANCE ABUSE DAY TREATMENT PROGRAM CANNOT EXCEED A SIX WEEK PERIOD.
P761	THE CLIENT DOES NOT APPEAR TO BE ABLE OR WILLING TO ABSTAIN FROM ALCOHOL/DRUG USAGE WHILE IN TREATMENT. THEREFORE, SUBSTANCE ABUSE DAY TREATMENT SERVICES ARE NOT APPROVED.
P764	THIS CLIENT HAS COMPLETED INTENSIVE SUBSTANCE ABUSE TREATMENT WITHIN THE PAST 12 MONTHS. THE DOCUMENTATION PROVIDED IS NOT ADEQUATE TO JUSTIFY ADDITIONAL INTENSIVE TREATMENT AT THIS TIME.
P785	A LESS THAN SIX-WEEK HEALING PERIOD HAS BEEN SPECIFIED FOR THIS PRIOR AUTHORIZATION. THEREFORE IT IS NOT NECESSARY TO WAIT THE FULL SIX WEEKS AFTER EXTRACTIONS BEFORE TAKING DENTURE IMPRESSIONS.
P818	SIX-WEEK HEALING TIME IS REQUIRED BETWEEN EDENTULATION AND FINAL IMPRESSIONS. PAYMENT FOR DENTURES WILL BE DENIED OR RECOUPED IF HEALING PERIOD IS NOT OBSERVED.
P849	COLORADO MEDICAID HAS DETERMINED THERE WERE (ARE) SEVERAL HOME HEALTH AGENCIES WILLING TO PROVIDE MEDICALLY NECESSARY SKILLED NURSING SERVICES TO THIS CLIENT.
P864	THE DOCUMENTATION YOU HAVE SUBMITTED DOES NOT MEET THE REQUIREMENTS OF COLORADO MEDICAID.
P873	THE MEDICAL NECESSITY FOR THE HOURS REQUESTED IS NOT SUPPORTED BY THE INFORMATION SUBMITTED.
P874	THE DOCUMENTATION SUBMITTED INDICATES THE TASKS SPECIFIED CAN BE COMPLETED DURING THE VISITS APPROVED.
P878	THE DOCUMENTATION SUBMITTED DOES NOT INDICATE THAT MEDICALLY ORIENTED TASKS ARE MEDICALLY NECESSARY; THEREFORE PERSONAL CARE SERVICES HAVE BEEN APPROVED.
P880	THE QUANTITY OF SERVICES AUTHORIZED FOR THIS CLIENTS PERSONAL CARE HAS BEEN AMENDED BASED ON INFORMATION RECEIVED FROM ONE OR MORE OF THESE SOURCES: THE CLIENT, THEIR PHYSICIAN, AND/OR THE IN-HOME VISIT BY STAFF OF THE OIG (OFFICE OF INSPECTOR GENERAL).
P885	THE USE OF THIS DRUG FOR THE INTENDED PURPOSE IS NOT COVERED BY COLORADO MEDICAID, CONSISTENT WITH COLORADO ADMINISTRATIVE CODE AND FEDERAL LAW.
P924	THE MEDICAL RECORDS SUBMITTED WITH THE CURRENT REQUEST CONFLICT OR DISAGREE WITH OUR MEDICAL RECORDS ON THIS CLIENT.
P950	INDEPENDENT NURSES, PLEASE NOTE PAYABLE SERVICES MAY NOT EXCEED 12 HOURS/DAY OR 60 HOURS/WEEK.
P951	SERVICES CAN ONLY BE AUTHORIZED THROUGH ONE YEAR FROM THE PRESCRIPTION DATE.
P952	LEAD INSPECTION IS A COVERED COLORADO MEDICAID SERVICE WHEN THE CHILD HAS BEEN SHOWN TO HAVE LEAD POISONING (E.G., CHILD HAS A BLOOD LEAD LEVEL > 19 UG/DL OR TWO CONSECUTIVE BLOOD LEAD LEVELS OF 15-19 UG/DL DONE AT LEAST 90 DAYS APART). THE INSPECTION MUS
P953	THE SERVICE CODES HAVE BEEN AUTHORIZED AS A GROUP. UNITS/DOLLARS AUTHORIZED APPLY TO ALL SERVICE CODES COMBINED WITHIN THAT GROUP.
P954	THE RENDERING PROVIDER NUMBER CANNOT BE CHANGED ON THE PRIOR AUTHORIZATION. A CLAIM HAS BEEN PAID FOR THIS SERVICE.
P956	THE REQUEST CAN ONLY BE BACKDATED A MAXIMUM OF 14 DAYS FROM FIRST DATE RECEIVED BY COLORADO MEDICAID.
