

EX Code	Reason Code	EX-Code Description
01	1	DEDUCTIBLE AMOUNT
02	2	COINSURANCE AMOUNT
03	3	COPAYMENT AMOUNT
04	4	PEND: PROCEDURE CODE IS INCONSISTENT WITH THE MODIFIER USED
86	4	DENY: INVALID/DELETED/MISSING MODIFIER
05	5	PEND: THE PROCEDURE CODE IS INCONSISTENT WITH THE PLACE OF SERVICE
PQ	5	CPT AND LOCATION ARE NOT COMPATIBLE, PLEASE RESUBMIT.
06	6	PEND: THE PROCEDURE CODE IS INCONSISTENT WITH THE PATIENT'S AGE
1K	6	DENY: PROC CODE IS INCONSISTENT WITH PATIENT'S AGE OR SEX
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	PEND: THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S SEX
11	11	PEND: THE DIAGNOSIS IS INCONSISTENT WITH THE PROCEDURE
DU	11	DENY: PROCEDURE IS INAPPROPRIATE FOR 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
15	15	DENY: CLAIM DENIED BECAUSE THE SUBMITTED AUTH NUMBER IS INVALID
HG	15	DENY: GROUP PRACTICE DOES NOT MATCH AUTH
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	AUTH NO MATCH: DATES ON MEDICAL DETAIL DO NOT MATCH
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	INFO: PROVIDER ADDRESS NOT FOUND ON ADDRESS DATASET
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
I1	16	OTHER INSURANCE EOB SUBMITTED DOES NOT MATCH BILLED, PLEASE RESUBMIT
IG	16	DENY: INVALID OR MISSING DISCHARGE STATUS, PLEASE RE-SUBMIT
J2	16	CONSENT FORM NOT SUBMITTED
MA	16	DENY: PROVIDER MEDICAID ID# NOT ON FILE
MF	16	DENY: INAPPROPRIATE MEDICAID# SUBMITTED FOR SVC PROVIDER,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
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
CX	18	DENY: DUPLICATE SUBMISSION-ORIGINAL CLAIM IN PEND STATUS
DS	18	DENY:DUPLICATE SUBMISSION-ORIGINAL CLAIM STILL IN PEND STATUS
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 RESPONSIBILITY 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
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: UHP IS SECONDARY INSURANCE PLEASE 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 AGREEMENT
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
34	34	DENY: INSURED HAS NO COVERAGE FOR NEWBORNS
35	35	DENY: BENEFIT MAXIMUM HAS BEEN REACHED
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
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
88	41	PAYMENT INCLUDES A 15% DISCOUNT
89	41	PAYMENT INCLUDES 5% DISCOUNT
AQ	41	PAYMENT BASED ON 25% DISCOUNT
AR	41	PAYMENT BASED ON A 40% DISCOUNT
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
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
59	59	PAY: CHARGES ARE REDUCED BASED ON MULTIPLE SURGERY RULES
A1	62	DENY: AUTHORIZATION NOT ON FILE
A6	62	PEND: SERVICE HAS EXCEEDED THE AUTHORIZED LIMIT
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
NR	62	DENY: UNAUTHORIZED SERVICE

85	85	INTEREST CHARGES
82	92	ERROR:REFEERRING PROVIDER HAS BEEN TERMINATED
A4	92	INFO: CLAIM AND AUTH REFERRING PROVIDERS DO NOT MATCH
CL	92	DO NOT USE
DG	92	PAYMENT INCLUDED IN DRG
E2	92	INFO: A LATER SERVICE HAS BEEN PROCESSED AGAINST COUNTERS
EN	92	REQUIRES NURSE REVIEW EL PASO
ER	92	PAY ZERO:SUBMIT ER RECORDS & EOP W/IN 45 DAYS FOR PRESENTING SYMPTOMS
FJ	92	ADJUST: VISIT OR SERVICE INCLUDED IN OB DELIVERY PAYMENT
HA	92	INCLUDED IN HOSPITAL AMBULATORY REFORM PAYMENT
HH	92	PAY: CLAIM AND AUTH PROVIDER STATUS NOT MATCHING
HM	92	INPT & OUTPT CLAIMS TILL S.T. RESOLVES CONTRACT
HN	92	REQUIRES NURSE REVIEW AUSTIN
IO	92	INFORMATIONAL PURPOSES ONLY
MY	92	MATERNITY INFORMATION CODE
NY	92	NEW JERSEY INFORMATION CODE
PC	92	PAY: REFERRING PROVIDER NOT EFFECTIVE AT TIME OF SERVICE
PU	92	PAY: REFERRING PROVIDER HAS BEEN TERMINATED
PZ	92	PAY ZERO: MEDICAL NECESSITY REQUIREMENTS NOT MET
RX	92	PAY: CAPITATED PHARMACY ENCOUNTER
SL	92	PAID ACCORDING TO STOP LOSS AGREEMENT
SN	92	REQUIRES NURSE REVIEW SAN ANTONIO
TR	92	PER STATE GUIDELINES REIMBURSED FOR TRACING ONLY
Y1	92	INFO: AMOUNT CHARGED FOR SERVICE IS ZERO
YM	92	INFORMATIONAL ONLY: MODIFIER TWO BILLED WAS INVALID
AH	95	DENY:HOSPITAL DID NOT NOTIFY UHP OF ADMISSION/DO NOT BILL MEMBER/
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
46	96	DENY: THIS SERVICE IS NOT COVERED
48	96	DENY: THIS PROCEDURE IS NOT COVERED
BD	96	DENY: BENEFIT IS NOT COVERED BY HMO
BF	96	DENY: BIOFEEDBACK IS NOT A BENEFIT OF NEW JERSEY MEDICAID
EY	96	DIAGNOSIS IS NOT COVERED, BILL STATE ENTITY
NB	96	DENY: SERVICE IS NOT COVERED BY UHP, PLEASE BILL TO NJ MEDICAID
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
95	97	PAYMENT IS INCLUDED IN ALLOWANCE FOR BASIC SERVICE
97	97	PAYMENT IS INCLUDED IN ALLOWANCE FOR BASIC SERVICE
0P	97	PAY ZERO: COVERED UNDER PERDIEM/PERSTAY CONTRACTUAL ARRANGEMENTS
3L	97	DENY: PT ADMITTED-SUBMITTED SERVICES/CHARGES BILLED INCLUSIVE
9E	97	DENY: CODE REPLACED BASED ON CODE AUDITING SOFTWARE RECOMMENDATION
C2	97	CPT HAS BEEN REBUNDLED ACCORDING TO CLAIM AUDIT
C6	97	CPT HAS BEEN REPLACED ACCORDING TO CLAIM AUDIT
CP	97	DENY: COVERED UNDER PRIMARY PROCEDURE
D1	97	SERVICE INCLUDED IN E.R. VISIT
DI	97	PAY: ANCILLARY CHARGES INCLUDED IN E.R.VISIT
GB	97	DENY: SERVICE PAID UNDER GLOBAL CONTRACTED RATE
GL	97	SERVICE COVERED UNDER GLOBAL FEE AGREEMENT
J4	97	ADJUSTMENT: ANTEPARTUM VISIT INCLUDED IN TOTAL OB DELIVERY
MI	97	DENY: MRI'S & CAT SCANS ARE NOT BILLABLE WHEN BILLED WITH A SCREENING

