



WISCONSIN DENIAL CODE CHECKLIST

Your 5-Minute Audit Tool for Remittance Advice

Shoreline Medical Billing Company

End-to-End Revenue Cycle Management & Denial Prevention Experts across United States

Last Updated: 15 July 2026

info@shorelinemb.com | 1-855-838-1370

How to Use This Checklist

When you receive an ERA (Electronic Remittance Advice) or ForwardHealth R/S Report, use this checklist to:

- Categorize each denial by Group Code (CO, PR, OA, PI, CR)
- Identify Wisconsin-specific payer rules that apply
- Determine whether denial is recoverable or write-off
- Spot patterns in your denial data month-over-month

STEP 1: Categorize by Group Code

Every denial has a Group Code that determines your responsibility.

Group Code	Responsibility	Action
CO (Contractual Obligation)	Providers Responsibility ✗ Cannot bill patient	WRITE OFF No appeal possible
PR (Patient Responsibility)	Patient's Responsibility ☑ Can bill patient	BILL PATIENT Deductible/copay/coinsurance
OA (Other Adjustment)	Case-by-case review ⚠ Do not assume write-off	REVIEW & APPEAL Check if recoverable
PI (Payer Initiated)	May be recoverable ⚠ No contract support	APPEAL WITH DOCS Cite medical necessity
CR (Correction/ Reversal)	Check previous adjudication ⚠ Review carefully	INVESTIGATE Verify if reversal valid

STEP 2: Check Wisconsin-Specific Triggers

ForwardHealth (Wisconsin Medicaid & BadgerCare Plus)

Timely Filing Alert: Claim submitted >365 days after DOS? If yes, claim is unrecoverable UNLESS exception applies (religious institution, disaster relief).

Missing Information (CO-16): ForwardHealth-specific fields incomplete? Correct and resubmit within 365-day window.

Duplicate Claim (CO-18): Resubmitted before R/S Report response? Wait for R/S Report; resubmit once only.

Quartz & Dean Health Plan

CO-4 (Modifier Inconsistent): Wrong/missing modifier? Verify current payer rules (change quarterly). Resubmit with correct modifier within 120 days.

CO-11 (Diagnosis Inconsistent): ICD-10 lacks specificity or secondary diagnosis? Add secondary code. Resubmit within 120 days.

CO-197 (Missing Prior Auth): Resubmit with authorization proof. Service not patient's liability if auth was required.

Anthem BCBS Wisconsin & Commercial Plans

30-Day Prompt-Pay Law: If claim unpaid >30 days AND claim is clean: File Wisconsin prompt-pay complaint with OCI. Recover payment + 7.5% annual interest.

STEP 3: Determine Your Action Path

Group Code = CO?

→ WRITE OFF (mandatory)

Group Code = PR?

→ BILL PATIENT (verify coverage limits)

Can you fix the issue by resubmitting?

(e.g., missing modifier, wrong diagnosis, incomplete fields)

→ RESUBMIT within deadline:

- ForwardHealth: 365 days from DOS
- Regional plans: 120 days from denial
- Medicare: 180 days from denial

Cannot fix by resubmitting?

(e.g., medical necessity, bundling, prior auth dispute)

→ APPEAL with clinical documentation within deadline

Top 10 Wisconsin Denial Codes & Quick Fixes

Code	Meaning	Wisconsin Trigger	Quick Fix
CO-4	Modifier inconsistent	Quartz/Dean modifier rule mismatch (update quarterly)	Verify payer-specific modifier requirements and resubmit
CO-11	Diagnosis inconsistent	ICD-10 specificity gap or missing secondary code	Add supporting diagnosis
CO-16	Missing information	ForwardHealth required fields incomplete	Complete all required fields
CO-18	Duplicate claim	Resubmitted before R/S Report response posted	Wait for R/S Report before resubmit
CO-22	COB issue	Medicare/BadgerCare dual-eligible sequencing error	Verify Medicare billed primary
CO-97	Bundling conflict	NCCI rule or payer-specific bundling issue	Review bundling edits and apply an appropriate modifier
CO-197	Missing prior auth	Service requires authorization not obtained	Resubmit with auth proof
PR-1/2/3	Patient responsibility	Deductible/coinsurance/copay	Bill patient (verify coverage)

TFO ForwardHealth EOB code	Timely filing expired	ForwardHealth >365 days from DOS	Unrecoverable (check exception)
OA-23	Prior payer impact	Medicare secondary to BadgerCare Plus sequencing	Do not auto-write-off; verify

Disclaimer

This checklist is provided as an educational tool and general reference guide only. It does not constitute legal advice, financial advice, or medical billing guidance. While Shoreline Medical Billing Company has prepared this based on current payer guidelines and Wisconsin law, payer rules change frequently and vary by specific plan, policy, and contract terms. Users must verify all denial codes and payer requirements with their specific payer before taking action.

Shoreline Medical Billing Company makes no guarantee that following this checklist will result in claim approval or denial recovery. Results vary based on Individual claim approval depends on various circumstances, documentation quality and payer contract terms.