P957	COMPLETE PERIODONTAL CHARTING AT TIME OF SERVICE, AND SUBMIT CHARTING, COPY OF OPERATIVE REPORT, TOGETHER WITH A COPY OF THE PRIOR AUTHORIZATION DENTAL REQUEST FORM (PA/DRF), F-11035, TO PA UNIT ATTENTION DENTAL CONTSULTANT.
P958	NOTE THAT CODE D4341 HAS BEEN CHANGED. REFER TO THE DECISION NOTICE FOR AUTHORIZED QUANTITY.

Denial Code	Long Description
P960	YOUR PA HAS BEEN APPROVED FOR 90 DAYS. THE 90 DAY APPROVAL DOES NOT IMPLY THE PA REQUEST MEETS PRIOR AUTHORIZATION CRITERIA. AFTER ADDITIONAL INFORMATION IS AVAILABLE IN INTERCHANGE, COLORADO MEDICAID WILL CREATE AN AMENDMENT REQUEST TO EXTEND THE PA FOR
P961	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
P962	PROVIDERS ARE REMINDED THAT PRIOR AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PROVIDERS MUST ADHERE TO THE SERVICE LIMITATIONS SPECIFIED BY THE PLAN.
PA10	THE REQUESTED END DATE IS INVALID.
PA12	PLEASE FURNISH A WRITTEN DESCRIPTION OF THE CLIENTS DIAGNOSIS.
PA13	PROVIDE DIAGNOSES WITH DATES OF ONSET.
PA14	IDENTIFY PROBLEMS TO BE TREATED.
PA15	THE AUDIOLOGISTS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION REQUEST FOR HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS1), F-11020, AND PRIOR AUTHORIZATION REQUEST/HEARING INSTRUMENT AND AUDIOLOGICAL SERVICES (PA/HIAS2), F-11021.
PA16	THE PHYSICIANS SIGNATURE IS REQUIRED ON THE PRIOR AUTHORIZATION/PHYSICIAN OTOLOGICAL REPORT (PA/POR), F-11019.
PA17	SUBMIT BRIEF HISTORY WITH REFERRAL INFORMATION, LIVING SITUATION, FUNCTIONAL STATUS, AND OTHER PERTINENT INFORMATION. WHAT CHANGE OF STATUS RESULTED IN REFERRAL AT THIS TIME?
PA18	PLEASE FURNISH THE CLIENTS HEIGHT AND WEIGHT.
PA19	PLEASE SUBMIT CLINICAL INFORMATION SUFFICIENT TO VERIFY THE NEED FOR THE REQUESTED SERVICE(S).
PA20	PLEASE RESUBMIT WITH COMPLETE PERIODONTAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PA21	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL EDUCATIONAL PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA22	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUAL PROGRAM PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA23	REFER TO THE DURABLE MEDICAL EQUIPMENT INDEX FOR APPROPRIATE CODE AND DESCRIPTION. DO NOT USE AN "UNLISTED" CODE.
PA24	ATTACH SUPPORTIVE DOCUMENTATION; INDIVIDUALIZED FAMILY SERVICE PLAN AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA25	INFORMATION ON THE REQUEST FORM IS ILLEGIBLE, AND THE REQUEST CANNOT BE PROCESSED.
PA26	RE-EVALUATE YOUR GOALS. EMPHASIS SHOULD BE ON FUNCTIONAL SELF-CARE. GOALS MUST BE RELATED TO FUNCTIONAL OUTCOME.
PA27	PLEASE CLARIFY THE NUMBER OF HOURS PER WEEK REQUESTED.
PA28	PLEASE CLARIFY THE NUMBER OF HOURS PER DAY REQUESTED.
PA29	PLEASE CLARIFY THE NUMBER OF VISITS PER DAY REQUESTED.
PA30	ATTACH SUPPORTIVE DOCUMENTATION; HOME EXERCISE PROGRAM AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA31	THE DIAGNOSIS CODE INDICATED ON THE REQUEST DOES NOT CORRESPOND TO THE DIAGNOSIS CODE DESCRIPTION.
PA32	PLEASE SUBMIT ADDITIONAL INFORMATION SUFFICIENT TO VERIFY APPROPRIATENESS AND NEED FOR TRANSPLANT.
PA33	PLEASE SUBMIT THE INITIAL AND PROGRESSIVE OBJECTIVE FINDINGS.
PA34	ATTACH SUPPORTIVE DOCUMENTATION, FACILITY PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA35	PLEASE SUBMIT THE CLIENTS ORIGINAL COMPLAINTS AND EXAMINATION FINDINGS.
PA36	ATTACH SUPPORTIVE DOCUMENTATION, IN-HOME AUTISM PLAN, AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.
PA37	PLEASE SUBMIT YOUR TREATMENT PLAN FOR THIS CLIENT.
PA38	ATTACH SUPPORTIVE DOCUMENTATION AND WRITTEN EVIDENCE OF TREATMENT COORDINATION WITH OTHER PROVIDERS.