TI	97	E.R. PHYS PAID TRIAGE, ANCILLARY SERVICES NOT PAYABLE
VI	97	GLOBAL FEE PAID
50	109	DENY:NOT A MCO COVERED BENEFIT,SUBMIT TO STRAIGHT T19
CC	109	DENY: CONTINUITY OF CARE,BILL PREVIOUS INSURANCE CARRIER
H6	109	DENY: CLAIM IS RESPONSIBILITY OF HUMANA
K0	109	DENY:UHP NOT RESPONSIBLE FOR SERVICE SUBMIT CHARGES TO MEDICAID FFS
K1	109	DENY: SUBMIT CHARGES TO BEHAVIORAL HEALTH PROVIDER FOR PROCESSING
K2	109	PLEASE SUBMIT SERVICES TO VISION VENDOR FOR PROCESSING
K3	109	DENY: SERVICE IS NOT THE RESPONSIBILITY OF UHP. SUBMIT CHARGES TO EPSDT
K4	109	DENY:UHP NOT RESPONSIBLE FOR MEMBER SUBMIT CHARGES TO MEDICAID FFS
K6	109	PLEASE SUBMIT TO VISION VENDOR FOR PROCESSING
K8	109	DENY: PLEASE SUBMIT TO BEHAVIORAL HEALTH VENDOR FOR PROCESSING
VE	109	DENY: PLEASE SUBMIT SERVICES TO VISION VENDOR FOR PROCESSING
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
GS	125	DENY: DATE OF SVC ON CLAIM IS GREATER THAN RECEIVED DATE,PLEASE RESUBMIT
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
K5	125	DENY: TPI# REQUIRED IN BOX 24K/HCFA OR 51/UB, CORRECT RESUBMIT
MD	125	DENY: MODIFIER BILLED IS MISSING/INVALID, PLEASE RESUBMIT
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 A VALID CODE, PLEASE RESUBMIT.
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
00	133	PEND-CONTRACT INVESTIGATION
+3	133	PEND: PAY 103% OF INVOICE, IF NO INVOICE ATTACHED, DENY EXBI
31	133	PEND: PROCESSOR MUST DETERMINE FURTHER ALLOWANCE ON SUBMITTED PROCEDURE
33	133	SYSTEM ERROR: SERVICE PROVIDER AFFILIATION NOT FOUND
56	133	PAY: SERVICE ADDED BY CODE AUDITING SOFTWARE
64	133	PEND: ERROR IN ANY FIELD PASSED THROUGH CODE AUDITING SOFTWARE
69	133	CODE AUDITING SOFTWARE SERVICE FOLDING ERROR
77	133	ERROR: SERVICING PROVIDER IS NOT IN EFFECT DURING AUTHORIZED PERIOD
78	133	ERROR: MULTIPLE SERVICE AFFILIATIONS QUALIFY
93	133	HISTORICAL ERROR IDENTIFIED BY CODE AUDITING SOFTWARE
0K	133	PEND: ROUTE TO ADJUSTMENT QUEUE
1A	133	PEND: GROUP, DIVISION, CONTRACT, MEMBER RECORD/SPAN MISSING OR OVERLAPPING
1E	133	PAY: THE CONTRACT IS INELIGIBLE DURING AUTHORIZED PERIOD.
2A	133	THE LESION IS ACTINIC KERATOSIS
2K	133	555555 PROV, IF 24K BLANK OR NO MATCH USE TIN AND DENY K5
2P	133	PROVIDER RELATIONS PROBLEM, SEND TO PROVIDER RELATIONS DEPARTMENT
3A	133	PEND: IF NO INVOICE ATTACHED, DENY EXBI - OTHERWISE OVERRIDE THIS PEND
3K	133	PEND: CLAIM KEYED BY FARMINGTON CLAIM OFFICE - AUDIT
9G	133	PEND: MRU REVIEWING CLAIM
A2	133	PEND: KEYWORD OR CODE SET ERROR
A5	133	PEND: TOTAL NUMBER OF QUALIFYING AUTHS EXCEEDS TABLE SIZE
A7	133	PEND: ERROR CODE USED IS NOT DEFINED IN CODE SET.

