EX Code	Reason Code	EX-Code Description
01	1	DEDUCTIBLE AMOUNT
I3	1	DENY: ICD-9 PROCEDURE CODE REQUIRES A 3RD DIGIT
02	2	COINSURANCE AMOUNT
03	3	COPAYMENT AMOUNT
04	4	PEND: PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED
86	4	DENY: THIS IS NOT A VALID MODIFIER FOR THIS CODE
IM	4	DENY: RESUBMIT WITH MODIFIER SPECIFIED BY STATE FOR PROPER PAYMENT
RM	4	DENY: MODIFIER REQUIRED FOR PAYMENT OF SERVICE - RESUBMIT W/MODIFIER
05	5	PEND: THE PROCEDURE CODE IS INCONSISTENT WITH THE PLACE OF SERVICE
06	6	PEND: THE PROCEDURE CODE IS INCONSISTENT WITH THE PATIENT'S AGE
1K	6	DENY: CPT OR DX CODE IS NOT VALID FOR AGE OF PATIENT
07	7	DENY: THE PROCEDURE CODE IS INCONSISTENT WITH THE PATIENT'S SEX
08	8	PEND: THE PROCEDURE CODE IS INCONSISTENT WITH THE PROVIDER TYPE
09	9	DENY: THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S AGE
10	10	DENY: THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S SEX
11	11	PEND: THE DIAGNOSIS IS INCONSISTENT WITH THE PROCEDURE
9M	11	DENY: THIS CPT CODE IS INVALID WHEN BILLED WITH THIS DIAGNOSIS
12	12	PEND: THE DIAGNOSIS IS INCONSISTENT WITH THE PROVIDER TYPE
13	13	PEND: THE DATE OF DEATH PRECEDES THE DATE OF SERVICE
14	14	DENY: THE DATE OF BIRTH FOLLOWS THE DATE OF SERVICE
HG	15	DENY: GROUP PRACTICE DOES NOT MATCH AUTH
HH	15	PAY: CLAIM AND AUTH PROVIDER STATUS NOT MATCHING
HL	15	DENY: CLAIM AND AUTH LOCATIONS DO NOT MATCH
HP	15	DENY: CLAIM AND AUTH SERVICE PROVIDER NOT MATCHING
HS	15	DENY: CLAIM AND AUTH PROVIDER SPECIALTY NOT MATCHING
HT	15	DENY: CLAIM AND AUTH TREATMENT TYPE NOT MATCHING
HU	15	DENY: CLAIM TYPE DOES NOT MATCH CLAIM TYPE ON THE AUTHORIZATION
16	16	DENY: REVENUE CODE NOT REIMBURSABLE - CPT/HCPCS CODE REQUIRED

99	16	DENY:MISC/UNLISTED CODES CAN NOT BE PROCESSED W/O DESCRIPTION/REPORT
9K	16	CLAIM CANNOT BE PROCESSED WITHOUT PATHOLOGY REPORT
9N	16	CLAIM CANNOT BE PROCESSED WITHOUT OPERATIVE REPORT
A3	16	DENY: SERVICES SUBMITTED WITHOUT PSHP PROVIDER NUMBER
BG	16	DENY: TYPE OF BILL MISSING OR INCORRECT ON CLAIM, PLEASE RE-SUBMIT
BI	16	DENY: CLAIM CANNOT BE PROCESSED WITHOUT AN ITEMIZED BILL
DD	16	DENY: SIGNED CONSENT FORM HAS NOT BEEN RECEIVED
GM	16	DENY: RESUBMIT W/ MEDICAID# OF INDIVIDUAL SERVICING PROVIDER IN BOX 24K
HQ	16	DENY: EDI CLAIM MUST BE SUBMITTED IN HARD COPY W/CONSENT FORM ATTACHED
I1	16	OTHER INSURANCE EOB SUBMITTED DOES NOT MATCH BILLED, PLEASE RESUBMIT
IB	16	DENY: PROCEDURE ONLY COVERED WITH DIAGNOSIS OF DIABETIC FOOT DISEASE
IG	16	DENY: INVALID OR MISSING DISCHARGE STATUS, PLEASE RE-SUBMIT
J2	16	CONSENT FORM NOT SUBMITTED
LY	16	DENY: PLEASE RESUBMIT WITH INVOICE FOR PAYMENT
MA	16	MEDICAID# MISSING OR NOT ON FILE, PLEASE CORRECT AND RESUBMIT
MF	16	DENY: INAPPROPRIATE MEDICAID# SUBMITTED FOR SVC PROVIDER,PLEASE RESUBMIT
OP	16	PAY: DRG / CCR PAYMENT - OUTLIER CONSIDERATION BY APPEAL
SR	16	SUBMIT ER RECORDS & EOP W/IN 45 DAYS FOR PRESENTING SYMPTOM ASSESSMENT
TM	16	TO COMPLETE PROCESSING, WE NEED THE TIME UNITS, PLEASE RESUBMIT.
U1	16	CLAIM CANNOT BE PROCESSED WITHOUT MEDICAL RECORDS
U2	16	PEND: UNLISTED PROCEDURE NEED RECORDS TO PROCESS
U3	16	PEND:U.R.NEEDS MED.RECORDS
U5	16	DENY:UNLISTED / UNSPECIFIC CODE -RE-BILL MORE SPECIFIC CODE
UI	16	DENY:PER REVIEW NO RECORD OF INPT STAY,SEND DISCHARGE SUMMARY
VC	16	DENY - PLEASE RESUBMIT ACCORDING TO VACCINES FOR CHILDREN GUIDELINES
XJ	16	DENY: NO INFO PROVIDED FOR ED PAYMENT RECONSIDERATION - PLEASE RESUBMIT
17	17	DENY: REQUESTED INFORMATION WAS NOT PROVIDED
9I	17	INFORMATION REQUESTED WAS NOT RECEIVED WITHIN THE TIME FRAME SPECIFIED
18	18	DENY: DUPLICATE CLAIM/SERVICE

AX	18	ADJUSTMENT: DUPLICATE PAYMENT PER CLAIM AUDIT
DS	18	DENY: DUPLICATE SUBMISSION-ORIGINAL CLAIM STILL IN PEND STATUS
IO	18	PAY: OUTLIER PYMT DENIED-ITEMIZATION OF CHRGS NOT REC'D WITHIN 90 DAYS
JN	18	ADJUST: DUPLICATE PAYMENT
19	19	DENY: WORK RELATED INJURY AND THE LIABILITY OF WORKER'S COMP CARRIER
20	20	DENY: THIS INJURY IS COVERED BY THE LIABILITY CARRIER
21	21	DENY: CLAIM THE RESPONSIBLITY OF THE NO-FAULT CARRIER
22	22	DENY: THIS CARE IS COVERED BY A COORDINATION OF BENEFITS CARRIER
6L	22	EOB INCOMPLETE-PLEASE RESUBMIT WITH REASON OF OTHER INSURANCE DENIAL
JG	22	ADJUST: PATIENT RESPONDED TO ACCIDENT LETTER
L0	22	PLEASE RESUBMIT WITH THE PRIMARY MEDICARE EXPLANATION OF BENEFITS
L5	22	DENY: NO RESPONSE TO LETTER REGARDING OTHER HEALTH INSURANCE
L6	22	DENY: BILL PRIMARY INSURER 1ST. RESUBMIT WITH EOB.
LR	22	DENY:WHEN PRIME INS.RECIEVES INFO-RESUBMIT TO SECONDARY INS.
OI	22	ADJUSTMENT: PSHP IS SECONDARY INSURANCE/BILL PRIMARY
23	23	DENY: CHARGES HAVE BEEN PAID BY ANOTHER PARTY-COB
71	23	ADJUST: PRIMARY INS/MEDICARE PAYMENT AMOUNT ADJUSTED
JB	23	ADJUST: RECEIVED COB PAYMENT
JD	23	ADJUST: RECEIVED MEDICARE PAYMENT
JV	23	ADJUST: OTHER INSURANCE PAID PROVIDER
MX	23	PAY: MAXIMUM ALLOWABLE HAS BEEN PAID BY PRIME INS
TZ	23	ADJUSTMENT: THIRD PARTY LIABILITY, SUBROGATION RECOVERY RECEIVED
24	24	DENY: CHARGES COVERED UNDER CAPITATION
90	24	SERVICE IS PAID UNDER CAPITATION OR BLOCK AGREEMENT
JC	24	ADJUSTMENT: PAYMENT TO CAPPED PROVIDER
26	26	DENY: EXPENSES INCURRED PRIOR TO COVERAGE
27	27	DENY: EXPENSES INCURRED AFTER COVERAGE WAS TERMINATED
29	29	DENY: THE TIME LIMIT FOR FILING HAS EXPIRED
LC	29	PEND: TIMELY FILING LIMIT HAS EXPIRED