Denial Code	Long Description
PA39	INITIAL EVALUATIONS MUST BE PERFORMED BY AN OCCUPATIONAL THERAPIST REGISTERED (OTR), PER AMERICAN OCCUPATIONAL THERAPY ASSOCIATION (AOTA) STANDARDS.
PA41	IDENTIFY THE PLACE OF SERVICE AND ITS EFFECT ON SUPPORTING THE DESIRED TREATMENT OUTCOME.
PA42	PLEASE INDICATE THE HOURS OF USE OF OXYGEN PER 24-HOUR PERIOD.
PA43	PROVIDE BASELINE DOCUMENTATION FOR THIS CLIENTS LIMITATIONS USING UNITS OF MEASUREMENT THAT ARE APPLIED CONSISTENTLY WHEN REPORTING STATUS.
PA44	IDENTIFY FUNCTIONAL LIMITATIONS AS THEY ARE RELATED TO IDENTIFIED CONDITIONS.
PA46	CORRELATE PLAN OF CARE TO REQUESTED PROCEDURE CODES.
PA47	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE FREQUENCY/DURATION REQUESTED.
PA48	PLEASE PROVIDE THE NAME AND CREDENTIALS OF THE RENDERING PROVIDER.
PA50	COLORADO MEDICAID RECORDS INDICATE THE CLIENT OWNS A WHEELCHAIR. DOCUMENT THE REASON AND NEED FOR REPLACEMENT AND COST TO REPAIR CURRENT WHEELCHAIR.
PA51	PLEASE DISTINGUISH PRIMARY AND SUPPORTIVE MODALITIES.
PA52	PLEASE SUBMIT A PROGRESS REPORT.
PA53	MULTIPLE FAMILY CLIENTS TREATMENT BY THE SAME PROVIDER REQUIRES FURTHER INFORMATION DOCUMENTING COORDINATION OF TREATMENT PLAN.
PA54	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE MINUTES REQUESTED.
PA55	MEDICAL NECESSITY OF TREATMENT REQUIRES ADDITIONAL DOCUMENTATION.
PA56	GIVEN AGE, DIAGNOSES, CURRENT LEVEL OF FUNCTION, PAST RESPONSE TO TREATMENT, AND LIVING SITUATION, EXPAND ON POTENTIAL FOR SIGNIFICANT FUNCTIONAL PROGRESS WITHIN THE NEXT SIX MONTHS. EMPHASIZE WHY PROGRESS IS EXPECTED WITH SERVICES AT THIS TIME.
PA57	SUBMIT THE INITIAL FINDINGS. INCLUDE A COMPREHENSIVE EVALUATION.
PA58	SUBMIT PROGRESSIVE, OBJECTIVE FINDINGS. INCLUDE A PERTINENT RE-EVALUATION.
PA59	PLEASE SUPPLY INFORMATION REGARDING THE CLIENTS MEDICATION REQUIREMENTS, IF ANY.
PA60	PLEASE SPECIFY IF THE CLIENT IS IN AN EDUCATIONAL SETTING.
PA61	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA62	PLEASE FURNISH THE COMPLETE ADDRESS OF THE BILLING PROVIDERS PRACTICE LOCATION, INCLUDING THE ZIP+4 CODE.
PA63	THE SKILLS OF A THERAPIST ARE PURPOSEFUL AND SKILLED INTERVENTIONS REQUIRED TO CONTINUALLY DESIGN, IMPLEMENT, REASSESS, MODIFY/GRADE, AND/OR DISCONTINUE A PLAN OF CARE IN A TIMELY MANNER, BASED ON THE COMPLEXITY OF THE CLIENTS MEDICAL CONDITION AND/OR CO
PA64	PLEASE SUBMIT A THERAPY PLAN OF CARE, INCLUDING A CURRENT, DATED EVALUATION.
PA65	A PLAN OF CARE SIGNED AND DATED BY THE PHYSICIAN IS REQUIRED.
PA66	THE SKILLS OF A THERAPIST ARE REQUIRED WHEN ONLY THE THERAPIST CAN SAFELY AND EFFECTIVELY DELIVER THE THERAPEUTIC PROCEDURES BECAUSE OF THEIR UNIQUE KNOWLEDGE, TRAINING, AND EXPERTISE. DESCRIBE THE REASON THAT SOMEONE OTHER THAN A THERAPIST CANNOT SAFELY
PA67	PLEASE SPECIFY IF THE CLIENTS WORK SITE DEMANDS GOOD BINAURAL HEARING.
PA68	DESCRIBE THE REASON, BASED ON THE CLIENTS COGNITIVE, PHYSICAL, COMMUNICATION, OR RESOURCE STATUS, THAT A HOME PROGRAM, EQUIPMENT, OR ENVIRONMENTAL ADAPTATIONS ALONE CANNOT MEET CLIENTS NEEDS.