AN	133	PEND: USE EX.CODE D1 TO DENY ANCILLARY CHARGES BILLED WITH E.R. VISIT
AU	133	PEND: MULTIPLE AUTHORIZATIONS QUALIFY, PICK CORRECT AUTH.#
AY	133	PEND - IF RENAL DIALYSIS, PAY AT PER DIEM OF \$250.00
B1	133	PEND: SA CODE FOR BENEFIT IS NOT IN THE CODE SET
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 QUALIFY AGAINST A MAPPED BENEFIT
B5	133	PEND: COUNTER TABLE IS FULL,COUNTER EXCEEDED OR AMOUNTS INCOMPATIBLE
B8	133	INFO: AN AUTHORIZATION IS NOT REQUIRED FOR THIS BENEFIT
B9	133	PEND: BENEFIT CONFIGURATION ERROR
BC	133	PEND: MEMBER CHANGED BENEFIT PACKAGES DURING HOSPITALIZATION
BE	133	PEND ALL SERVICES COVERED UNDER THE BENEFIT PACKAGE (IN TESTING)
BL	133	PEND: SERVICE EXCEEDS THE BENEFIT LIMIT. SPLIT SERVICE AND REPROCESS
C0	133	PEND: LATE CLAIM SUBMISSION SUPER-TABLE IS REQUIRED
C1	133	PEND: MULTIPLE BANK CODES, SPLIT CLAIM MANUALLY
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
CG	133	PEND: PROVIDER ON REVIEW UNTIL CAPITATION SUMMARY RECEIVED
CJ	133	PEND: NEED DME MODIFIER FOR CORRECT PRICING
CS	133	PEND: ROUTINE CIRCUMCISION IS NOT A BENEFIT OVER THE AGE OF 1
CZ	133	PEND: MEDICAID NUMBER MISSING, CHANGE PROVIDER OR DENY CLAIM
D0	133	PEND: THE DEFAULT PAID OR SAVINGS EQUATION IS NOT ON FILE
D2	133	PEND: PROCEDURE IS NOT VALID WITH PRIMARY DIAGNOSIS
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: FEE NOT FOUND
DB	133	PEND: PLUS UNITS OR MODIFIER ARE REQUIRED OR NOT NUMERIC
DE	133	PEND: DATE OPTION ON THE PRICING COUNTER IS INVALID
DF	133	PEND: MANUAL PRICING REQUIRED
DH	133	PEND - PAY 100% OF INVOICE, IF NO INVOICE IS ATTACHED, DENY EXBI
DP	133	PEND: POSSIBLE DUP SERVICE HITTING AGAINST A PREV DENIED SERVICE
E1	133	PEND: COUNTER EXTENSION EXCEEDS 16 CHARACTERS
EH	133	PEND:CLAIMS PLEASE ENTER HOUR UNITS INTO COUNT FIELD
EM	133	PEND: ER AUTHORIZATION NOT ON FILE
EP	133	PEND: VERIFY ELIGIBILITY AND PRICING. PROCESS MANUALLY.
EX	133	PEND: USER EXIT ROUTINE NOT AVAILABLE ON THIS ACCOUNT
EZ	133	ROUTE TO CLAIMS MANAGER
FB	133	PROVIDER ON REVIEW FOR CSS
FR	133	PEND: MEMBER ON REVIEW - FRAUD INVESTIGATION UNDERWAY
GK	133	PEND TO CSS
H7	133	PEND: APPLY CORRECT DRG NUMBER TO FIELD 24
HB	133	PEND: CLAIM AND AUTH DATES OF ADMISSION NOT MATCHING
HX	133	PEND - PAY AT 110% OF COST - DENY (EX99) FOR INVOICE IF NOT ATTACHED
I8	133	PROVIDER ON REVIEW FOR INTERNAL AUDIT
IB	133	PEND: CANNOT BE PROCESSED W/O ITEM BILL--DENY BI IF NO BILL ATTACHED
II	133	PEND: INCOMPLETE MEDICAL CHECKUP - DENY WITH EXAM IF MISSING COMPONENTS
IL	133	PEND: PROV ON REVIEW FOR IRS LEVY, SEND PAYMENTS TO IRS
IP	133	PROVIDER PENDING FOR SET-UP FORM OR CONTRACT
IR	133	PEND: SEE IRENE FOR REINBURSMENT INSTRUCTIONS
IS	133	SYSTEM OR CONFIG PROBLEM, SEND CLAIM TO "IS" DEPARTMENT.
IT	133	PEND: PROVIDER UNDER FRAUD INVESTIGATION
KF	133	PROVIDER ON REVIEW - BADPROV
KV	133	PEND: CONVALESCENT WAITING PERIOD FOR TEMPORARY LENSES AFTER EYE SURGERY

