Top 15 Most Frequent Denial Codes: A Reference Guide

This quick reference guide provides a list of common claim denial codes, along with their definitions and recommended actions for resubmission or correction. Please use this resource to help reduce rework, prevent denials, and resolve issues efficiently.

Denial Codes	Denial Explanation	What Does This Mean?	Actions To Consider
CDD	Duplicate Service	Indicates a new claim was submitted for the same Tax ID, date of service and procedure for a specific Member that was previously submitted, processed for payment, or denied.	Identify the original claim that was submitted and denied or paid. Claim look up functionality is available via the MVP Provider Portal. Submit a replacement claim (frequency of 7) with correction for consideration. ***Submission of a new claim will result in duplicate denial.*** More information regarding claim submission and adjustments can be found in the *Claims* Section of the MVP Provider Policies
YFL	Duplicate claim to a previously paid/denied/in process claim	Indicates a new claim was submitted for the same Tax ID, date of service and procedure for a specific Member that was previously submitted, processed for payment, or denied.	Identify the original claim that was submitted and denied or paid. Claim look up functionality is available via the MVP Provider Portal. Submit a replacement claim (frequency of 7) with correction for consideration. ***Submission of a new claim will result in duplicate denial.*** More information regarding claim submission and adjustments can be found in the *Claims* Section of the MVP Provider Policies
YFH	Duplicate claim previously paid	Indicates a new claim was submitted for the same Tax ID, date of service and procedure for a specific Member that was previously submitted and processed.	No action required. Claim for that date of service has been paid. Refer to the original claim. Claim look up functionality is available via the MVP Provider Portal. More information regarding claim submission and adjustments can be found in the *Claims* Section of the MVP Provider Policies
YFI	Duplicate claim previously denied	Indicates a new claim was submitted for the same Tax ID, date of service and procedure for a specific Member that was previously submitted and denied.	Identify the original claim that was submitted and denied. Claim look up functionality is available via the MVP Provider Portal. Submit a replacement claim (frequency of 7) with correction for consideration. ***Submission of a new claim will result in duplicate denial.*** More information regarding claim submission and adjustments can be found in the *Claims* Section of the MVP Provider Policies

TF1	This claim was submitted after the timely filing limit	This means the claim was received after the timely filing limit. Refer to the Claims section of the MVP Medical Policy and Payment Policies for timely filing requirements.	Timely filing requirements can be found in the *Claims* Section of the MVP Provider Policies
YWM	Procedure Code not on Medicaid Fee Sched	This denial means that the code(s) being billed is not found on any NYS Medicaid fee schedule. This is not a benefit denial.	Review the claim submitted to determine if a value and rate code was submitted on the claim and/or was the service billed with correct procedure code.
ST	Member no longer eligible for benefits under this plan /Termination	The Member's coverage has terminated.	Members are not eligible for date of service submitted.
KCS	Not Billed in Accordance with NYS Guidance	The claim submitted does not include the required data elements required by NYS billing guidance documentation.	The most common reason for this denial is that the rate code, procedure, modifiers on the claim do not match the NYS billing guidance for the specific service being billed. **Review the claim submitted to determine the following:** 1. Does the rate codes, procedure code, modifier(s) submitted match the NYS Billing guidance for that service? - If no, then a replacement claim would need to be submitted with correction. 2. For CFTSS/CHCBS Services specifically, is value code and rate code for the service indicated in Box 39 **AND** the value code and FIPS/Proxy locator county code indicated in Box 40 -If no, then a replacement claim would need to be submitted with the correction. In the event a correction to the claim is required, a replacement claim (frequency of 7) referencing the original claim must be submitted. ***Submission of a new claim instead of a replacement claim will result in a duplicate denial.*** More information regarding claim submissions and adjustments can be found in the Claims Section of the MVP Provider Policies

KCR	Not Billed in Accordance with NYS Guidance	The claim submitted does not include the required data elements required by NYS billing guidance documentation.	The most common reason for this denial is that the rate code, procedure, modifiers on the claim do not match the NYS billing guidance for the specific service being billed. **Review the claim submitted to determine the following:** 1. Does the rate codes, procedure code, modifier(s) submitted match the NYS Billing guidance for that service? - If no, then a replacement claim would need to be submitted with correction. 2. For CFTSS/CHCBS Services specifically, is value code and rate code for the service indicated in Box 39 **AND** the value code and FIPS/Proxy locator county code indicated in Box 40 -If no, then a replacement claim would need to be submitted with the correction. In the event a correction to the claim is required, a replacement claim (frequency of 7) referencing the original claim must be submitted. ***Submission of a new claim instead of a replacement claim will result in a duplicate denial.*** More information regarding claim submissions and adjustments can be found in the *Claims* Section of the MVP Provider Policies
YL1	No Pre-Authorization / Prior Approval obtained	It indicates that no prior Authorization or prior notification has been received and/or approved for the service billed as required by MVP.	1. Refer to the Behavioral Health section of the MVP Provider Policies and Payment policies to determine what services require prior Authorization or notification. 2. Confirm that a prior Authorization / notification approval was obtained. Authorization look up functionality is available on the MVP Provider Portal. 3. if Authorization was obtained, submit a claim adjustment request form via the MVP Provider Portal with indication Authorization was obtained.
YPY	Behavioral Health Prior Approval Not Obtained Before Date of Service	Indicates that no prior Authorization / prior notification has been received and/or approved for the service billed as required by MVP.	1. Refer to the Behavioral Health section of the MVP Provider Policies to determine what services require prior Authorization or notification. 2. Confirm that a prior Authorization / notification approval was obtained. Authorization look up functionality is available on the MVP Provider Portal. 3. if Authorization was obtained, submit a claim adjustment request form via the MVP Provider Portal with indication Authorization was obtained.
YHB	Out of Network Benefits Are Not Available without Prior Authorization.	The service is being billed under a product that the provider is not participating with MVP for and thus requires an Authorization.	Confirm participation status in the Member's product by reviewing your MVP Agreement. If product is included in the Agreement, contact your Behavioral Health Provider Relations Representative for further assistance.

YAO	Service not contracted	Generally, this means a service is being billed that is not included within your contract, however, it could also indicate a system set up issue or service not being billed as the contract indicates.	**Consider the following:** 1. Is this a new service that you were recently licensed/designated? If so, did you advise MVP of the new service to ensure system set up was completed? If not, please reach out to your Behavioral Health Provider Relations Representative for further assistance. 2. This denial could also be generated if you are billing an Inpatient bill type with an Outpatient service. In this scenario where a correction may be required, submit a replacement claim (frequency of 7) with correction for consideration.
YJT	COB/Deny MVP/ASO Secondary-bill primary	MVP is the secondary carrier, and the claim needs to be billed to the primary carrier prior to sending to MVP	Indicates that another carrier should be billed as primary. Please check with the patient to determine if they have additional coverage. MVP has some COB information available on the MVP Provider Portal. For scenarios where primary Medicare does not cover a specific service, NYS Zero Fill Guidance may apply. Review the claim submission to ensure that all data elements are accurately included in accordance with the NYS Zero Fill Guidance for these scenarios.
P02/P03	Never Pay or Stand Alone	New York has deemed a variety of services as Never Pay or Stand-Alone events. Typically, these are services billed alone without a major procedure on it (clinical visit, etc.)	**Never Pay**-Is excluded from APG payment, it will never price under APGs no matter what it's billed with. It may be payable under another program under Medicaid (CFTSS, Partial Hosp, etc.) **Stand Alone**-This service is only payable only when billed with another payable APG service on a claim, such as a clinic visit.