AEU Benefits Plan
Medical Claims Determination Statement
Explanation Code and Description List

EXPLANATION_CODE	EXPLANATION_DESC
+0	The allowable amount reflects the contracted rate.
+1	considered to be the PPO discount and the patient is not responsible to pay the difference between the billed charges and the allowed amount.
+6	the PPO discount and the patient is not responsible to pay the difference between the billed charges and the allowed amount.
+8	discount and the patient is not responsible to pay the difference between the billed charges and the allowed amount.
+g	PROCEDURE UNBUNDLED
+U	This is a duplicated charge that has previously been submitted for payment.
00	Paid in accordance with Zelis Adjustment Exchange, Inc. Adjustment.
0006	NOT A COVERED EXPENSE
0014	
0017	
0021	MATERNITY NOT COVERED FOR DEPENDENT CHILDREN
0032	
0035	
0039	INCURRED BEFORE EFFECTIVE DATE
0059	DUPLICATE CLAIM
0083	
02	TIME LIMIT FOR FILING THIS CLAIM HAS EXPIRED
05	NOT A COVERED EXPENSE
08	PATIENT INELIGIBLE FOR BENEFITS ON INCURRED DATE
1	DEDUCTIBLE AMOUNT
1	WE HAVE COORDINATED BENEFITS WITH PRIMARY CARRIER
10	EXCEEDS VISIT LIMIT
11	EMPLOYEE/PROVIDER SPLIT PAYMENT
11	Ineligible service/charge. Refer to your plan document.
13	DISCOUNT APPLIED
14	This condition/diagnosis is not covered by the plan. Please refer to the exclusions in your plan booklet.
141	ACCIDENT DETAILS REQUIRED
147	PENDING PRIMARY PPO REPRICING
15	CO-BENEFITS APPLIED
16	DUPLICATE CHARGES ARE CURRENTLY BEING PROCESSED
16	STOP LOSS MET THIS LINE
19	CHARGE LIMITED TO REASONABLE & CUSTOMARY AMOUNT
19	DUPLICATE CHARGES WERE APPLIED TOWARD DEDUCTIBLE
2	COINSURANCE AMOUNT
2	WE HAVE CONSIDERED AMOUNT PAID BY MEDICARE
2+	Duplicate charges previously considered.
2008	DEPENDENT NOT COVERED
2016	NO DIAGNOSIS GIVEN
2031	
21	Charges billed by a Non-Plan Provider are not covered. Refer to your plan document.
2171	
2184	NO SEPARATE PAYMENT WITH PROCEDURE 98941
2199	NON PPO ROUTINE NOT COVERED
22	Plan does not cover expenses for services or settings which are not medically necessary.
2214	INCOMPLETE CLAIM INFORMATION
2257	
2292	DIAGNOSIS DOES NOT MATCH PROCEDURE
23	Charges billed by a Non-Plan Provider are limited to Usual and Customary Rates. Member is responsible for any
2319	
2321	NOT ALLOWED WITH PROCEDURE 90471
2333	

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2339	
2365	
2367	
2370	NOT MEDICAL PROTOCOL
2386	ADD ON CODE
24	DUPLICATE CHARGE
2441	
2513	NOT GENERALLY ACCEPTED BILLING
2601	
2606	
2619	COSMETIC/DISCRETIONARY NOT COVERED
27	No benefits are payable when patient's coverage is not active.
29	OVER CONTRACT ALLOWANCE; PATIENT IS NOT RESPONSIBLE FOR NETWORK SAVINGS AMOUNT WHEN USING A
2980	
3	DEDUCT & COINSURANCE AMT
3090	INCIDENTAL + BUNDLED
3163	
35	CLAIM CLOSED; THE MEMBER HAS NOT PROVIDED THE REQUESTED INFORMATION REGARDING OTHER COVERAGE
37	EXCEEDS SCHEDULED OR REASONABLE/CUSTOMARY AMOUNT
4	NOT COVERED
40	CLAIM CLOSED; THE MEMBER HAS NOT PROVIDED THE REQUESTED INFORMATION STATING HOW THE INJURY
44	PENALTY DUE TO LACK OF NOTIFICATION
44	Services not specifically covered in plan booklet
5	CONSIDERED TO BE INCLUDED IN THE MAJOR PROCEDURE.
51	PLEASE SUBMIT CHARGES TO THE PRIMARY CARRIER
57	CHARGES INCURRED AFTER TERMINATION DATE
78	Claim denied. Provider needs to bill the Pricing Network, see the back of the member's ID card for the address.
8	CHARGE EXCEEDS UCR
86	INCURRED PRIOR TO COVERAGE
87	INCURRED AFTER COVERAGE TERMED
9	DIAGNOSIS IS INCONSISTENT WITH PATIENT'S AGE
9	EXCEEDS FILING TIME LIMIT
aa	Over maximum age for service per USPSTF guidelines
ab	Below minimum age for service per USPSTF guideline
ADJ	The reduction amount reflects prior payment.
ARM	
ASR	Assistant Surgeon discount applied.