PA69	PLEASE SPECIFY IF THE CLIENT HAS AN ACCOMPANYING DISABILITY THAT ADDS TO THE HEARING PROBLEM.
PA70	DISTINGUISH REQUESTED PROCEDURES AND GOALS FROM OTHER SERVICES THIS CLIENT RECEIVES. THEY MAY NOT BE DUPLICATIVE.
PA71	PLEASE INDICATE THE NUMBER OF DAYS REQUESTED.
PA73	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA74	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).
PA75	PLEASE DOCUMENT CARRYOVER OF THE THERAPY PROGRAM TO NURSING.
PA76	PLEASE SUBMIT ADDITIONAL INFORMATION THAT SUPPORTS THE CLINICAL NEED FOR THE REQUESTED SERVICE(S).

Denial Code	Long Description
PA79	PROVIDE EVIDENCE OF SIGNIFICANT FUNCTIONAL PROGRESS IN LAST SIX MONTHS.
PA84	THE GRANT DATE OF THIS REQUEST CANNOT BE PRIOR TO THE SIGNATURE DATE OF THE PRESCRIBING PHYSICIAN.
PA86	PROVIDE EVIDENCE OF SKILLS GAINED IN THERAPY CARRYING OVER TO OTHER SETTINGS WITHIN SIX MONTHS.
PA87	DISCUSS HOW GOALS AND REHABILITATION POTENTIAL ARE SUPPORTED BY THE NUMBER OF SESSIONS REQUESTED.
PA88	THE REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL SCOPE OF PRACTICE.
PA89	PRIOR AUTHORIZATION IS NOT REQUIRED UNTIL LIMITATION OF SERVICE HAS BEEN REACHED.
PA91	PLEASE SUBMIT REQUIRED X-RAYS.
PA92	PLEASE PROVIDE AN EXPLANATION FOR THE MATERIAL SUBMITTED WITH THE REQUEST.
PA95	PLEASE DESCRIBE HOW THE PROVISION OF THIS SERVICE WOULD PREVENT INSTITUTIONALIZATION OF THE CLIENT.
PA96	COULD THE EXISTING DENTURE(S) BE RELINED OR REBASED? IF NOT, PLEASE EXPLAIN WHY NOT.
PA97	REQUESTED TREATMENT DOES NOT APPEAR TO BE WITHIN THE PROFESSIONAL STANDARDS OF PRACTICE.
PA98	PLEASE INDICATE IF THE CLIENT IS CURRENTLY BEING TUBE FED.
PB02	PLEASE PROVIDE THE REQUIRED DATED SIGNATURES ON THE ATTACHMENTS.
PB03	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING THE LOSS/DESTRUCTION/THEFT OF THE HEARING AID.
PB04	DESCRIBE THE CLIENTS ABILITY TO STAND OR AMBULATE SUFFICIENTLY TO ACCOMPLISH SELF-CARE ACTIVITIES.
PB07	PLEASE SUBMIT AN ORTHODONTIC STUDY MODEL OR DIAGNOSTIC CASTS.
PB09	PLEASE PROVIDE A PHOTOGRAPH OF THE INVOLVED AREA(S).
PB10	PLEASE PROVIDE AN ESTIMATION (IN GRAMS) OF THE TOTAL AMOUNT OF TISSUE TO BE RESECTED.
PB11	PLEASE SUBMIT THE PLAN OF CARE FOR CO-TREATMENT.
PB12	FURNISH A DETAILED DESCRIPTION FOR THE PROCEDURE CODE REQUESTED.
PB13	THE RENDERING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB15	THE BILLING PROVIDER TAXONOMY CODE IS MISSING OR INVALID.
PB18	PLEASE COMPLETE THE ATTACHED OUT-OF-STATE PROVIDER DATA SHEET, F-11001, AND RESUBMIT.
PB20	A SIGNED AND DATED PRESCRIPTION IS REQUIRED WITHIN THREE MONTHS OF RECEIPT BY COLORADO MEDICAID FOR INITIAL REQUESTS AND WITHIN 12 MONTHS OF RECEIPT BY COLORADO MEDICAID FOR SUBSEQUENT REQUESTS.
PB21	PLEASE COMPLETE THE APPROPRIATE PRIOR AUTHORIZATION ATTACHMENT. CONTACT PROVIDER SERVICES OR THE PRIOR AUTHORIZATION UNIT FOR ASSISTANCE.
PB23	PHYSICAL THERAPY ASSISTANT NOTES AND ALL FORMS SUBMITTED MUST BE COSIGNED BY A REGISTERED PHYSICAL THERAPIST.
PB31	ARE YOU REQUESTING A COMPLETE APPLIANCE, OR REPLACEMENT PARTS?
PB32	THE PROCEDURE CODE INDICATED ON THE REQUEST DOES NOT MATCH THE DESCRIPTION OF SERVICE; PLEASE CORRECT AND RESUBMIT.