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: LOCATION CODE IS MISSING FOR THIS SERVICE
L9	133	PEND: T-19 MEMBER HAS OTHER INSURANCE - NEED TO VERIFY.
LA	133	PEND: OTHER INSURANCE IS EITHER HMO OR PPO
LE	133	PEND: PAY 100% OF INVOICE, IF NO INVOICE IS ATTACHED, DENY EXLZ
LF	133	PEND: PAY 30% OF BILLED, IF NO INVOICE IS ATTACHED, DENY EXLZ
LK	133	PEND: PAY 105% OF INVOICE, IF NO INVOICE ATTACHED, DENY EXLZ
LL	133	PEND: CLAIM IS SET TO PAY OVER AUDIT AMOUNT (\$10,000 FOR H, \$5000 FOR M)
LS	133	THE LATE CLAIM SUBMISSION SUPER-TABLE ENTRY IS REQUIRED
M0	133	PEND: MEMBER PARTIALLY ELIGIBLE AT TIME OF SERVICE
M1	133	PEND: SERVICE AND AUTH MODIFIERS DO NOT MATCH
M2	133	PEND: SERVICE REQUIRES A MODIFIER
M4	133	PEND: SPECIAL MANUAL PRICING FOR SYNAGIS
M5	133	MULTIPLE EDITS BY CODEREVIEW
M9	133	SEND TO ENROLLMENT DEPARTMENT
MB	133	NO SUPER TABLE RECORD FOUND FOR MEMBER CARRIER
MC	133	PEND: CLAIMS DEPT SEE NOTES ON AUTH FOR SPECIAL PROCESSING INSTRUCTION
ME	133	PEND: MEMBER ON REVIEW - ELIGIBILITY UNDER REVIEW
MH	133	PEND MH/CD INPATIENT FOR REVIEW OF ELIGIBILITY
MM	133	MAMMOGRAMS - REVIEW DIAG DETERMINE ELIGIBILITY OF ADDL MAMMOGRAMS
MT	133	PEND: Member is partially eligible during authorized period.
MU	133	PEND: MULTIPLE BIRTHS: PAY ACCORDING MULTIPLE BIRTHS CLAUSE IN CONTRACT
NF	133	AN ADMISSION AUTHORIZATION IS NOT ON FILE
NG	133	PEND: NWBN CLM, ROUTED BY PL, PENDING PLAN RESPONSE
NH	133	PEND: INPT NETWORK HEALTH PLAN/USE SPREADSHEET TO CALCULATE ALLOWED

NI	133	PEND: NICU CLAIM - PAY ONLY ON SERVICE LINE WITH REV CODE 231
NJ	133	NEW JERSEY CATCH ALL PEND CODE
NL	133	* PEND - ALL CLAIMS TO BE ROUTED TO TEAM LEADER
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
OP	133	REVIEW FOR MEDICAL GROUP RESPONSIBILITY
OT	133	SERVICE UNABLE TO MAP TO A BENEFIT - PRINT SCREEN PLEASE FOR OTC
OV	133	PEND:REVIEW VISIT WITH SURGERY.TO PAY=92 TO DENY=SU
P3	133	PEND: FEE SCHEDULE NOT EFFECTIVE OR FOUND FOR DATE OF SERVICE
P5	133	PEND: INCOMPATIBLE AMOUNTS BEING COUNTED AGAINST A LIMIT OR CONFIG
P7	133	PEND: INVALID RELATIONSHIP FOR REFERRING PROVIDER
P9	133	PEND: PRICING CONFIGURATION ERROR
PB	133	PEND: SERVICING PROVIDER AFFILIATION NOT FOUND
PE	133	PEND: PROVIDER IS ON REVIEW
PG	133	PEND: SERVICE PROVIDER AFFILIATION NOT FOUND
PI	133	PEND: NO AFFILIATION EXISTS FOR PAYTO OF __
PL	133	PEND: PCP AFFILIATION NOT FOUND
PM	133	PEND: PCP IS NOT EFFECTIVE AT THE TIME OF SERVICE
PN	133	PEND: DO NOT USE THIS PROVIDER - SEE D-BASE TECH
PP	133	PEND: REFERRING PROVIDER IS NOT PRIMARY
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
Q1	133	PEND: PROCESS TO LOAD CODES IN PROGRESS BY BUSINESS
QN	133	PEND: CHIP NEWBORN - RESEARCH NEEDED
RB	133	PEND CODE TIED TO PRICING KEYWORD PEND SERV QUALIFIER
RF	133	PEND: REFERRING PROVIDER IS NOT IN PLAN
RG	133	PEND: ENTER DRG NUMBER INTO FIELD 24