65	30	PAYMENT REDUCED.PT DID NOT SELECT MEDICARE PART B,BILL PT THE BALANCE
1M	31	MEMBER SERVICE PROBLEM, SEND TO MEMBER SERVICES DEPARTMENT
BM	31	BAD MEMBER
MQ	31	DENY: MEMBER NAME/NUMBER/DATE OF BIRTH DO NOT MATCH,PLEASE RESUBMIT
CS	32	DENY: PATIENT IN CHILD PROTECTIVE SERVICES
34	34	DENY: INSURED HAS NO COVERAGE FOR NEWBORNS
35	35	DENY: BENEFIT MAXIMUM HAS BEEN REACHED
3L	35	DENY: BENEFIT IS LIMITED TO 4 IN A 90 DAY PERIOD
5A	35	DENY: MAXIMUM ANNUAL BENEFIT HAS BEEN REACHED FOR MEMBER
UB	35	PEND: 50 THERAPY VISITS PER YEAR-LIMIT EXCEEDED
36	36	BALANCE DOES NOT EXCEED COPAYMENT AMOUNT
38	38	DENY: SERVICES NOT PROVIDED OR AUTHORIZED BY OUR PROVIDERS
52	38	DENY: PROVIDER NOT CONTRACTED FOR THIS MEMBER'S GROUP
AR	38	DENY: NON-MEMBER LAB - BILL REFERRING PROVIDER
NP	38	DENY: AUTHORIZATION REQUESTED FOR NON-PLAN PROVIDER
NT	38	DENY:PROVIDER NOT CONTRACTED FOR THIS SERVICE-DO NOT BILL PATIENT
T4	38	DENY:PROVIDER NOT CONTRACTED FOR SERVICE-DO NOT BILL PATIENT
39	39	DENIED AT THE TIME OF AUTHORIZATION REQUEST
40	40	DENY: CHARGES DO NOT MEET QUALIFICATIONS FOR EMERGENCY CARE OUT OF AREA
AS	40	DENY: BASED ON REVIEW OF MED REC - PLP EMERGENCY DEFINITION NOT MET
XA	40	DENY: PLP NOT MET - DENIAL UPHELD ON RECONSIDERATION
42	42	CHARGES EXCEED YOUR CONTRACTED FEE SCHEDULE
NM	42	UNABLE TO CALCULATE PROVIDER ALLOWED. PROCESSOR MUST SUPPLY IT
P8	42	PAID AT DOWN GRADED LEVEL
43	43	GRAMM RUDMAN REDUCTION
44	44	PROMPT PAY DISCOUNT
45	45	CHARGES EXCEED REASONABLE AND CUSTOMARY AMOUNTS
RO	45	PAY: PAID AMT ADJUSTED - EXCEEDED OP REIMBURSEMENT CAP ON CCR PAID SERVS
47	47	DENY: THIS DIAGNOSIS IS NOT COVERED

49	49	DENY: THESE ARE NONCOVERED SERVICES BECAUSE THIS IS A ROUTINE EXAM
JQ	52	ADJUST: NOT AUTHORIZED BY PCP, BILL PATIENT
JR	52	ADJUST: NOT AUTHORIZED BY PCP, DO NOT BILL PATIENT
9H	57	DENY: CODE QUESTIONED BY CODE AUDIT SOFTWARE-DENIED AFTER MEDICAL REVIEW
N5	57	DENY: NAME OF DRUG, NDC NUMBER AND QUANTITY IS REQUIRED TO PROCESS CLAIM
2L	58	DENY: NO AUTH OBTAINED FOR LOCATION BILLED/SUBMITTED
I2	58	DENY: PROCEDURE IS ONLY PAYABLE FOR INPATIENT LOCATION
NU	58	DENY: PSHP RECORDS DO NOT INDICATE BABY WAS NICU ON THIS DATE
59	59	PAY: PAYMENT REDUCED BASED ON MULTIPLE SURGERY RULES
M2	59	PEND: MANUAL PRICING REQUIRED - SEE WORK PROCESS FOR MULTIPLE SURGERY
S9	59	PEND: REFER TO WORK PROCESS FOR BILATERAL SURGERY PROCESSING
A1	62	DENY: AUTHORIZATION NOT ON FILE
A6	62	PEND: SERVICE HAS EXCEEDED THE AUTHORIZED LIMIT
A8	62	DENY: NO AUTHORIZATION ON FILE
AA	62	DENY: UNAUTHORIZED SERVICE: BILL PATIENT
AB	62	DENY: UNAUTHORIZED ADMISSION PER INPATIENT REVIEW
AC	62	DENY: UNAUTHORIZED SERVICE - DO NOT BILL PATIENT
AD	62	DENY: UNAUTHORIZED ADMISSION. DO NOT BILL PATIENT. (INPATIENT REVIEW)
AE	62	DENY: HOSPITAL CONFINEMENT CEASED PER MED REVIEW
DZ	62	DENY: SERVICE HAS EXCEEDED THE AUTHORIZED LIMIT
MN	62	PAY: CONTINUED INPT STAY NOT MEDICALLY NECESSARY
XF	64	PAY: PLP MET ON RECONSIDERATION
XH	64	PAY: ED PAYMENT ADJUSTED ON RECONSIDERATION
XK	64	PAY: ED PAYMENT ADJUSTED ON APPEAL
XO	64	PAY: ED RECONSIDERATION - PLP MET
OQ	70	ADJUST: CLAIM QUALIFIES FOR OUTLIER PAYMENT - OUTLIER AMT PAID
85	85	INTEREST CHARGES
CL	92	DO NOT USE
DI	92	ANCILLARY CHARGES INCLUDED IN ER/TREATMENT ROOM VISIT

FJ	92	ADJUST: VISIT OR SERVICE INCLUDED IN OB DELIVERY PAYMENT
GD	92	PAY: REPROCESSED USING STATE GUIDELINES
GZ	92	PAY: SERVICE COVERED UNDER GLOBAL FEE AGREEMENT
HM	92	INPT & OUTPT CLAIMS TILL S.T. RESOLVES CONTRACT
HN	92	PAY: THE MODIFIER DOES NOT MATCH
HR	92	PAY: ADDITIONAL PAYMENT FOR MEDICALLY HIGH-RISK DIAGNOSIS
IJ	92	ADJUST: VISIT IS INCLUDED IN SURGICAL FEE
J3	92	ADJUSTMENT: PAYMENT ADJUSTED TO APPROPRIATE TRANSFER CASE PER DIEM
NI	92	PAY: NICU BABY
NN	92	OB GLOBAL FEE PAID
OF	92	PLEASE USE THE CORRECT LOCATION CODE 11 FOR FUTURE BILLING
OK	92	ADJUST: PER CLAIM AUDIT, GLOBAL RATE PAID FOR PROCEDURE IN ERROR
OZ	92	INFO: TO ALLOW THE VOIDING OF A CLAIM/SERVICE
PU	92	PAY: REFERRING PROVIDER HAS BEEN TERMINATED
PW	92	MEMBER IS IN THE MCPD TEAM SELECT PROGRAM
SZ	92	PAID ACCORDING TO NEGOTIATED SETTLEMENT
TA	92	DENY: NO AUTHORIZATION ON FILE
UH	92	PATIENT READMITTED WITHIN 14 DAYS-RECOMM. TO CASE MGMT
V9	92	PAY: PROCEDURE BILLED AS 2 UNITS, PER GUIDELINES ONLY 1 UNIT ALLOWED
VT	92	MUST BE BILLED WITH TREATMENT ROOM OR STAND ALONE SERVICE
VY	92	SEND MD DC ORDER & MED REC W/IN 45 DAYS TO VERIFY MD ORDER/MED NECESSITY
AH	95	DENY:PER MEDICAL REVIEW PATIENT NOT HOSPITALIZED AT TIME OF SERVICE
DQ	95	DENY: MEMBER UNDER 21 YRS OF AGE WHEN SIGNING CONSENT FORM
J1	95	CONSENT FORM NOT VALID AT TIME OF SERVICE
JY	95	ADJUST:MEMBER UNDER AGE OF 21 AT TIME OF SIGNING TUBAL CONSENT FORM
NC	95	DENY:TUBAL WAS PERFORMED BEFORE THE 30 DAY WAITING PERIOD
NV	95	DENY: STERILIZATION CONSENT FORM IS NOT VALID OR IS MISSING INFORMATION
46	96	DENY: THIS SERVICE IS NOT COVERED
48	96	DENY: THIS PROCEDURE IS NOT COVERED