PB35	THE SERVICE REQUESTED DOES NOT REQUIRE PRIOR AUTHORIZATION.
PB41	PLEASE FURNISH A CURRENT MENTAL HEALTH DAY TREATMENT FUNCTIONAL ASSESSMENT, F-11090 (DATED WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID).
PB45	THE CERTIFICATION PERIOD ON THE PLAN OF CARE (POC) DOES NOT COVER THE REQUESTED GRANT/START DATE. PLEASE RESUBMIT YOUR REQUEST WITH A NEW POC.
PB49	A CERTIFIED OCCUPATIONAL THERAPY ASSISTANTS NOTES MUST BE COSIGNED BY AN OCCUPATIONAL THERAPIST REGISTERED.
PB51	ADDITIONAL INFORMATION IS REQUIRED ON PRIOR AUTHORIZATION TO ENABLE PRICING.
PB54	REQUESTED SERVICES DO NOT MATCH SERVICES ON THE PHYSICIANS ORDERS.
PB59	PLEASE PROVIDE AN INDIVIDUAL EDUCATIONAL PLAN (IEP), WHICH HAS BEEN SIGNED BY THE PROVIDER NO EARLIER THAN NINE MONTHS PRIOR TO RECEIPT AT COLORADO MEDICAID; OTHERWISE, DOCUMENT WHY NO IEP EXISTS.
PB65	PLEASE FURNISH THE ANTICIPATED TOTAL CHARGES FOR THIS REQUEST.
PB66	A PHOTOCOPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED; THE DATE MUST BE WITHIN SIX MONTHS OF RECEIPT BY COLORADO MEDICAID.

Denial Code	Long Description
PB67	THE PRESCRIPTION DATE MUST INCLUDE MONTH, DAY, AND YEAR.
PB68	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 90 DAYS OF RECEIPT BY COLORADO MEDICAID.
PB73	THE SERVICES IDENTIFIED ON THE PLAN OF CARE DO NOT APPEAR APPROPRIATE FOR THE PROCEDURE CODE(S) REQUESTED ON THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018.
PB74	THE CLIENT/PROVIDER DOES NOT HAVE RETROACTIVE ENROLLMENT.
PB75	THE REQUESTED START DATE IS MORE THAN 14 DAYS BEFORE OR 62 DAYS AFTER RECEIPT.
PB82	THE SERVICE REQUESTED IS NOT A COVERED BENEFIT.
PB83	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A HOME HEALTH AIDE. PLEASE RESUBMIT AS A PERSONAL CARE WORKER OR PROVIDE ADDITIONAL DOCUMENTATION.
PB86	THE SERVICES REQUESTED ARE NOT BEING PROVIDED IN THE CLIENTS RESIDENCE. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL.
PB87	THE PLAN OF CARE DOES NOT DOCUMENT THE MEDICAL NECESSITY OF THE SKILL LEVEL OF A NURSE. PLEASE RESUBMIT AS A HOME HEALTH AIDE OR PROVIDE ADDITIONAL DOCUMENTATION.
PB92	PLEASE FURNISH THE CLIENTS COMPLETE ADDRESS.
PB94	IF THE CLIENT IS A RESIDENT OF A NURSING HOME, SUPPLY THE COMPLETE NAME AND ADDRESS OF THE NURSING HOME.
PB99	THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF), F-11018, MUST BE SIGNED AND DATED.
PC01	PLEASE SUPPLY THE RENDERING PROVIDERS PROVIDER NUMBER.
PC03	THE DRUG ENFORCEMENT ADMINISTRATION NUMBER IS MISSING OR INVALID.
PC06	PLEASE DESCRIBE YOUR PROGRAM; INCLUDE ENTRY DATE, TERMINATION DATE, HOURS PER WEEK, AND NUMBER OF WEEKS OF PRIMARY INTENSIVE SERVICE REQUESTED.
PC07	PLEASE DESCRIBE YOUR "AFTERCARE/FOLLOW-UP" PLANS FOR THIS CLIENT.
PC08	PLEASE SUPPLY DOCUMENTATION OF PREVIOUS SUBSTANCE ABUSE SERVICES WITH DATE(S) AND OUTCOME.
PC09	PLEASE DESCRIBE IN DETAIL THE TREATMENT OBJECTIVES/GOALS FOR THIS CLIENT.
PC10	PLEASE DESCRIBE THE FAMILY SITUATION/DYNAMICS. EXPLAIN HOW THE FAMILY WILL BE INCORPORATED INTO THE CLIENTS PLAN OF CARE.
PC12	PLEASE EXPLAIN IF YOUR SERVICE ENCOURAGES THE CLIENT TO ATTEND SELF-HELP GROUPS.