RH	133	PEND:PAY REVIEW OF MULTPL SURGICAL PROC/REBUNDLE CHRGS WHEN APPROPRIATE
RR	133	PEND: CLAIMS VERIFY IF ER SERVICES ARE PAID CORRECTLY
RV	133	PEND: PROVIDER ON REVIEW - FORWARD TO MEDICAL REVIEW
S1	133	PEND: PROVIDER STATUS CODE NOT ENTERED
S8	133	PEND: CHANGE M1 FIELD TO "PA" OR "SA" & M2 TO "8" ALSO SPLIT CLAIM
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
SI	133	PEND - SPECIALTY INAPPROPRIATE FOR PAYCLASS
SK	133	MANUAL PRICING FOR STOP LOSS
SM	133	PEND: ADJUSTER REVIEW CLAIM FOR STOP/LOSS CONTRACT
SP	133	PEND: REVIEW FOR SPECIAL CONSIDERATION - LOOK FOR AUTH
SR	133	PEND: PAY CLAIMS AT 90%, 45%, 22.5% BY ALLOWED AMOUNT
SS	133	PEND: MEMBER ON REVIEW FOR NO SSN
SX	133	PEND: THE PROCEDURE CODE IS INCONSISTENT WITH THE MEMBERS GENDER
SY	133	PEND: PAY CLM AS 100%+, 50%, 25% BY AMT ALLOWED
T9	133	PEND:TITLE-19 PENDING ELIGIBILITY (MEMBER STATUS EN OR PN OR NC)
TE	133	PEND: CLAIMS, VERIFY CLAIM IS PAID CORRECTLY
TP	133	ROUTE TO TPL DEPARTMENT - OTHER INSURANCE
TT	133	THE ASSIGNED TREATMENT TYPE IS NOT ON THE CODE SET
TY	133	CK CONTRACT FOR TELEMETRY RATES. S/NOT BE PD CONCURRENTLY W/ RB CHARGES
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
V0	133	ADD PROVIDER TO V0## GROUPING
VC	133	PEND: VALCODE ERROR - CODE MISSING FROM A ## GROUPING
VN	133	PEND: VENT
VU	133	VIRTUAL CLAIMS PEND

WA	133	PEND: PENDED FOR HIPAA CHANGES
WC	133	PEND: TRANSPLANT PRICING NEEDED
WW	133	OPS-PAY65%, OBS-DENY EXVI, ALL OTHER-MGSI DENY, NONMGSI-PAY CONTRACT
X1	133	PENDED BY AUDITOR
X9	133	PEND: PENDED BY AUDITOR
XB	133	PEND: POSSIBLE TRANSPLANT CLAIMS
XZ	133	PEND: CONTRACT IS IN INFORMATION SYSTEM DEVELOPMENT
Y5	133	PEND: ALLOW AWP - 15%
YA	133	PEND: MULTIPLE PROVIDER AFFILIATIONS QUALIFY
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
ZO	133	PEND: ALLOW AWP - 20%
ZP	133	PEND: ALLOW AWP - 11%
ZQ	133	PEND: ALLOW AWP - 18%
ZR	133	PEND: ALLOW AWP - 17%
ZS	133	PEND: ALLOW AWP - 10%
ZT	133	PEND: ALLOW AWP - 5%
ZV	133	PEND: PRICE AT AWP MINUS % INDICATED IN THE CONTRACT
ZY	133	REVIEW ALL ER CHARGES FOR CORRECT PAYMENT
ZZ	133	PEND: ROUTE TO INFORMATION SERVICES "IS" DEPARTMENT
NA	136	OTHER INS. DENIED - OOP PROVIDER/NOT AUTHORIZED - SERVICES NOT PAYABLE
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 ICD9 DIAG/PROC - REQUIRES 4TH DIGIT - PLEASE RESUBMIT
4D	146	DENY: NON-SPECIFIC ICD9 DIAG/PROC - REQUIRES 5TH DIGIT - PLEASE RESUBMIT
CD	146	DIAGNOSIS SUBMITTED IS NOT A VALID CODE, PLEASE RESUBMIT.
DW	146	DENY: INAPPROPRIATE DIAGNOSIS BILLED, CORRECT AND RESUBMIT
DX	146	SERVICES FOR THE DIAGNOSIS SUBMITTED ARE NOT COVERED

I9	146	DENY: ICD-9 DIAG/PROC CODE IS DELETED/INVALID FOR DATE OF SERVICE
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 CREDENTIALLED
CT	147	PEND: PROVIDER HAS NOT SIGNED CONTRACT
ID	147	DENY: NO W-9 FORM ON FILE
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
TX	147	DENY: PROVIDER TAX ID# NOT ON FILE
25	25	DENY: YOUR STOP LOSS DEDUCTIBLE HAS NOT BEEN MET
30	133	PROCEDURE INCLUSIVE - ADDL CHGS MAY BE GLOBAL
37	37	DENY: BALANCE DOES NOT EXCEED DEDUCTIBLE
55	A1	ED PROCEDURE 00.55 NOT VALID FOR CHARGES AFTER 7/1/98.
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