0R	96	DENY: SERVICE NOT ON HMO RADIOLOGY SCHEDULE-INELIGIBLE FOR REIMBURSEMENT
4J	96	ADJUST: REVENUE CODE NOT COVERED BY GA MEDICAID/DO NOT BILL MEMBER
BD	96	DENY: BENEFIT IS NOT COVERED BY HMO
EY	96	DIAGNOSIS IS NOT COVERED, BILL STATE ENTITY
JO	96	ADJUST: NOT A COVERED BENEFIT
57	97	DENY: CODE WAS DENIED BY CODE AUDITING SOFTWARE
58	97	DENY: CODE REPLACED BASED ON CODE AUDITING SOFTWARE RECOMMENDATION
66	97	CODE IS BEING QUESTIONED BY CODE AUDITING SOFTWARE
67	97	PAY: CODE WAS SUPERSEDED BY CODE AUDITING SOFTWARE
80	97	REPLACEMENT CODE REBUNDLED BY HPR CODEREVIEW SOFTWARE
81	97	ORIGINAL CODE WAS REPLACED BY HPR CODEREVIEW SOFTWARE
83	97	CODE IS DENIED BY HPR CODEREVIEW SOFTWARE
84	97	PAID AT REDUCED RATES PER HPR CODEREVIEW
96	97	DENY: SERVICE CAN NOT BE COMBINED WITH OTHER SERVICE ON SAME DAY
97	97	PAYMENT IS INCLUDED IN ALLOWANCE FOR BASIC SERVICE
0D	97	PAID: SERVICE INCLUDED IN MONTHLY DIALYSIS CAP PAYMENT
7N	97	DENY: SERVICE IS NOT PAYABLE CONCURRETLY WITH VISION EXAM AS BILLED
8T	97	DENY: SERVICE INCLUDED IN DELIVERY PAYMENT
9E	97	DENY: CODE REPLACED BASED ON CODE AUDITING SOFTWARE RECOMMENDATION
A0	97	PAY: FIRST 10 MILES ARE INCLUDED IN GLOBAL AMBULANCE REIMBURSEMENT
C2	97	CPT HAS BEEN REBUNDLED ACCORDING TO CLAIM AUDIT
C6	97	CPT HAS BEEN REPLACED ACCORDING TO CLAIM AUDIT
D1	97	DENY: SERVICE INCLUDED IN E.R. VISIT
D8	97	DENY: SERVICES INCLUDED IN THE DRG PAYMENT
DN	97	DENY: PROCEDURES INCLUDED IN FINAL RESTORATION
GL	97	SERVICE COVERED UNDER GLOBAL FEE AGREEMENT
IQ	97	PAY: SUPPLIES INCLUDED IN DME RENTAL/PURCHASE REIMBURSEMENT
J4	97	ADJUSTMENT: ANTEPARTUM VISIT INCLUDED IN TOTAL OB DELIVERY
J5	97	ADJUSTMENT: SERVICES ARE 3 DAYS PRIOR TO INPT INCLUDED IN DRG

K8	97	DENY: SERVICES INCLUDED IN GLOBAL SETTLEMENT AGREEMENT
O1	97	PAY: TOTAL OB REFLECTS A DEDUCTION OF ANTEPARTUM ALREADY PAID
RR	97	DENY: RECOVERY ROOM INCLUDED IN ASC RATE
SU	97	DENY: VISIT IS INCLUDED IN SURGERY
TI	97	E.R. PHYS PAID TRIAGE, ANCILLARY SERVICES NOT PAYABLE
V1	97	DENY: SERVICE IS INCLUDED IN THE DELIVERY PAYMENT
VI	97	PAY: REIMBURSEMENT INCLUDED IN GLOBAL FEE
9B	101	PAY: SERV NOT ON FEE SCHED - PAID AT PLAN DEFAULT PRICING - 45% OF CHRGS
50	109	DENY:NOT A MCO COVERED BENEFIT
0A	109	DENY: NOT REIMBURSABLE - BILL UNDER AMBULANCE MEDICAID ID
CC	109	DENY: CONTINUITY OF CARE,BILL PREVIOUS INSURANCE CARRIER
CH	109	FORWARDED TO OUR CAPPED CHIROPRACTIC PROVIDER
DT	109	DENY: PLEASE FORWARD TO THE DENTAL VENDOR FOR PROCESSING.
JZ	109	ADJUST: STATE RECOUPED CAPITATION,BILL STRAIGHT T-19
K4	109	DENY: MEMBER IS NOT THE RESPONSIBILITY OF PEACH STATE HEALTH PLAN
SQ	109	DENY: NOT REIMBURSEABLE TO THIS PROVIDER - BILL DIALYSIS CENTER
MU	112	PEND: MOM OF NICU BABY
RE	119	DENY: RENTAL BENEFIT EXHAUSTED - AFTER 10 RENTALS CONSIDERED PURCHASED
0J	125	ADJUSTMENT: ADJUSTED PER POST PAYMENT MEDICAL AUDIT
5J	125	ADJUST: CHARGES INCLUDED IN ASC PAYMENT
6J	125	ADJUST: PREVIOUS PAYMENT BASED ON INCORRECT UNIT BILLING
7B	125	ADJUSTMENT: ORIGINAL CLAIM BILLED USING INCORRECT CPT/HCPC CODE
7J	125	ADJUST: ADMISSION INAPPROPRIATE PER MEDICAL REVIEW OF RECORD
9J	125	ADJUST: PREVIOUS ANESTHESIA PAYMENT BILLED/PAID INCORRECTLY
BS	125	DENY: INVALID DATES OF SERVICE PLEASE RE-SUBMIT
C9	125	NEW CPT ISSUED DUE TO CLAIM AUDIT
CB	125	AUTHORIZATION IS CANCELLED -ERROR IN ENTRY
CK	125	ADJUSTMENT: PROVIDER BILLED INCORRECTLY & SUBMITTED REIMBURSEMENT
EA	125	ADJUST: APPEAL APPROVED -AUTHORIZATION ENTERED

GS	125	DENY: DATE OF SVC ON CLAIM IS GREATER THAN RECEIVED DATE,PLEASE RESUBMIT
HJ	125	ADJUST: CORRECTION OF PREVIOUS PAYMENT FOR THIS DRUG
J0	125	ADJUSTMENT: ADJUSTED PER CORRECTED BILLING FROM PROVIDER
JM	125	ADJUST: PROCESSED FOR INCORRECT MEMBER, RESUBMIT CORRECT MEMBER
JP	125	ADJUST: BENEFIT MAXIMUM REACHED, BILL PATIENT
JS	125	ADJUST: PROCESSED FOR INCORRECT PROVIDER OR PROVIDER AFFILIATION
JT	125	ADJUST: PROCESSED FOR INCORRECT MEMBER
JU	125	ADJUSTMENT TO PREVIOUSLY SUBMITTED CLAIM
JW	125	ADJUSTMENT: ORIGINAL SERVICE PAID INCORRECT AMOUNT
JX	125	ADJUST: EMPLOYER GROUP RETRO TERMINATED CONTRACT, BILL MEMBER
LJ	125	ADJUST: ADJUSTMENT DONE TO CLEAR NEGATIVE BALANCE
MG	125	DENY: SIGNATURE MISSING FROM BOX 31, PLEASE RESUBMIT
MJ	125	ADJUST: ADJUSTED DUE TO CHANGE IN CODE AUDITING SOFTWARE DECISION
MK	125	INAPPROPRIATE MEDICAID NUMBER FOR TAX ID SUBMITTED. CORRECT AND RESUBMIT
MO	125	MODIFIER BILLED IS NOT VALID, PLEASE RESUBMIT WITH CORRECT CODE.
NX	125	DENY: INVALID OR NO TAX ID NUMBER SUBMITTED ON CLAIM, PLEASE RESUBMIT
RJ	125	DENY: REVENUE CODES NOT BILLED ON THE UB92, PLEASE RE-SUBMIT
SE	125	CORRECTION FOR SYSTEM ERROR
UP	125	PAY: AUTHORIZED TO PAY - PER MEDICAL REVIEW
UZ	125	DENY: SERVICES BILLED ON INCORRECT FORM, PLEASE REBILL ON A UB92
1C	129	MEDICAL/HOSPITAL DETAIL RECORD CANCELLED
XG	129	DENY: ED RECONSIDERATION - CONTRACT RATE WAS PAID
XL	129	DENY: ED APPEAL - CONTRACT RATE WAS PAID
15	133	PEND: PROCEDURE CODE ENTERED IS NOT ADDED IN THE PROCEDURE DETAIL
31	133	PEND: PROCESSOR MUST DETERMINE FURTHER ALLOWANCE ON SUBMITTED PROCEDURE
56	133	PAY: SERVICE ADDED BY CODE AUDITING SOFTWARE
64	133	PEND: ERROR IN ANY FIELD PASSED THRU CODE AUDITING SOFTWARE
69	133	CODE AUDITING SOFTWARE SERVICE FOLDING ERROR
93	133	HISTORICAL ERROR IDENTIFIED BY CODE AUDITING SOFTWARE