PC13	PLEASE SUPPLY A SPECIFIC SCHEDULE OF ACTIVITIES, INCLUDING DAY, TIME OF DAY, LENGTH OF SESSION, AND SERVICE TO BE RENDERED DURING THAT TIME.
PC15	PLEASE FURNISH DIAGNOSTIC RATIONALE.
PC17	PLEASE DOCUMENT IF THE CLIENT EVER RECEIVED SUBSTANCE ABUSE ASSESSMENT AND/OR TREATMENT.
PC19	PLEASE FURNISH MORE EXTENSIVE AND IN-DEPTH HISTORICAL AND PSYCHOSOCIAL DATA.
PC20	PLEASE SUPPLY THE DATE THE CLIENT BECAME TOTALLY ENDENTULOUS.
PC23	PLEASE SUBMIT A PHYSICIANS STATEMENT REGARDING THE MEDICAL NECESSITY OF DENTURES FOR THIS CLIENT. THE PHYSICIANS STATEMENT MUST DOCUMENT THE MEDICAL NEED FOR DENTURES.
PC24	THE SERVICE REQUESTED WAS PREVIOUSLY AUTHORIZED. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT INDICATING THIS FACT IS REQUIRED.
PC25	PLEASE SUPPLY SUFFICIENT MITIGATING CIRCUMSTANCES TO WARRANT THE CONSTRUCTION OF NEW DENTURES(S).
PC26	TREATMENT REQUESTED HAS NOT BEEN PROVEN TO BE OF MEDICAL VALUE OR USEFULNESS OR HAS BEEN DETERMINED TO BE EXPERIMENTAL IN NATURE.
PC28	PLEASE SUBMIT A PHYSICIANS STATEMENT INDICATING DENTURES ARE NECESSARY FOR THIS NURSING HOME CLIENT.
PC29	PLEASE SUBMIT DOCUMENTATION SUBSTANTIATING LOSS OR DESTRUCTION OF DENTURE(S). INCLUDE SIGNED STATEMENT FROM CLIENT OR FACILITY DIRECTOR REGARDING HOW, WHEN AND WHERE LOST.
PC30	PLEASE PROVIDE COMPLETE INTRAORAL CHARTING AND AMERICAN ASSOCIATION OF PERIODONTISTS CLASSIFICATION OF PERIODONTAL CASE TYPE.
PC31	PLEASE DESCRIBE ANY RELATED DEFORMITIES OF THE FEET.
PC34	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD WITH REQUESTED DME ITEM(S) AND DOCUMENT IF THE CLIENT CAN USE SAFELY AND INDEPENDENTLY.
PC35	PLEASE INDICATE THE LENGTH OF TRIAL PERIOD AND DESCRIBE THE RESULTS AND EFFECTIVENESS OF THE SERVICE REQUESTED.

Denial Code	Long Description
PC39	PLEASE INDICATE LITER FLOW PER MINUTE, HOURS OF USE PER 24 HOUR PERIOD, AND THE EXPECTED DURATION OF NEED.
PC40	THE ITEM DOES NOT REQUIRE PRIOR AUTHORIZATION UNTIL THE LIFE EXPECTANCY HAS BEEN REACHED.
PC41	PLEASE SUPPLY INFORMATION INDICATING THE NECESSITY OF POSITIONING THE CLIENT'S BODY IN MULTIPLE POSITIONS.
PC42	PLEASE INDICATE IF THE BED HEIGHT MUST BE CHANGED TO ALLOW FOR SAFE TRANSFER OR ADEQUATE BED CARE.
PC43	SUPPLY A PHYSICIANS STATEMENT INDICATING TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR UNIT HAS REDUCED PAIN, IMPROVED/INCREASED THE CLIENTS ACTIVITY LEVEL, AND/OR REDUCED CLIENTS USE OF PAIN MEDICATION.
PC44	A CURRENT AUTHORIZATION FOR THIS SERVICE IS ON FILE FOR ANOTHER PROVIDER. IF THE SERVICE WAS NOT PROVIDED, A STATEMENT OF THAT FACT IS REQUIRED BY THE CLIENT OF FIRST PROVIDER.
PC59	DOCUMENT DECLINE OR PROGRESS IN SPECIFIC, MEASURABLE, OBJECTIVE TERMS.
PC60	DOCUMENT IF CLIENT HAS DEMONSTRATED A GOOD APPOINTMENT COMPLIANCE RECORD.
PC61	THE PHYSICIANS SIGNATURE DATE MUST NOT EXCEED 90 DAYS FROM THE DATE OF RECEIPT BY COLORADO MEDICAID.
PC62	REQUESTS FOR A CONTINUATION OF THERAPY SHOULD NOT BE SUBMITTED MORE THAN FOUR WEEKS PRIOR TO THE EXPIRATION DATE OF THE CURRENT AUTHORIZATION.