B	THIS SERVICE/SUPPLY IS NOT COVERED UNDER YOUR PLAN
CIG	Payment made in accordance with GWH-CIGNA Healthcare discount. Patient not liable.
CIZ	Must be sent to CIGNA for discount - payor ID 62308- PO Box 188061, Chattanooga, TN 37422
COB	Benefits have been coordinated with the primary insurance carrier.
COC	We have applied the primary carrier's discount rate.
DB	DUPLICATE BILLING RECEIVED
DP	These charges are a duplicate of charges or discounts already considered by this plan.
DP2	These charges are a duplicate of charges or discounts already considered by this plan.
DX	DIAGNOSIS(ES) DOES NOT WARRANT PROCEDURE
E1	The services on this claim were rendered prior to the effective date of coverage. No benefits are due.
e1e	Procedure/treatment is deemed experimental/investigational by the payer.
E2	This charge was incurred after termination date and is not covered by the plan.
e9	Not allowed separate payment with procedure
eb	Rebundled with other procedure(s) into procedure
ec	Payment reduced as secondary procedure
ek	As per Ncci, not allowed separate payment with procedure.
el	As per NCCI, mutually exclusive to procedure.

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em	Too many procedures of this type billed.
es	Procedure not compatible with diagnosis.
eu	Paid according to maximum allowable per plan guidelines.
FE	MODIFIER IS MISSING INVALID OR INCORRECT FOR THE PROCEDURE BILLED PLEASE RESUBMIT THE CLAIM WITH
ff	Office Visit Frequency
GC	CIGNA PPO DISCOUNT APPLIED. MEMBER NOT LIABLE.
GL	Already paid in part, or for the global amount, on another claim/provider.
hb	AGREEMENT. MEMBER IS NOT RESPONSIBLE FOR THE DISCOUNTED AMOUNT. SUBMIT CLAIM ELECTRONICALLY TO NEIC #38224.
hc	AGREEMENT. MEMBER IS NOT RESPONSIBLE FOR THE DISCOUNTED AMOUNT. SUBMIT CLAIM ELECTRONICALLY TO NEIC #62308.
HCI	Non-payment/reduction based on CPT coding protocols/guidelines. Patient not responsible.
HE	CHARGES ARE PAID IN ACCORDANCE WITH CIGNA/ HEALTH PARTNERS OF KANSAS DISCOUNT RATE AGREEMENT. MEMBER IS NOT RESPONSIBLE FOR THE DISCOUNTED AMOUNT. SUBMIT CLAIM ELECTRONICALLY TO NEIC #63665.
hg	Charges are paid in accordance with Cigna/Community Health Network discount rate agreement. Member is not responsible for the discounted amount. Submit claims electronically to NEIC# 81040.
HW	CHARGES ARE PAID IN ACCORDANCE WITH CIGNA PPO DISCOUNT RATE AGREEMENT. MEMBER IS NOT RESPONSIBLE FOR THE DISCOUNTED AMOUNT. SUBMIT CLAIMS ELECTRONICALLY TO NEIC # 62308.
HZ	**SEE COMMENTS BELOW**
I4	THIS IS NOT A SEPARATELY REIMBURSABLE SERVICE OR SUPPLY AS A REMINDER SUPPLY CODES SHOULD BE
IF	Additional information requested of the patient has not been received. Once requested information has been received your claim will be reprocessed.
IJ	THE NUMBER OF UNITS BILLED FOR THIS SERVICE APPEARS TO BE INCORRECT IT EXCEEDS THE TYPICAL FREQUENCY PER DAY FOR THIS PROCEDURE CODE WE'VE ADJUSTED THE UNITS FOR THIS PROCEDURE CODE AND CHARGE
IK	THIS SERVICE REPLACED A SERVICE THAT WAS BILLED WITH UNITS OVER THE TYPICAL FREQUENCY PER DAY FOR THIS PROCEDURE CODE THIS SERVICE USES THE SAME PROCEDURE CODE AS THE ORIGINAL BUT ASSUMES THAT THAT THE NUMBER OF UNITS IS THE TYPICAL FREQUENCY PER DAY THE
INV	
IT	Please resubmit with itemization.
K0	FOR PROCESSING PURPOSES WE ARE ADJUSTING THE CLAIM YOU SUBMITTED WITH BILATERAL MODIFIER 50 ON TWO LINES RATHER THAN ONE LINE
KM	THIS IS NOT A REIMBURSABLE SERVICE THERE MAY BE A MORE APPROPRIATE CPT OR HCPCS CODE THAT DESCRIBES
KT	THIS SERVICE LINE IS BEING RECODED TO REVISE THE PROCEDURE CODE MODIFIER ANESTHESIA MINUTES AND
KV	THIS PROCEDURE CODE IS NOT ELIGIBLE FOR AN ASSISTANT SURGEON THEREFORE BENEFITS ARE NOT PAYABLE
KZ	THE CLAIM YOU SUBMITTED WITH BILATERAL MODIFIER 50 WILL BE REPROCESSED ON TWO LINES RATHER THAN A
LMT	The annual limit for allowable expenses in this category has been reached.