94	133	PEND: CLAIMS DENY CLAIM WITH EX:96
95	133	PEND: CHECK TO SEE IF OTHER EXAMS PERFORMED ON SAME DAY, DENY EX:7N
1A	133	PEND: GROUP,DIVISION,CONTRACT,MEMBER RECORD/SPAN MISSING OR OVERLAPPING
1E	133	PAY: THE CONTRACT IS INELIGIBLE DURING AUTHORIZED PERIOD.
2P	133	PROVIDER RELATIONS PROBLEM, SEND TO PROVIDER RELATIONS DEPARTMENT
5P	133	PEND: FOR REVIEW BY PROVIDER RELATIONS
6P	133	PEND: FOR REVIEW BY MEMBER SERVICES
7P	133	PEND: FOR REVIEW BY APPEALS COORDINATOR
8D	133	PEND:MOM OR BABY STAYED OVER 8 DAYS,ADJUSTOR MANUALLY PROCESS
8Y	133	PEND: CLAIMS PLEASE DENY WITH EX:8T
9A	133	PEND: AWAITING ADDITIONAL INFORMATION -CLAIM QUESTIONED BY CODEREVIEW
9G	133	PEND: MRU REVIEWING CLAIM
9Z	133	PEND: PROVIDER ON REVIEW FOR NEGATIVE BALANCE RECONCILIATION
A2	133	PEND: KEYWORD OR CODE SET ERROR
A4	133	PEND: MATERNITY ANESTHESIA MANUALLY CALCULATE PAYMENT
A5	133	PEND: TOTAL NUMBER OF QUALIFYING AUTHS EXCEEDS TABLE SIZE
A7	133	PEND: ERROR CODE USED IS NOT DEFINED IN CODE SET.
AL	133	PEND: MOM MUST HAVE OTHER INSURANCE FOR BABY TO PAID EXTRA$
AM	133	IF PT. ADMITTED, CHANGE LOCATION TO 21, THEN PAY
AN	133	PEND: USE EX.CODE D1 TO DENY ANCILLARY CHARGES BILLED WITH E.R. VISIT
AP	133	PEND: PAY SERVICE IF AUTHORIZED. DENY WITH EX=35.
AU	133	PEND: MULTIPLE AUTHORIZATIONS QUALIFY, PICK CORRECT AUTH.#
AY	133	PEND: ANESTHESIA SERVICE MUST BE ON THE SAME DATE OF SERVICE TO PAY
AZ	133	INPATIENT LIMIT NOTIFICATION, SEND TO MEDICAL MANAGEMENT DEPARTMENT
B2	133	PEND: BENEFIT OR RIDER HAS NOT BEEN PURCHASED OR IS NO LONGER EFFECTIVE
B3	133	PEND: SERVICE DOES NOT MAP TO A BENEFIT
B4	133	PEND: SERVICE DOES NOT MAP TO EXISTING BENEFIT, BECAUSE OF KEY IN.
B5	133	PEND: COUNTER TABLE IS FULL,COUNTER EXCEEDED OR AMOUNTS INCOMPATIBLE
BA	133	PEND: DUPLICATE MEMBER RECORDS, PLEASE CORRECT.

BB	133	PEND: IF BOARDER BABY PAY EXTRA PER DIEM-IF NOT INCLUDED IN MOM
BC	133	PEND: MEMBER CHANGED BENEFIT PACKAGES DURING HOSPITALIZATION
BH	133	PEND: POSSIBLE BEHAVIORAL HEALTH CLAIM
BL	133	PEND: SERVICE EXCEEDS THE BENEFIT LIMIT. SPLIT SERVICE AND REPROCESS
BN	133	PEND: CHIPS BENEFIT PACKAGE IS UNDER CONFIGURATION
C0	133	PEND: LATE CLAIM SUBMISSION SUPER-TABLE IS REQUIRED
C1	133	PEND: ADJUSTOR MUST REVIEW CARDIAC SERVICES FOR PAYMENT
C3	133	PEND: POSSIBLE DUPLICATE SERVICE
C4	133	PEND: VERIFY THE TREATMENT TYPE ASSIGNMENT
C5	133	PEND: SUPER TABLE ENTRY DUPLICATE SERVICE IS NOT ON FILE
C7	133	PEND: VERIFY ANESTHESIA UNITS ON SWITCH TABLE
CA	133	PEND: MAIN DEFAULT SUPER TABLE ENTRY IS NOT ON FILE
CD	133	PEND: CARDIAC INPT CODES REVIEW DIAG FOR PAYMENT
CE	133	PEND: PROCESSOR NEEDS TO ENTER "CI" CODE FOR CORRECT %
CF	133	PEND: WAITING FOR CONSENT FORM
CG	133	PEND: PROVIDER ON REVIEW UNTIL CAPITATION SUMMARY RECEIVED
CJ	133	PEND: NEED DME MODIFIER FOR CORRECT PRICING
CO	133	PEND: REVIEW COPAY & IF CORRECT USE EX CODE=03
CP	133	PEND: MEMBER CHANGED PROGRAMS DURING CLAIM COVERAGE PERIOD
CQ	133	PEND: SPLIT SERVICES TO CAPTURE CORRECT UNITS BILLED
CX	133	PEND: ONE SPINAL PER YEAR-CHANGE COUNT =1 /OR DENY 2ND
CZ	133	PEND: CLAIMS VERIFY CORRECT PROVIDER/AFFILATION WAS PICKED
D0	133	PEND: THE DEFAULT PAID OR SAVINGS EQUATION IS NOT ON FILE
D2	133	PEND:M.D. BILLING DENTAL CODE PICK NEW AFFIL.
D5	133	PEND: MODIFIER SUPER TABLE ENTRY IS MISSING OR INVALID
D6	133	PEND: SUPER TABLE ENTRY IS MISSING OR INVALID
D7	133	PEND: LIMITED TO EXCEEDED OR MISSING KEYWORD
D9	133	PEND: SERVICE DOES NOT QUALIFY AGAINST A PROVIDER PAY/FUND CLASS
DA	133	PEND: PROVIDER-SPECIFIC FEE NOT FOUND

DB	133	PEND: ADD UNITS TO ANESTHESIA SERVICE - SEE MANUAL PRICING INSTRUCTIONS
DC	133	PEND: MEMBER CHANGED DIVISIONS DURING THE HOSPITALIZATION
DE	133	PEND: DATE OPTION ON THE PRICING COUNTER IS INVALID
DF	133	PEND: MANUAL PRICING REQUIRED
DG	133	PEND:IF ORAL SURG.GET CPT CODE,IF NOT DENY WITH "DT"
DH	133	PEND: DEPENDENT OF A DEPENDENT & MOM TURNED 18
DK	133	PEND: CLAIM GROUPED TO AN INVALID DRG, CHECK CLAIM FOR ERRORS
DO	133	PEND: POSSIBLE DUP SERVICE HITTING AGAINST A PREV DENIED SERVICE
DP	133	DEPENDENT REACHED MAXIMUM AGE - VERIFY STUDENT STATUS
DR	133	PEND: MANUALLY CALCULATE DRG#, DIAG NOT GROUPABLE OR ENTER BIRTH WEIGHT
DU	133	COPAY IS WAIVED IF ADMISSION OCCURS FROM ER VISIT
EE	133	PEND: NO EVIDENCE OF AN ER VISIT, DENY CLAIM
EO	133	PEND: HOLD, PENDING RECEIPT OF EVIDENCE OF AN ER VISIT
EP	133	PEND: VERIFY ELIGIBILITY AND PRICING. PROCESS MANUALLY.
ER	133	PEND: REVIEW COUNT & COPAY. (ER VISITS > 1/DAY).
ET	133	PEND: VERIFY ECT TREATMENT BEFORE COVERING ANESTHESIA SERVICES
EX	133	PEND: USER EXIT ROUTINE NOT AVAILABLE ON THIS ACCOUNT
EZ	133	ROUTE TO CLAIMS MANAGER
FB	133	PROVIDER ON REVIEW FOR CSS
FF	133	PEND: MULTIPLE COUNT SHOULD ONLY PAY "1" AT FLAT RATE
FR	133	PEND: MEMBER ON REVIEW - FRAUD INVESTIGATION UNDERWAY
GK	133	PEND TO CSS
GR	133	REVIEW THE COUNT PER PROCEDURE IN A ROLLING THIRTY DAY PERIOD
GY	133	PEND:DEDUCT ALL ANTE/POSTPARTUM VISITS ASSOC.WITH DELIVERY
H2	133	PEND: WRONG AFFILIATION ON CLAIM- RE PICK CORRECT ONE
H4	133	PEND:MUST BE BILLED WITH TREATMENT RM -USE "TR" TO DENY
H5	133	PEND: ENTER CPT/HCPCS INSTEAD OF REV CODE & MANUALLY PRICE
H7	133	PEND: CALCULATE TRANSFER PER DIEM OR TOTAL STAY DRG
HA	133	PEND: HOLD, A WAITING EVIDENCE OF A PARENTERAL INFUSION PUMP