PC63	PLEASE FURNISH THE STYLE AND MANUFACTURER OF THE FRAME.
PC64	PLEASE FURNISH THE CLIENTS LENS FORMULA.
PC66	ALL REQUESTS FOR TINTS REQUIRE DOCUMENTATION OF THE VISUAL OR MEDICAL CONDITION RELATED TO PHOTOPHOBIA.
PC67	PLEASE DOCUMENT THE REASON AND JUSTIFICATION FOR REPLACEMENT BEYOND THE FIRST LENS/FRAME.
PC68	DOCUMENT IF ALL REMAINING MAXILLARY AND/OR MANDIBULAR TEETH ARE DECAY-FREE, PROPERLY RESTORED, AND PERIODONTICALLY SOUND.
PC72	SUPPLY MORE DETAIL REGARDING PROGRESS (ATTACHMENT OF GOALS, ETC.). CORRELATE PROGRESS TO PREVIOUS GOALS AND IDENTIFIED LIMITATIONS.
PC77	PLEASE SUBMIT A PLAN OF CARE DESCRIBING THE SERVICES THAT WOULD BE PROVIDED.
PC78	PLEASE DOCUMENT SPECIFIC, MEASURABLE GOALS.
PC82	THE PRIOR AUTHORIZATION (PA) SYSTEM CAN PROCESS ONLY 26 DETAILS PER PA REQUEST. PLEASE RESUBMIT YOUR REQUEST WITH NO MORE THAN 26 DETAILS.
PC83	PLEASE SUPPLY A PHYSICIANS PRESCRIPTION DATED WITHIN ONE MONTH OF REQUESTED SUBSTANCE ABUSE DAY TREATMENT.
PC84	PLEASE PROVIDE INFORMATION INDICATING THIS CLIENT IS APPROPRIATELY DETOXIFIED FROM ALCOHOL AND/OR OTHER DRUGS.
PC85	PLEASE PROVIDE INFORMATION TO INDICATE THE CLIENTS ABILITY TO ABSTAIN FROM ALCOHOL OR DRUGS WHILE IN THE SUBSTANCE ABUSE DAY TREATMENT PROGRAM.
PC86	PLEASE INDICATE IF THIS CLIENT IS WILLING TO PARTICIPATE IN AFTERCARE OR CONTINUING CARE SERVICES.
PC87	PROVIDE MORE INFORMATION ON TREATMENT HISTORY; INCLUDE SERVICE PROVIDED, DATES, AND OUTCOME. PROVIDE DETAIL OF PREVIOUS TREATMENT.
PC88	PLEASE PROVIDE MORE RATIONALE FOR THE APPROPRIATENESS AND MEDICAL NECESSITY OF SUBSTANCE ABUSE DAY TREATMENT.
PC89	PROVIDE A TREATMENT PLAN THAT CONTAINS MEASURABLE GOALS AND OBJECTIVES CORRESPONDING TO THE IDENTIFIED DEFICIT.
PC91	PLEASE PROVIDE MORE INFORMATION ON FAMILY INVOLVEMENT TREATMENT.
PC92	PLEASE PROVIDE MORE HISTORY AND EXPLANATION ABOUT THE ISSUE OF ABSTINENCE FOR THIS CLIENT.
PC94	PLEASE PROVIDE THE ANTICIPATED BEGINNING DATE AND/OR THE ESTIMATED SUBSTANCE ABUSE DAY TREATMENT DISCHARGE DATE.
PC95	PLEASE SUPPLY JUSTIFICATION FOR BEGINNING CLIENT IN SERVICE PRIOR TO AUTHORIZATION BEING OBTAINED.
PC96	THE INITIAL THREE HOURS OF SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IN A CALENDAR YEAR DO NOT REQUIRE PRIOR AUTHORIZATION.

Denial Code	Long Description
PC97	REIMBURSEMENT FOR INITIAL SUBSTANCE ABUSE DAY TREATMENT ASSESSMENT IS LIMITED TO THREE HOURS IN A CALENDAR YEAR AND DOES NOT REQUIRE PRIOR AUTHORIZATION.
PC98	THIS DRUG IS CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE BILL USING THE APPROPRIATE NATIONAL DRUG CODE (NDC) OR SUBMIT A COMPLETED DRUG ADDITION REQUEST FORM IF THE NDC IS NOT LISTED IN THE DRUG INDEX.
PC99	THIS DRUG IS NOT CURRENTLY COVERED BY COLORADO MEDICAID. PLEASE REFER TO THE ONLINE HANDBOOK AREA OF THE PROVIDER SECTION OF THE COLORADO MEDICAID PORTAL, CURRENT ADMINISTRATIVE RULE, OR COLORADO DRUG INDEX FOR COVERAGE LIMITATIONS.