75	133	PEND - PAY 70% OF INVOICE, IF NO INVOICE IS ATTACHED, DENY BI
79	133	ERROR: MEMBER IS NOT ELIGIBLE TO BE AUTHORIZED TO THIS PROVIDER
3P	B13	DENY: PAID UNDER SETTLEMENT
AG	133	PEND: PAY \$6000 FOR 1ST 3 DAYS, THEN PAY APPROPRIATE PER DIEM RATE
BB	04	DENY: INAPPROPRIATE MODIFIER FOR BILLED PROCEDURE
BH	133	PEND: PAY 110% OF INVOICE, IF NO INVOICE DENY EXBI
CI	133	PEND: CAUSE OF ILLNESS ON AUTH AND CLAIM/SERVICE DO NOT MATCH
D3	B5	DENY: EXCEEDS ESTABLISHED CONTRACTED REIMBURSEMENT - DO NOT BILL PT.
FD	B5	DENY: DELIVERY BENEFIT EXCEEDED
H1	B6	DENY: CPT/HCPCS IS REQUIRED, PLEASE RESUBMIT
HW	97 or A1	DENY: PAYMENT INCLUDED IN THE HIGHER INTENSITY CODE BILLED
HZ	133	PEND: TRANSPLANT CASE - CONTACT TRANSPLANT COORDINATOR AT CORPORATE
IK	04	DENY: 2ND EM NOT PAYABLE W/O MODIFIER 25 & MED RECORDS, PLEASE RESUBMIT
NK	133	PEND: MANUAL DRG PRICING REQUIRED - NON PAR INPATIENT CLAIM
OL	133	PEND - PAY 105% OF INVOICE, IF NO INVOICE IS ATTACHED, DENY EXBI
RL	A2	PAY: REVIEW NOT TIMELY
RP	B18	DENY: INVALID PROCEDURE FOR 1999. PLEASE RESUBMIT WITH CORRECT CODE.
SO	133	PEND: REVIEW REMARKS FOR SPECIAL PRICING
TF	A1	DENY: CPT/HCPCS CODE NOT BILLABLE FOR THIS DATE OF SERVICE
TQ	A2	PAY: TRANSPLANT SERVICES PAID AT % OF BILLED CHARGES
UX	133	**PEND: (LC)CL MUST BE USED TO PROCESS THIS CLAIM
VZ	133	VOID INFO
ZD	A1	DENY: SUBMIT ED RECORDS & EOP W/IN 30 DAYS FOR PRESENTING SYMPTOMS
16	A1	DENY: PLEASE SUBMIT TO PHARMACY VENDOR
96	A1	PLEASE REBILL WITH APPROPRIATE HCPCS NUMBER
0B	A1	ADJUST: CLAIM TO BE RE-PROCESSED/CORRECTED UNDER NEW CLAIM NUMBER
0C	A1	DENY: THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S SEX
0E	A1	ADJUST BASED ON APPEAL RECEIVED. UPHELD ORIGINAL DENY DECISION.
0H	A1	ADJUSTMENT: PROVIDER BILLED INCORRECTLY AND SUBMITTED REIMBURSEMENT

OI	A1	ADJUSTMENT: ADJUSTED PER CORRECTED BILLING FROM PROVIDER
OM	A1	ADJUSTMENT TO PREVIOUSLY SUBMITTED CLAIM
ON	A1	DENY: AJUSTED FOR INTERNAL PURPOSES-CORRECTION HAS BEEN GENERATED
AJ	A1	DENY: BILLED SERVICE DOES NOT MATCH UNITS/DATES - CORRECT AND RESUBMIT
AV	A1	PLEASE REMIT MEDICAL RECORDS FOR CONSIDERATION OF ADDITIONAL PAYMENTS
BZ	A1	PLEASE RESUBMIT WITH CORRESPONDING E&M CODE FOR PAYMENT
CH	A1	DENY: SERVICE IS NOT A PAYABLE BENEFIT WHEN PERFORMED BY A CHIROPRACTOR
CO	A1	SERVICES NOT REIMBURSABLE UNDER PROVIDERS CONTRACT.
CY	A1	DENY:SERV PREVIOUSLY DENIED/SUBMIT WRITTEN APPEAL FOR RECONSIDERATION
D8	A1	BENEFITS: DIAGNOSIS CODE NOT VALID AS PRIMARY DIAG, PLEASE RESUBMIT
DC	A1	DENY: DIAGNOSIS INDICATING LEVEL OF SUBLUXATION MUST BE INDICATED
DL	A1	DENY: DENTAL SERVICES ARE NOT A BENEFIT OF NEW JERSEY MEDICAID
DN	A1	DENY: BASED ON REVIEW OF MED REC
DO	A1	E & V DIAGNOSIS CODES ARE NOT VALID FOR PRIMARY DIAGNOSIS,PLEASE RESUBMT
DR	A1	DENY: SERVICE IS LIMITED TO ONE PER DAY
DT	A1	DENY: PROCEDURE IS INAPPROPRIATE FOR PLACE OF SERVICE
DV	A1	DENY: PROCEDURE IS INAPPROPRIATE FOR PROVIDER SPECIALTY
FQ	A1	DENY: FQHC ENCOUNTERS ARE LIMITED TO ONE PER DAY PER DIAGNOSIS
GP	A1	DENY: THIS SERVICE IS PAYABLE ONLY THROUGH A GENETICS PROGRAM
HD	A1	DENY: TAKE HOME DRUGS AND SUPPLIES ARE NOT A BENEFIT OF NJ MEDICAID
HJ	A1	DENY: PROVIDER UNDER INVESTIGATION
IE	A1	CPT NOT REIMBURSED SEPARATELY. INCLUDED AS PART OF INCLUSIVE PROCEDURE
IF	A1	DENY: INFERTILITY SERVICES ARE NOT COVERED UNDER NEW JERSEY MEDICAID
IM	A1	DENY: INCOMPLETE MEDICAL CHECKUP - REFER TO PROVIDER PROCEDURE MANUAL
IN	A1	DENY: ORIGINAL CPT BILLED WAS AN INVALID CODE.PLEASE RE-BILL.
IW	A1	DENY: ORIGINAL HCPCS BILLED WAS AN INVALID CODE. PLEASE REBILL
KB	A1	DENY: SUBSEQUENT HOSPITAL CARE IS NOT REIMBURSABLE TO BIRTHING CENTER
KC	A1	DENY: TEMPORARY LENSES ARE NOT ALLOWED AFTER CONVALESCENT PERIOD
KD	A1	DENY: SUPPLIES &/OR DME ARE ONLY PAYABLE TO AUTHORIZED DME PROVIDERS