HB	133	PEND: CLAIM AND AUTH DATES OF ADMISSION NOT MATCHING
HE	133	PEND: CLAIMS DENY WITH EX:AU
I0	133	PEND: PAY PER INVOICE PAYMENT RULES - IF NO INVOICE DENY WITH EX LY
I8	133	PROVIDER ON REVIEW FOR INTERNAL AUDIT
IF	133	PEND: POSS. INFERTILITY SERVICES
IH	133	HOLD, WAIT FOR EVIDENCE OF INPATIENT HOSPITALIZATION
IP	133	PROVIDER PENDING FOR SET-UP FORM OR CONTRACT
IR	133	PEND: PROV ON REVIEW FOR IRS LEVY, SEND PAYMENTS TO IRS
IS	133	SYSTEM OR CONFIG PROBLEM, SEND CLAIM TO "IS" DEPARTMENT.
IT	133	PEND: PROVIDER UNDER FRAUD INVESTIGATION
IU	133	PEND: ICU ROOM DENY IF WITH GLOBAL CONTRACT FEE
IZ	133	PEND: CLAIMS, PLEASE DENY CLAIM WITH EX CODE AC.
K5	133	PEND: MEDICAID # REQUIRED IN BOX 24K/HCFA OR 51/UB, CORRECT & RESUBMIT
KF	133	PROVIDER ON REVIEW - BADPROV
KO	133	PEND: REVIEW PROV BILLED COUNT FIELD SHOULD BE ONLY 1
L1	133	PEND: MEMBER IS AGE 65+ WITH NO MEDICARE COVERAGE ON FILE
L2	133	PEND: MEMBER HAS HANDICAPPED STATUS AND NO MEDICARE COVERAGE ON FILE
L3	133	PEND: MEMBER OTHER COVERAGE INCOMPLETE OR NO RESPONSE
L4	133	PEND: LIABILITY RECOVERY CONFIGURATION ERROR
L7	133	PEND: MAKE SURE MEDICARE ALLOWED/PAID IS ENTERED
L8	133	PEND: UNABLE TO DETERMINE PRIMACY BETWEEN MULTIPLE INSURERS
L9	133	PEND: T-19 MEMBER HAS OTHER INSURANCE - NEED TO VERIFY.
LA	133	PEND:OTHER INSURANCE IS EITHER HMO OR PPO
LI	133	PEND: LITHOTRIPSY DIAG/PROC - REVIEW PROVIDER CONTRACT
LL	133	PEND: CLAIM IS SET TO PAY OVER AUDIT AMOUNT ($10,000 FOR H, $5000 FOR M)
LM	133	PEND:PART A ONLY-PAY 20% OF PAYMENT
M0	133	PEND: MEMBER PARTIALLY ELIGIBLE AT TIME OF SERVICE
M1	133	PEND: MRU TO REVIEW FOR PRICING
M4	133	MULTIPLE EDITS BY CODEREVIEW

M9	133	SEND TO ENROLLMENT DEPARTMENT
MB	133	PEND: ELIGIBILITY FOR STATE OF GA VERIFICATION
MC	133	ERROR ON SUPER TABLE FIND FOR MEMBER CARRIER
ME	133	PEND: MEMBER ON REVIEW - ELIGIBILITY UNDER REVIEW
MI	133	MOTHER OF HIV BABY
MS	133	PEND: MEMBER ON REVIEW - STUDENT STATUS UNDER INVESTIGATION
MT	133	PEND: MEMBER IS PARTIALLY ELIGIBLE DURING AUTHORIZED PERIOD.
MV	133	PEND: MOTHER OF VENTILATOR BABY
MW	133	PEND:IF BILLED WITHOUT MODIFER RR OR NU, DENY=EX-MO
NB	133	PEND:CONTRACT MOM&BABY PAID GLOBAL-MOM'S CL ON SYS?
NQ	133	PROVIDER SET-UP PROBLEM, SEND TO NETWORK QUALITY DEPARTMENT
NW	133	NEWBORN MEMBER NOT FOUND
OM	133	MODIFIER ON CLAIM NEEDS SET UP
OT	133	PEND:OFFICE THERAPY BY PHYS.REVIEW,TO DENY USE "TH"
OV	133	PEND:REVIEW VISIT WITH SURGERY.TO PAY=92 TO DENY=SU
P5	133	PEND: CHECK FOR SURGERY CPT & CHECK COUNT -ONLY ONE 1
P7	133	PEND: MENTAL HEALTH REVIEW, NOT OUR CAPPED PROVIDER
P9	133	PEND: PROCESSOR MUST REVIEW INFERTILITY BENEFITS
PB	133	PEND: SERVICING PROVIDER AFFILIATION NOT FOUND
PE	133	PEND: PROVIDER IS ON REVIEW
PG	133	PEND: SERVICE PROVIDER AFFILIATION NOT FOUND
PL	133	PEND: PCP AFFILIATION NOT FOUND
PM	133	PEND: PCP IS NOT EFFECTIVE AT THE TIME OF SERVICE
PP	133	PEND: REFERRING PROVIDER IS NOT PRIMARY
PQ	133	PEND: REVIEW PODIATRY SERVICES FOR DOCUMENTATION
PR	133	PEND: PRIVATE ROOM NOT COVERED UNLESS MEDICALLY NECESSARY
PS	133	PEND: SERVICE PROVIDER NOT EFFECTIVE AT TIME OF SERVICE
PT	133	PEND: SERVICE PROVIDER HAS BEEN TERMINATED
PX	133	POSSIBLE PRE-EXISTING CONDITION

PY	133	PEND - ER SERVICES - VERIFY CORRECT AFFILIATION
PZ	133	PEND: SEND TO PROVIDER RELATIONS FOR SETUP
Q1	133	PEND: PROCESS TO LOAD CODES IN PROGRESS BY BUSINESS
R1	133	PEND: REFRACTION CANNOT BE BILLED WITH EYE EXAM
R2	133	PEND: PROVIDER REQUIRES AN AREA CODE / SPECIFIC PROV RATE ON FEE SCHED
RB	133	PEND CODE TIED TO PRICING KEYWORD PEND SERV QUALIFIER
RF	133	PEND: REFERRING PROVIDER IS NOT IN PLAN
RG	133	PSHP REVIEWING DRG
RH	133	PEND:PAY REVIEW OF MULTPL SURGICAL PROC/REBUNDLE CHRGS WHEN APPROPRIATE
RN	133	PEND: GET MOD/CHECK COUNT & LOC=12 & BILLED $
RU	133	PEND: PAY EACH SERVICE LINE AT CONTRACT %
RV	133	PEND: PROVIDER ON REVIEW - FORWARD TO MEDICAL REVIEW
S1	133	PEND:CHECK FOR MULTI SURGERIES & NEED CPT CODE FOR PRICING
S7	133	PEND: DENY ALL NON-SURGICAL PROC ON THIS CLAIM WITH EX GL
SA	133	PEND: ADJUSTOR MUST REVIEW FOR ANESTHESIA & OR SERVICES
SF	133	PEND:PRICE PER CONTRACT-CHECK CLAIM FOR TIER LEVEL
SG	133	PEND: POSSIBLE SUBROGATION CASE
SH	133	PEND: ENTER ROOM CODE SUFFIX C,H,M,OR N FOR CORRECT FEE
SM	133	PEND: ADJ. REVIEW CLAIM FOR STOP/LOSS CONTRACT
SN	133	CONTACT STATE FOR SKILLED NURSING FACILITY (DHSS) RATE
SP	133	PEND: REVIEW FOR SPECIAL CONSIDERATION - LOOK FOR AUTH
SS	133	PEND: MEMBER ON REVIEW FOR NO SSN
ST	133	PEND: MANUAL PRICING REQUIRED - POSSIBLE INPATIENT SHORT STAY
T8	133	PEND: SENT FOR COB AUTHORIZATION SET-UP
T9	133	PEND:TITLE-19 PENDING ELIGIBILITY (MEMBER STATUS EN OR PN OR NC)
TE	133	PEND: CLAIMS, VERIFY THE CLAIM IS PAID GLOBALLY
TN	133	PEND: NO PROV TX# ON FILE,BUT PAYING MEM.INFORM PROV.TECH
TP	133	ROUTE TO TPL DEPARTMENT - OTHER INSURANCE
TT	133	PEND: INVALID OR MISSING LOCATION CODE