PD01	DOCUMENT THAT CLIENT HAS ACHIEVED GOOD ORAL HYGIENE, PERIODONTAL CASE TYPE 1 OR 2, AND IS MOTIVATED TO MAINTAIN SAME.
PD03	PLEASE PROVIDE AN ARTERIAL BLOOD GAS READING OR PULSE OXIMETRY RESULTS DONE ON ROOM AIR SIGNED AND DATED BY A MEDICAL DOCTOR. THIS SHOULD BE DONE WITHIN 60 DAYS OF REQUESTED SERVICE.
PD04	A COPY OF THE PHYSICIANS SIGNED AND DATED PRESCRIPTION IS REQUIRED. THE DATE MUST BE WITHIN 30 DAYS OF RECEIPT BY COLORADO MEDICAID.
PD07	SUBMIT A PHOTOCOPY OF A VALID PRESCRIPTION, ISSUED WITHIN THE PAST YEAR, OR COMPLETE SECTION B OF THE PRIOR AUTHORIZATION/DRUG ATTACHMENT (PA/DGA), F-11049.
PD10	BRAND MEDICALLY NECESSARY MUST BE IN THE PRESCRIBERS OWN HANDWRITING AND WRITTEN DIRECTLY ON THE PRESCRIPTION OR A SEPARATE ORDER ATTACHED TO THE ORIGINAL PRESCRIPTION.
PD12	COMPLETE DENTURES, PARTIAL DENTURES, DENTURE RELINES, AND FIXED PROSTHODONTIC SERVICES ARE NOT COVERED SERVICES FOR ADULTS FOR DATES OF SERVICE ON AND AFTER OCTOBER 1, 1995.
PD22	PLEASE COMPLETE ALL REQUIRED ELEMENTS ON THE PERSONAL CARE SCREENING TOOL (PCST), F-11133.
PD24	THIS PRIOR AUTHORIZATION REQUEST IS UNABLE TO BE PROCESSED. PLEASE RESUBMIT WITH ADDITIONAL REQUIRED FORMS, INCLUDING THE ENTIRE PERSONAL CARE SCREENING TOOL (PCST), F-11133; PERSONAL CARE ADDENDUM, F-11136; AND SUPPORTING DOCUMENTATION, AS DIRECTED.
PD25	THERE IS A PERSONAL CARE SCREENING TOOL (PCST), F-11133, COMPLETED BY ANOTHER AGENCY. CONTACT THE AGENCY TO TRANSFER SCREEN.
PD26	THERE IS A LIMITED TERM CARE FUNCTIONAL SCREEN (LTC-FS) COMPLETED BY ANOTHER AGENCY. THE PERSONAL CARE SCREENING TOOL (PCST), F-11133, INFORMATION IS IN CONFLICT WITH LTC-FS.
PD27	ONLY ONE LEVEL OF FUNCTION MAY BE SELECTED FOR ALL ELEMENTS EXCEPT TOILETING. COLORADO MEDICAID IS UNABLE TO PROCESS THE PRIOR AUTHORIZATION REQUEST.
PD28	NO UNITS MAY BE REQUESTED USING THIS PRIOR AUTHORIZATION PROCESS. PLEASE SUBMIT WITH THE APPROPRIATE ATTACHMENTS FOR REQUESTING SPECIFIC PERSONAL CARE WORKER UNITS.
PD29	CLIENT IS NOT ELIGIBLE FOR THE REQUESTED SERVICE(S) AS OF THE REQUESTED START DATE.
PD30	NO TRAVEL TIME MAY BE AUTHORIZED WHEN NO PERSONAL CARE WORKER SERVICE IS AUTHORIZED.
PD32	PROVIDER NOT CERTIFIED TO RENDER THE SERVICE(S) REQUESTED.
PD34	BASED ON THE DOCUMENTATION SUBMITTED, THIS REQUEST CAN NOT BE PRIOR AUTHORIZED. REFER TO THE PA MESSAGES FROM THE CONSULTANT FOR COMPLETE EXPLANATION.
PD98	PLEASE DOCUMENT HOW AND WHEN EACH PREVIOUSLY AUTHORIZED PRO RE NATA VISIT WAS USED.

Appendix N Revisions Log

Revision Date	Appendix	Pages	Made by
12/01/2016	*Manual revised for interChange implementation. For manual revisions prior to 12/01/2016 Please refer to Archive.*	*All*	*HPE (now DXC)*
1/19/2017	*Contents replaced with current Denial Reasons List as provided by the Department.*	*All*	*HPE (now DXC)*
1/26/2017	*Updates based on Department 1/20/2017 approval email*	*Accepted tracked changes throughout*	*HPE (now DXC)*
5/22/2017	*Updates based on Fiscal Agent name change from HPE to DXC*	*957*	*DXC*

Note: In many instances when specific pages are updated, the page numbers change for the entire section. Page numbers listed above, are the page numbers on which the updates/changes occur.