MB	MAXIMUM BENEFIT HAS BEEN REACHED.
MC1	
MC140	
MN	PLEASE PROVIDE MEDICAL APPROPRIATENESS
MP	PREFERRED PROVIDER THROUGH MULTIPLAN
MSR	Multiple Surgery discount applied.
NE	
NPM	
NWK	Payment made in accordance with HealthUtah discount rate agreement.
O5	THIS PROCEDURE OR SUPPLY IS PART OF THE GLOBAL SERVICE THESE CHARGES ARE NOT ELIGIBLE FOR SEPARATE
O6	OUR RECORDS SHOW THESE SERVICES HAVE BEEN PREVIOUSLY SUBMITTED BY ANOTHER PHYSICIAN OR OTHER
O7	OUR RECORDS SHOW WE HAVE ALREADY PROCESSED THIS CHARGE
O9	THE NUMBER OF UNITS REPORTED EXCEEDS THE TYPICAL FREQUENCY PER DAY FOR THIS PROCEDURE CODE THEREFORE THE NUMBER OF UNITS THAT EXCEED THE TYPICAL FREQUENCY PER DAY IS NOT BEING CONSIDERED IF THE PROVIDER HAS ADDITIONAL DOCUMENTATION PLEASE SEND IT TO US FO
OC	The Coordination of Coverage verification requested from the patient has not been received.
OON	Patient is covered by a plan that does not have benefits for non-contracted providers.
P7	PAID IN ACCORDANCE WITH THE PHCS RATE AGREEMENT

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PAP	A provider penalty discount has been applied for no pre-authorization.
PE	PENALTY APPLIED FOR FAILURE TO CONTACT MEDICAL ADVOCACY PROGRAM.
PHC	Payment in accordance with PHCS discount agreement. Patient is not responsible.
pj	PAYMENT MADE IN FULL & FINAL THRU TRPN/MCS NETWORK
q1	Service incidental to primary procedure. Patient not responsible.
Q4	THIS SERVICE LINE IS BEING RECODED TO ADJUST THE ANESTHESIA MINUTES
QF	FOR PROCESSING PURPOSES THIS SERVICE LINE HAS BEEN RECODED TO ADJUST/INCLUDE THE ADDITIONAL ANESTHESIA MINUTES FOR A PHYSICAL STATUS MODIFIER
RAP	
RC	
RNA	Reduced for no authorization submitted prior to service
RUC	Reduced for Usual and Customary
RUR	
TF	Claims must be submitted within 12 months from the date of service.
tp	primary procedure. Participating providers are prohibited by contract from balance billing the member for this charge.
tq	This service is denied because it is considered to be part of another service already performed and reimbursed.
TTA	Payment made in accordance with Tall Tree Administrators discount rate agreement.
tv	published/maintained by CMS (Center of Medicaid/Medicare Services). Participating providers are prohibited by contract from balance billing the member
ty	The procedure(s) billed exceed the maximum frequency limitation allowed for this service.
u1	Unlisted procedures are not covered unless deemed medically necessary.
UC	Charges exceed the usual allowance due to non-network provider.
ud	This is a duplicated charge that has previously been submitted for payment.
UG	KK = THIS SERVICE LINE IS BEING RECODED TO REVISE THE PROCEDURE CODE MODIFIER ANESTHESIA MINUTES AND
UL	YD = FOR PROCESSING PURPOSES THIS SERVICE LINE HAS BEEN RECODED FROM THE GLOBAL SERVICE TO THE PROFESSIONAL OR TECHNICAL COMPONENT
UNB	Non-payment/reduction based on CPT coding protocols/guidelines. Patient not responsible.
VD	THIS SERVICE LINE SUBMITTED AS THE GLOBAL SERVICE WILL BE RECODED TO THE PROFESSIONAL AND TECHNICAL
vv	Inappropriate Modifier or Missing/incomplete/invalid value code(s) or amount(s).
W9	Please resubmit claim with an updated W9 for tax identification number that you are billing with.
X3	THIS SERVICE LINE IS BEING RECODED TO REVISE THE PROCEDURE CODE MODIFIER AND ANESTHESIA MINUTES
X4	THE MOST APPROPRIATE PROCEDURE CODE MODIFIER HAS BEEN ASSIGNED BASED ON OTHER ANESTHESIA SERVICES PROCESSED FOR THIS PATIENT THE ANESTHESIA MINUTES FOR THIS SERVICE HAVE BEEN ADJUSTED AND WILL REFLECT ANESTHESIA TIME FOR ADD-ON PROCEDURE CODES AND/OR PHYS
Y1	THIS SERVICE LINE SUBMITTED WITH MULTIPLE UNITS WILL BE RECODED TO MULTIPLE SERVICE LINES TO SEPARATE
Y2	FOR PROCESSING PURPOSES THIS SERVICE LINE HAS BEEN RECODED WITH A SINGLE UNIT