U6	133	PEND: REVIEW FOR NDC PRICING -IF NONE-DENY =U5
U8	133	PEND: VERIFY PATIENT AGE-IF OVER 18 SEND TO MEDICAL SERVICES
UA	133	PEND: AUTHORIZATION PROBLEM - MEDICAL SERVICES TO REVIEW
UE	133	PEND TO UR - MEDICAL REVIEW
UJ	133	PEND: UR REVIEWING DOCUMENTATION
UM	133	MED MANAGEMENT PROBLEM, SEND TO MED MANAGEMENT DEPARTMENT
VN	133	PEND: VENT
VR	133	PEND: CLAIMS, VERIFY CLAIM IS PRICING PER CONTRACT
WA	133	PEND: PENDED FOR HIPAA CHANGES
WC	133	PEND: TRANSPLANT PRICING NEEDED
WR	133	PEND: PLEASE CHECK SPECIALTY FIELD FOR CORRECT SPECIALTY ON AFFILIATION
X1	133	PENDED BY AUDITOR
X9	133	PEND: PENDED BY AUDITOR
XB	133	PEND: POSSIBLE TRANSPLANT CLAIMS
XD	133	I.S. UNDEFINED EX CODE ?????
XZ	133	PEND: CONTRACT IS IN INFORMATION SYSTEM DEVELOPMENT
Y7	133	PEND: PROVIDER SET-UP ISSUE, PLEASE REVIEW AND CORRECT
YA	133	PEND: MULTIPLE PROVIDER AFFILIATIONS QUALIFY
YP	133	PEND: DUPLICATE PROVIDERS FOUND WITH THE SAME IRS# & MEDICAID#
YY	133	PEND: CLAIMS PROCESSING REVIEW
Z2	133	PEND: DEFAULT SYSTEM ERROR MESSAGE PEND CODE
ZA	133	THIS TRANSACTION WAS FOR INTERNAL DATA CORRECTION. NO ACTION NECESSARY
ZK	133	PEND: CLAIMS VERIFY PROVIDER OF SERVICE, IF CORRECT DENY:ZC
ZZ	133	PEND: ROUTE TO INFORMATION SERVICES "IS" DEPARTMENT
NA	136	OTHER INS. DENIED - OOP PROVIDER/NOT AUTHORIZED - SERVICES NOT PAYABLE
XI	138	DENY: ED RECONSIDERATION NOT RECEIVED TIMELY
XM	138	DENY: ED APPEAL NOT RECEIVED TIMELY
A9	141	PEND: TOTAL NUMBER OF DAYS IS GREATER THAN COVERAGE PERIOD
QW	141	INFO: TOTAL NUMBER OF DAYS EXCEEDS COVERAGE PERIOD

3D	146	DENY: NON-SPECIFIC DIAGNOSIS- REQUIRES 4TH DIGIT PLEASE RESUBMIT
4D	146	DENY: NON-SPECIFIC DIAGNOSIS- REQUIRES 5TH DIGIT PLEASE RESUBMIT
DW	146	DENY: INAPPROPRIATE DIAGNOSIS BILLED, CORRECT AND RESUBMIT
DX	146	DIAGNOSIS BILLED IS INVALID, PLEASE RESUBMIT WITH CORRECT CODE.
EC	146	DIAGNOSIS CANNOT BE USED AS PRIMARY DIAGNOSIS, PLEASE RESUBMIT
I9	146	DENY: DIAGNOSIS IS AN INVALID OR DELETED ICD9 CODE
ND	146	DENY: THIS IS A DELETED CODE AT THE TIME OF SERVICE
SB	146	INFORMATIONAL: SUBSEQUENT DIAGNOSIS WAS NOT A VALID CODE.
1S	147	PEND: PROVIDER CONTRACT IS NOT ON FILE.
CR	147	PEND: PROVIDER NEEDS TO BE CREDENTIALED
CT	147	PEND: PROVIDER HAS NOT SIGNED CONTRACT
ID	147	DENY: NO W-9 FORM ON FILE
PC	147	REFERRING PROVIDER NOT EFFECTIVE AT TIME OF SERVICE
PJ	147	PAY: REFERRING PROVIDER AFFILIATION NOT FOUND
QB	147	INFO: SERVICE PROVIDER AFFILIATION NOT FOUND (AUTH)
QC	147	INFO: REFERRING PROVIDER IS NOT EFFECTIVE - AUTH PERIOD
QG	147	INFO: MULTIPLE SERVICE AFFILIATIONS QUALIFY (AUTH)
QJ	147	INFO: REFERRING PROVIDER AFFILIATION NOT FOUND (AUTH)
QK	147	INFO: MULTIPLE REFERRING AFFILIATIONS QUALIFY (AUTH)
QL	147	INFO: PCP AFFILIATION NOT FOUND (AUTH)
QM	147	INFO: PCP NOT EFFECTIVE DURING AUTH'D PERIOD (AUTH)
QP	147	INFO: REFERRING PROVIDER AFFILIATION NOT PRIMARY (AUTH)
QS	147	INFO: SERVICE PROV NOT EFFECTIVE - AUTH PERIOD
QT	147	INFO: SERVICE PROVIDER HAS BEEN TERMINATED (AUTH)
QU	147	INFO: REFERRING PROVIDER HAS BEEN TERMINATED (AUTH)
SD	147	DENY: CREDENTIALING WAS NOT APPROVED - ALL SERVICES ARE DENIED
FQ	171	DENY: RESUBMIT CLAIM UNDER FQHC/RHC CLINIC MEDICAID NUMBER
I4	181	DENY: ICD-9 PROCEDURE CODE REQUIRES A 4TH DIGIT
XN	193	DENY - ED RECONSIDERATION - PLP NOT MET

25	25	DENY: YOUR STOP LOSS DEDUCTIBLE HAS NOT BEEN MET
37	37	DENY: BALANCE DOES NOT EXCEED DEDUCTIBLE
70	97	ORIGINAL CODE REPLACED BY HPR CODEREVIEW SOFTWARE
72	133	CODE IS BEING QUESTIONED BY CODEREVIEW
73	97	THIS CODE WAS SUPERCEDED BY HPR CODEREVIEW SOFTWARE
74	97	THIS CODE HAS BEEN DENIED BY HPR CODEREVIEW SOFTWARE
9C	B18	DENY: SEND COMPLETE MEDICAL RECORDS FROM DOS 1/97 TO PRESENT
9L	A1	DENY: PROC MUST BE BILLED WITH COMMERICAL AMBULATORY SVC BASE RATE
AG	A1	DENY: SERVICE DOES NOT MEET EMERGENCY CRITERIA, BILL PATIENT
BP	B20	PRICING: BIRTHING AND PARENTING CLASS FACILITY DIAGS
BZ	A1	DENY: PLEASE RESUBMIT WITH CORRESPONDING E & M CODE FOR PAYMENT
D3	A1 or B5	DENY: EXCEEDS ESTABLISHED CONTRACTED REIMBURSEMENT - DO NOT BILL PT.
HW	97 or A1	DENY: PAYMENT INCLUDED IN THE HIGHER INTENSITY CODE BILLED
IK	04	DENY: 2ND EM NOT PAYABLE W/O MODIFIER 25 & MED RECORDS, PLEASE RESUBMIT
RL	A2	PAY: REVIEW NOT TIMELY
YU	A1	DENY: MEDICAID AND TIN NUMBERS ON FILE DO NOT MATCH
ZD	A1	SUBMIT ED RECORDS & EOP W/IN 30 DAYS FOR PRESENTING SYMPTOM ASSESS
ZU	A1	DENY: PROCEDURE IS ONLY VALID AFTER 01/01/1999
OC	A2	PAY: CHARGES PAID AT PROVIDER'S COST-TO-CHARGE RATIO ON DATE OF PAYMENT
OD	B1	ADJUST: CLAIM DOES NOT QUALIFY FOR OUTLIER PAYMENT
55	A1	DENY: THIS ITEM AVAILABLE FOR PURCHASE ONLY
4E	A1	DENY: 2004 CPT CODES NOT ACCEPTABLE FOR SERVICE DATES PRIOR TO 4/01/04
5L	A1	DENY: BENEFIT LIMIT FOR SERVICES WITHOUT AN AUTHORIZATION HAS BEEN MET
AT	A1	APNTA MONITORS WERE NOT PURCHASED
AV	A1	PLEASE REMIT MEDICAL RECORDS FOR CONSIDERATION OF ADDITIONAL PAYMENTS
AW	A1	DENY: RESUBMIT WITH ANESTHESIA SERVICE TO RECEIVE REIMBURSEMENT FOR PROC
CY	A1	DENY: SERV PREVIOUSLY DENIED/ SUBMIT WRITTEN APPEAL FOR RECONSIDERATION
ED	A1	DENY - PLEASE RESUBMIT EPSDT SERVICES UNDER PROVIDER'S EPSDT ID NUMBER
FD	A1	DENY: RESUBMIT CLAIM TO FIRST DENT FOR PAYMENT