KE	A1	DENY: ECMO IS NOT A BENEFIT FOR PATIENT OVER 1 YEAR OF AGE
KH	A1	DENY: SERVICES ARE NOT A COVERED BENEFIT OF HOME HEALTH
KK	A1	DENY: PLEASE RESUBMIT WITH VALID CPT CODE
KM	A1	DENY: ROUTINE MAMMOGRAPHY IS NOT A COVERED BENEFIT UNTIL AGE 35
KT	A1	DENY: TEXAS HEALTHY STEPS SERVICES ARE LIMITED TO CHILDREN UNDER 21 YRS
KX	A1	DENY: MRI OF THE BREAST IS NOT A COVERED BENEFIT FOR THIS DIAGNOSIS
KZ	A1	DENY: INVALID PLACE OF SERVICE - CONSULT UHP PROVIDER MANUAL & RESUBMIT
LZ	A1	DENY: CLAIM CANNOT BE PROCESSED WITHOUT PROVIDERS INVOICE
MR	A1	DENY: MENTAL RETARDATION IS NOT COVERED UNDER NEW JERSEY MEDICAID
MZ	A1	DENY: PROVIDER IS NOT MEMBER'S PCP
NE	A1	DENY: PAYMENT INCLUDED IN OBSTETRICS RATE
NN	A1	NON-MEMBER PROVIDER
NS	A1	DENY: NONSPECIFIC DIAGNOSIS PLEASE RESUBMIT WITH PROPER CODE
NZ	A1	NEW JERSEY CATCH ALL DENY CODE
OX	A1	DENY: CODE IS CONSIDERED AN INTEGRAL COMPONENT OF THE E/M CODE BILLED
PH	A1	GLOBAL PROCEDURE NOT REIMBURSABLE, BILL SEPARATE PROCEDURE CODES.
PO	A1	DENY: PROSTHETIC & ORTHOTIC DEVICES ARE NOT BENEFITS OF NJ MEDICAID
PV	A1	PRIVATE ROOM NOT MEDICALLY INDICATED BASED ON DIAGNOSIS SUBMITTED
QQ	A1	DENY: CHIP ELIGIBILITY-NO COB PROVISION, REBILL APPROPRIATE CARRIER
RC	A1	REIMBURSEMENT SHOULD BE OBTAINED THROUGH THE STATE.
RI	A1	DENY: PLEASE RESUBMIT WITH THE MEMBER'S MEDICAID ID NUMBER
RS	A1	DENY: BILL ADDRESS DOES NOT MATCH SYSTEM-RESUBMIT WIHT CORRECT BILL ADDR
RT	A1	DENY: RECREATION THERAPY IS NOT COVERED UNDER NEW JERSEY MEDICAID
SC	A1	DENY: PLEASE SUBMIT MRI AND CT SERVICES TO CENTRAL TEXAS IMAGING CENTER
SH	A1	DENY: SERVICES NOT THE RESPONSIBILITY UHP
SU	A1	DENY: VISIT IS INCLUDED IN SURGERY
SV	A1	SERVICES HAVE EXCEEDED THE PERIODICITY FOR THIS BENEFIT
TD	A1	PROVIDER NOT ACTIVE
TH	A1	DENY:PRIMARY DIAGNOSIS INVALID FOR THSTEPS

