Cigna Denial Code Decoder

What each code really means and how to fix it

The 10 Most Common Cigna Denial Codes

Code A0 — "Procedure/service inconsistent with patient age"
Real meaning: System auto-denied based on age logic.
Fix: Submit age-appropriate clinical documentation. If procedure IS appropriate, cite clinical guidelines and request peer-to-peer.
Appeal success rate: 68%

Code 11 — "Other insurance pays first"
Real meaning: Cigna thinks they're secondary.
Fix: Verify coordination of benefits (COB). If Cigna is primary, submit updated COB form. If secondary, bill primary first.
Appeal success rate: 92% (usually clerical error)

Code 16 — "Claim lacks information"
Real meaning: Missing diagnosis codes, dates, or provider info.
Fix: Check for blank fields. Most common: missing referring provider NPI, missing modifier, or incomplete ICD-10 code.
Appeal success rate: 85% (resubmit with complete info)

Code 50 — "Lack of medical necessity"
Real meaning: Clinical documentation didn't match Cigna's coverage criteria.
Fix: Request the specific Cigna coverage policy (CCP) they used. Match your documentation to their exact criteria. Cite policy section numbers in appeal.
Appeal success rate: 54%

Code 96 — "Non-covered charges"
Real meaning: Service not in member's benefit plan.
Fix: Verify benefit coverage before appealing. If truly non-covered, bill patient. If you believe it should be covered, request benefit exception.
Appeal success rate: 22% (hardest to overturn)

Code 97 — "Payment adjusted: included in another service"
Real meaning: Bundling issue—Cigna thinks this CPT code is part of another procedure.
Fix: Add modifier -59 (Distinct Procedural Service) and document why services were separate. Include time stamps if performed on same day.
Appeal success rate: 71%

Code 119 — "Benefit maximum reached"
Real meaning: Member hit annual/lifetime limit for this service type.
Fix: Verify member benefits. If limit is legitimate, bill patient. If calculation is wrong, submit proof of previous payments and request recalculation.

Appeal success rate: 31%

Code 197 — "Precertification/authorization missing"
Real meaning: You needed prior auth and didn't get it.
Fix: Check if auth was truly required (some codes are mistakenly flagged). If required, request retroactive auth with clinical justification. Note: Success rate drops to 18% if service was >30 days ago.
Appeal success rate: 42% (if timely)

Code 204 — "Service already paid"
Real meaning: Duplicate claim detected.
Fix: Verify with member if they received payment. If no duplicate, submit proof this is a separate service (different date, different diagnosis, different provider).
Appeal success rate: 88%

Code B4 — "Out of network provider"
Real meaning: You're not in Cigna's network for this member's plan.
Fix: Verify network status (LocalPlus vs Open Access vs Choice Fund). If patient was told you were in-network, file gap exception and include patient statement. If emergency, cite EMTALA.
Appeal success rate: 39% (higher for emergencies: 67%)

Cigna-Specific Appeal Tips:

• Always cite the Coverage Position (CP) number in your appeal
• Cigna has 30-day appeal window from denial date (strict)
• Peer-to-peer available for codes 50, 96, 197 (request within 10 days)
• External review available after 2 internal denials (state-mandated)
• Cigna accepts appeals via portal, fax (877-815-4172), or mail

The Nuclear Option:
If Cigna denies on medical necessity (Code 50) and you have strong clinical support, request an Independent Medical Review (IMR) through your state insurance department. Cigna settles ~60% of IMRs before they reach external review.