FP	A1	DENY: CLAIMS DENIED FOR PROVIDER FRAUD.
G1	A1	DENY: RPOCEDURE UNDER THIS PROGRAM IS NOT COVERED FOR THE MEMBER'S AGE
G8	A1	DENY: ONE CLAIM ALLOWED FOR TYPE OF SERVICE DURING 6 MTH PERIOD
GA	A1	DENY: PROCEDURE NOT COVERED FOR THE MEMBER'S AGE
GB	A1	DENY: GLOBAL CODE IS INVALID PER STATE GUIDELINES
GC	A1	DENY:PER ST. GUIDELINES DELIVERY MUST BE BILLED SEPARATE FROM VISITS
GE	A1	DENY: GLOBAL CODE IS INVALID PER STATE GUIDELINES
H3	A1	DENY: INCLUDED IN ASC FEE
HK	A1	DATES ON MEDICAL DETAIL DO NOT MATCH
I5	A1	DENY: NON-COVERED ICD-9 PROCEDURE, SERVICE DENIED
I6	A1	DENY: DIAGNOSIS OR CPT/HCPCS/ICD-9 PROC CODE INVALID FOR DATE OF SERVICE
IE	A1	CPT NOT REIMBURSED SEPARATELY. INCLUDED AS PART OF INCLUSIVE PROCEDURE
IL	A1	VERIFY THE CORRECT LOCATION CODE FOR SERVICE BILLED AND RESUBMIT
IN	A1	DENY: ORGINIAL CPT BILLED WAS AN INVALID CODE.PLEASE RE-BILL.
IW	A1	DENY: ORIGINAL HCPCS BILLED WAS AN INVALID CODE. PLEASE REBILL
KZ	A1	DENY: INVALID PLACE OF SERVICE, PLEASE CONSULT THE GEORGIA PROV MANUAL
LO	A1	DENY: CPT & LOCATION ARE NOT COMPATIBLE, PLEASE RESUBMIT.
M5	A1	DENY: IMMUNIZATION ADMINISTRATION INCLUDED IN INJECTION FEE
MD	A1	DENY:SERVICES PREVIOUSLY DENIED BY OUR MENTAL HEALTH PROVIDER
MP	A1	DENY: PLEASE RESUBMIT TO THE MEDICAL PLAN FOR CONSIDERATION
MY	A1	DENY: MEMBER'S PCP IS CAPITATED - SERVICE NOT REIMBURSABLE TO OTHER PCPS
MZ	A1	DENY:PLEASE RESUBMIT WITH PROVIDERS MEDICAID ID NUMBER.
NR	A1	DENY: THIS SERVICE IS NOT COVERED FOR NON-REGISTERED RECIPIENTS
NS	A1	SERVICE NOT COVERED WHEN OBTAINED FROM A PROVIDER NON PAR IN MHS NETWORK
OX	A1	DENY: CODE IS CONSIDERED AN INTEGRAL COMPONENT OF THE E/M CODE BILLED
QD	A1	TAX ID SUBMITTED IS INCORRECT FOR DATE OF SERVICE. PLEASE RESUBMIT
RC	A1	DENY: REQUIRED REFERRAL CODE FOR HEALTH CHECK VISIT INVALID OR MISSING
RD	A1	DENY: REVENUE CODE AND DIAGNOSIS ARE NOT COMPATIBLE. PLEASE RESUBMIT.
RI	A1	BABY'S ASSIGNED RID NUMBER IS NEEDED FOR CLAIM PROCESSING

RS	A1	DENY: BILL ADDRESS DOES NOT MATCH SYSTEM-RESUBMIT WITH CORRECT BILL ADDR
RX	A1	DENY: PLEASE SUBMIT TO THE PHARMACY VENDOR FOR PROCESSING.
T5	A1	DENY: PLEASE RESUBMIT TRANPORTATION CLAIMS TO MEDCOMPLY
TB	A1	DENY: TUBAL NOT PERFORMED IN THE 180 DAY TIME FRAME
TF	A1	DENY: CPT/HCPCS CODES NOT ACCEPTABLE FOR SERVICE DATES PRIOR TO NEW YEAR
TH	A1	DENY:PHYSICAL MEDICINE IS NOT COVERED IN PHYSICIAN'S OFFICE
TR	A1	DENY: PAYABLE WITH TREATMENT ROOM OR STAND ALONE SERVICE ONLY
TS	A1	TEMPERATURE GRADIENT STUDIES ARE NOT COVERED FOR THIS DIAGNOSIS
TU	A1	DENY: SUBMIT TO TRANSPORTATION VENDOR FOR PROCESSING
TX	A1	MEDICAID# PROVIDED NOT ON FILE, PLEASE CORRECT AND RESUBMIT
UD	A1	DENY: NO RECORD OF INPATIENT HOSPITAL STAY
UU	A1	DENY: ANTEPARTUM/POST PARTUM NOT PAYABLE INPT
V3	A1	MED RECORDS RECEIVED FOR WRONG DATE OF SERVICE
V4	A1	MED RECORDS RECEIVED NOT LEGIBLE
V5	A1	MED RECORDS RECEIVED FOR WRONG PATIENT
V6	A1	MED RECORDS WITHOUT LEGIBLE PATIENT NAME AND/OR DOS
V8	A1	MED RECORDS RECEIVED WITHOUT DOS
VA	A1	VOID ADJUSTMENT
VS	A1	DENY: PLEASE SUBMIT TO THE VISION VENDOR FOR PROCESSING.
W0	A1	DENY: TRANSPLANT CLAIM SUBMIT TO CIGNA LIFESOURCE FOR REPRICING
W6	A1	DENY: TRANSPLANT CLAIM SUBMIT TO INTERLINK FOR REPRICING
X5	A1	DENY: NO SIGNATURE ON CONSENT FORM
X6	A1	DENY: SERVICES ARE UNDER REVIEW
XE	A1	REVENUE/PROCEDURE CODE BILLED FOR THE DIAGNOSIS SUBMITTED IS NOT COVERED
XX	A1	COVERAGE NOT IN EFFECT ON DATE OF SERVICE - BILL THE STATE
Z4	A1	DENY: RESUBMIT WITH DOCUMENTATION THAT VALIDATES MEDICAL NECCESSITY
ZC	A1	DENY: PROCEDURE IS INAPPROPRIATE FOR PROVIDER SPECIALTY
ZY	A1	DENY: ALL ER CHARGES PENDING UNTIL FURTHER NOTICE
41	A2	PREFERRED PROVIDER DISCOUNT