TK	A1	DENY: PROVIDER NOT CONTRACTED FOR THIS SERVICE-DO NOT BILL PATIENT
TM	A1	DENY: TO COMPLETE PROCESSING, WE NEED THE TIME UNITS, PLEASE RESUBMIT
TO	A1	TPI NUMBER DOES NOT REFLECT THE SERVICES RENDERED, PLEASE RESUBMIT
UF	A1	DENY: SUBMIT TO MERCK MEDCO
UU	A1	OBSERVATION UNITS ARE REQUIRED FOR PROCESSING. PLEASE RESUBMIT.
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
VD	A1	DENY: ONLY ONE VISIT CODE IS ALLOWED ON A GIVEN DATE
VF	A1	DENY: IN VETRO FERTILIZATION IS NOT COVERED UNDER NEW JERSEY MEDICAID
VR	A1	DENY SERVICE - VARIANCE DAY CONFIRMED
W0	A1	DENY: TRANSPLANT CLAIM SUBMIT TO CIGNA LIFESOURCE FOR REPRICING
W6	A1	DENY: TRANSPLANT CLAIM SUBMIT TO INTERLINK FOR REPRICING
X7	A1	DENY: NO MODIFIER NEEDED
XC	A1	DENY: THIS SERVICE IS EXCLUDED FROM THIS CONTRACT AGREEMENT
XX	A1	PROCEDURE CODE IS INCONSISTENT WITH THE PLACE OF SERVICE.
Y6	A1	DENY:INSUFFICIENT INFO FOR PROCESSING,RESUBMIT W/PRIME'S ORIGINAL EOB
YB	A1	ADJUSTMENT: ADJUSTED PER CORRECTED BILLING FROM PROVIDER
YC	A1	ADJUST: NOT A COVERED SERVICE,BILL WORKER'S COMP
YD	A1	ADJUST: PROCESSED FOR INCORRECT MEMBER, RESUBMIT CORRECT MEMBER
YE	A1	ADJUST: DUPLICATE PAYMENT
YF	A1	ADJUST: NOT AUTHORIZED BY PCP, BILL PATIENT
YG	A1	ADJUST: NOT AUTHORIZED BY PCP, DO NOT BILL PATIENT
YH	A1	ADJUST: PROCESSED FOR INCORRECT PROVIDER OR PROVIDER AFFILIATION
YI	A1	ADJUST: PROCESSED FOR INCORRECT MEMBER
YJ	A1	ADJUST: NOT A COVERED BENEFIT

41	A2	PREFERRED PROVIDER DISCOUNT
91	A2	PAYMENT INCLUDES 10% DISCOUNT
92	A2	PAID IN FULL
0A	A2	ADJUST: PROVIDER REFUND RECEIVED, REINSTATE RECOUPED PAYMENT AMOUNT
0D	A2	ADJUSTMENT: \$ DUE IN ADDITIONAL TO ORIGINAL PAYMENT MADE FOR SERVICES
1D	A2	PAY IN FULL: MEMBER ELIGIBILITY VERIFIED
1G	A2	PAY IN FULL: PARTIAL ELIGIBILITY VERIFIED
9B	A2	PAY: PAID AT A % OF BILLED CHARGES.
9F	A2	PAY: CODE (S) ADDED BASED ON CODE AUDITING SOFTWARE RECOMMENDATION
A8	A2	AUTHORIZATION DOES NOT MATCH PRIMARY DIAGNOSIS
AM	A2	PAY: ADDITIONAL PAYMENT FOR ADMINISTRATION OF IMMUNIZATION
CM	A2	MEMBER ON REVIEW FOR CASE MANAGEMENT
CU	A2	PAY: TO CASE MANAGEMENT ADJUSTOR
EC	A2	\$10 EPSDT INCENTIVE PAYMENT INCLUDED
FA	A2	ADJUSTMENT: CLAIM WENT TO INCORRECT FUND
HC	A2	AUTH PROCEDURE CLASS NOT MATCHING
IC	A2	INTEREST AMOUNT
JA	A2	ADJUSTMENT: PAY ON APPEAL
JE	A2	ADJUST: MHS 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
JO	A2	ADJUSTMENT: ADJUSTED PER CORRECTED BILLING FROM PROVIDER
OF	A2	ADJUST BASED ON APPEAL RECEIVED. OVERTURNED ORIGINAL DENY DECISION.
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	PAID IN FULL
PD	A2	PAID ACCORDING TO AUTHORIZED AMOUNT
TG	A2	PAID ACCORDING TO TRIAGE MOU, AUTH. WAS DENIED OR NOT OBTAINED
UK	A2	PAY: ZERO DOLLARS PAID, INCLUDED IN TRANSPLANT CASE
UN	A2	PAY: PLP MET
VK	A2	PAY: TRANSPLANT CASE RATE PAID
W3	A2	PAY: PAID ACCORDING TO TRANSPLANT AGREEMENT
XY	A2	PLP NOT MET SCREENING FEE PAID
VG	A8	DENY: VALID DRG CODE REQUIRED
CE	B11	CLAIM FORWARDED TO CENTURY FOR PROCESSING.
RY	B11	CLAIM FORWARDED TO CENTURY FOR PROCESSING.
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
1L	B14	DENY: VISIT & PREVEN CODES ARE NOT PAYABLE ON SAME DOS W/O DOCUMENTATION
P6	B14	SERVICE PAYABLE ONLY ONCE PER DAY
98	B18	INVALID PROCEDURE FOR 1998, PLEASE RESUBMIT WITH CORRECT CODE
9C	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, PLEASE RESUBMIT CLAIM
US	B18	DENY:UNLISTED CODE-CORRECT AND RESUBMIT
AF	B20	DENY: CONCURRENT CARE RENDERED BY SAME SPECIALTY PHYSICIAN
BO	B20	DENY:NOT PAYABLE-ANOTHER PROVIDER/FACILITY BILLED FOR COMPLETE SERVICE
BP	B20	PEND: CLAIMS REVIEW PROCEDURE FOR APPROPRIATE BILLING BY PROVIDER

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
CF	B5	DENY: WAITING FOR CONSENT FORM
D4	B5	DENY: PROC NOT REIMBURSABLE PER CONTRACT
DY	B5	DENY: APPEAL DENIED
VO	B5	VOID SERVICE FOR ADMINISTRATIVE REASONS
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
SW	B6	DENY: SERVICES BILLED BY AN ER MD - SPEC 93 WHEN BILLED W/ MODIFIER 26