91	A2	PAYMENT IN FULL
92	A2	PAID ACCORDING TO CONTRACT / STATE PROCESSING GUIDELINES
1D	A2	PAY IN FULL : (MEMBER ELIGIBILITY VERIFIED)
1G	A2	PAY IN FULL: PARTIAL ELIGIBILITY VERIFIED
1J	A2	ADJUST: ONE TREATMENT ROOM PER DAY INCLUDING DRUGS AND SUPPLIES
1O	A2	INCENTIVE PAYMENT PREVIOUSLY MADE FOR THIS DELIVERY
2J	A2	ADJUST: COVERED STAND-ALONE REVENUE CODE LIMITED TO ONE UNIT
8J	A2	ADJUST: PAID AT DRG RATE INSTEAD OF LEVEL OF CARE RATE
9F	A2	PAY: CODE (S) ADDED BASED ON CODE AUDITING SOFTWARE RECOMMENDATION
AJ	A2	ADJUST: NO MEDICAL NECESSITY SHOWN FOR ANESTHESIA FOR THIS PROCEDURE
AO	A2	PEND: MANUALLY PAY REMAINING CHARGES AT 100%
BJ	A2	ADJUST: HOME EQUIPMENT OR SUPPLIES PREVIOUSLY PAID INCORRECTLY
CM	A2	MEMBER ON REVIEW FOR CASE MANAGEMENT
CU	A2	TO CASE MANAGEMENT ADJUSTOR
EJ	A2	ADJUST: HOME HEALTH VISIT OVERHEAD PREVIOUSLY PAID INCORRECTLY
FA	A2	ADJUSTMENT: CLAIM WENT TO INCORRECT FUND
GJ	A2	ADJUST: OB PAYMENT BASED ON INCORRECT FEE SCHEDULE
H6	A2	PROVIDER MUST BILL WITH HCPCS/CPT FOR CORRECT PRICING
HC	A2	AUTH PROCEDURE CLASS NOT MATCHING
HD	A2	PEND: DIAGNOSIS ON CLAIM DOES NOT MATCH DIAGNOSIS ON AUTHORIZATION
HF	A2	PAY:PROCEDURE DOES NOT MATCH AUTHORIZATION
HI	A2	PAY: HIGH COST
HO	A2	PAY: MEMBER ON REVIEW FOR HIGH RISK OB
HV	A2	PAY: HIV
IC	A2	INTEREST AMOUNT
J6	A2	ADJUSTMENT: DRG PAYMENT ADJUSTED PER REVIEW OF MEDICAL RECORDS
J7	A2	ADJUSTMENT: RECOUPMENT DUE TO PAYMENT BEYOND 90 DAYS.
J8	A2	ADJUST: HOME HEALTH VISITS PREVIOUSLY PAID INCORRECTLY
J9	A2	ADJUST: ADJUSTMENT TO CORRECT PMT OF 90% BILLED CHGS TO MEDICAID ALLOW

JA	A2	ADJUSTMENT: PAY ON APPEAL
JE	A2	ADJUST: PSHP IS PRIMARY INSURER FOR THIS SERVICE
JF	A2	ADJUST: PATIENT ELIGIBLE FOR DATE OF SERVICE
JH	A2	ADJUST: COVERED BENEFIT
JI	A2	ADJUST: SERVICE AUTHORIZED BY PCP
JJ	A2	ADJUST: GRIEVANCE - SERVICE AUTHORIZED
JK	A2	ADJUST: DATE OF SERVICE CORRECTED
JL	A2	ADJUST: NOT A COVERED SERVICE,BILL WORKER'S COMP
MR	A2	MEMBER ON REVIEW FOR CASE MANAGEMENT
NJ	A2	ADJUSTED: BHS PEND ERROR
OJ	A2	ADJUST: PER CLAIM AUDIT - VISITS LIMITED TO ONE PER DAY
P1	A2	BEYOND TIMELY FILING LIMIT, PAID IN GOOD FAITH
P2	A2	PAID AT AUTHORIZED AMOUNT
P4	A2	PAID ACCORDING TO T-19 RATES
PA	A2	PAY ACCORDING TO CONTRACTUAL AGREEMENT
PD	A2	PAID ACCORDING TO AUTHORIZED AMOUNT
T1	A2	TRIAGE PAYMENT COVERED UNDER CAPITATION
T2	A2	PAID ACCORDING TO T-19 DRG OUT-PATIENT RATE
T3	A2	PAID ACCORDING TO OUT OF STATE MEDICAID GUIDELINES
TG	A2	PAID ACCORDING TO TRIAGE MOU, AUTH. WAS DENIED OR NOT OBTAINED
TQ	A2	PAY: TRANSPLANT SERVICES PAID AT % OF BILLED CHARGES
UF	A2	PATIENT INPATIENT OVER 10 DAYS RECOMM.TO CASE MGMT.
UK	A2	PAY: ZERO DOLLARS PAID, INCLUDE IN TRANSPLANT CASE
UN	A2	PAY: PLP MET
VK	A2	PAY: TRANSPLANT CASE RATE PAID
W3	A2	PAY: PAID ACCORDING TO TRANSPLANT AGREEMENT
WP	A2	ADJUST INCORRECT PROVIDER PAID
XC	A2	PAY: PAY ON RECONSIDERATION - PLP MET
XY	A2	PLP NOT MET - SCREENING FEE PAID

YN	A2	MEDICAID # MUST BE BILLED IN 24K/HCFA, OR 51/UB
VG	A8	DENY: VALID DRG CODE REQUIRED
DL	B11	DENY: REBILL USING A PHARMACY CLAIM FOR THIS SERVICE
MH	B11	DENY: PLEASE SUBMIT TO MENTAL HEALTH PLAN FOR PROCESSING
TV	B11	CLAIM FORWARDED TO TRANSPORTATION VENDOR FOR PAYMENT
C8	B12	CPT HAS BEEN DENIED ACCORDING TO CLAIM AUDIT
EB	B12	DENY: DENIED BY MEDICAL SERVICES
EQ	B12	DENY: DIAGNOSIS DOES NOT SUPPORT E/M BILLED
FZ	B12	DENY: DOCUMENTATION DOES NOT REFLECT ALL COMPONENTS OF BILLED E/M
U4	B12	DENY:UPON REVIEW OF RECORDS-NO INDICATION OF PHYS SERVICES
3P	B13	DENY: PAID UNDER SETTLEMENT
1L	B14	DENY: VISIT & PREVEN CODES ARE NOT PAYABLE ON SAME DOS W/O DOCUMENTATION
P6	B14	SERVICE PAYABLE ONLY ONCE PER DAY
D4	B15	PAY: PER STATE GUIDELINES - PROCEDURE NOT SEPARATELY REIMBURSABLE
SI	B15	PAY: REIMBURSEMENT FOR PROCEDURE INCLUDED IN SURGICAL REIMBURSEMENT
98	B18	DENY: PROCEDURE INVALID FOR YEAR WHICH SERVICE WAS RENDERED
0C	B18	1999 CODE DELETED IN 2000, PLEASE REBILL WITH CORRECT CODE
DJ	B18	DENY:INAPPROPRIATE CODE BILLED,CORRECT & RESUBMIT
H8	B18	DENY: HOMEGROWN PROCEDURE CODES ARE NOT VALID FOR THIS DOS
H9	B18	DENY: HOMEGROWN MODIFIERS ARE NOT VALID FOR THIS DOS
IV	B18	DENY: INVALID/DELETED/MISSING CPT CODE
KK	B18	DENY:K CODES ARE NOT BILLABLE-USE APPROPRIATE HCPCS CODES
US	B18	UNLISTED CODE - INELIGIBLE FOR CONSIDERATION, PLEASE CORRECT & RESUBMIT.
AF	B20	DENY: CONCURRENT CARE RENDERED BY SAME SPECIALTY PHYSICIAN
BO	B20	DENY:NOT PAYABLE-ANOTHER PROIVDER/FACILTY BILLED FOR COMPLETE SERVICE
CN	B20	DENY: NOTPAYABLE/ANESTHESIOLOGIST BILLED FOR COMPLETE SERVICES
28	B5	DENY: COVERAGE NOT IN EFFECT WHEN SERVICE PROVIDED
AK	B5	DENY: UNTIL HOSPITAL CALLS IN ADMISSION
DM	B5	PEND: REFER TO PRICING FOR DME PURCHASE WITHIN A RENTAL PERIOD

DY	B5	DENY: APPEAL DENIED
RP	B5	RECOUP DUE TO PAYMENT BEYOND 90 DAYS
VO	B5	VOID SERVICE FOR ADMINISTATIVE REASONS
H1	B6	DENY: PROVIDER MUST USE HCPC/CPT FOR CORRECT PRICING
P0	B6	DENY:LAB BILLED NOT PAYABLE TO PATHOLOGIST-NO DIRECT MD WORK/INVOLVEMENT
PF	B6	DENY: PROFESSIONAL FEE MUST BE BILLED ON HCFA FORM
PK	B6	PAY: MULTIPLE REFERRING AFFILIATIONS QUALIFY
PO	B6	DENY: CLINICIAL LAB/X RAY NOT PAYABLE TO PATHOLOGISTS
SW	B6	DENY: SERVICES BILLED BY AN ER MD - SPEC 93 WHEN BILLED W/ MODIFIER 26