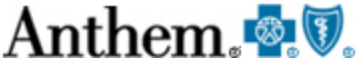
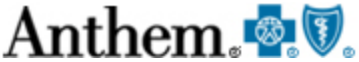


ANTHEM SOUTHEAST REMITTANCE REMARK CODE REPORT

For use by FACILITY (UB) and PROFESSIONAL (CMS) Providers

DENIED codes for FEP claims

Status:	Code:	Description:
DENIED	1	Deductible Amount
DENIED	2	Coinsurance Amount
DENIED	3	Co-payment Amount
DENIED	4	The procedure code is inconsistent with the modifier used or a required missing.
DENIED	5	The procedure code/bill type is inconsistent with the place of service.
DENIED	6	The procedure code is inconsistent with the patient's age.
DENIED	7	The procedure code is inconsistent with the patient's gender.
DENIED	8	The procedure code is inconsistent with the provider type.
DENIED	9	The diagnosis is inconsistent with the patient's age.
DENIED	10	The diagnosis is inconsistent with the patient's gender.
DENIED	11	The diagnosis is inconsistent with the procedure.
DENIED	12	The diagnosis is inconsistent with the provider type.
DENIED	13	The date of death precedes the date of service.
DENIED	14	The date of birth follows the date of service.
DENIED	15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.
DENIED	16	Claim/service lacks information which is needed for adjudication.
DENIED	17	Payment adjusted because requested information was not provided or was insufficient/incomplete.
DENIED	18	Duplicate claim/service.
DENIED	19	Claim denied because this is a work-related injury/illness and thus the Worker's Compensation Carrier.

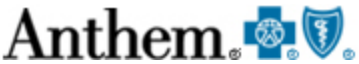


ANTHEM SOUTHEAST REMITTANCE REMARK CODE REPORT

For use by FACILITY (UB) and PROFESSIONAL (CMS) Providers

DENIED codes for FEP claims

Status:	Code:	Description:
DENIED	20	Claim denied because this injury/illness is covered by the liability carrier.
DENIED	21	Claim denied because this injury/illness is the liability of the no- fault carrier.
DENIED	22	Payment adjusted because this care may be covered by another payer per coordination of benefits.
DENIED	23	Payment adjusted because charges have been paid by another payer.
DENIED	24	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.
DENIED	25	Payment denied. Your Stop loss deductible has not been met.
DENIED	26	Expenses incurred prior to coverage.
DENIED	27	Expenses incurred after coverage terminated.
DENIED	28	Coverage not in effect at the time the service was provided.
DENIED	29	The time limit for filing has expired.
DENIED	30	Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.
DENIED	31	Claim denied as patient cannot be identified as our insured.
DENIED	32	Our records indicate that this dependent is not an eligible dependent as defined.
DENIED	33	Claim denied. Insured has no dependent coverage.
DENIED	34	Claim denied. Insured has no coverage for newborns.
DENIED	35	Benefit maximum has been reached.
DENIED	36	Balance does not exceed co-payment amount.
DENIED	37	Balance does not exceed deductible.
DENIED	38	Services not provided or authorized by designated (network) providers.



ANTHEM SOUTHEAST REMITTANCE REMARK CODE REPORT

For use by FACILITY (UB) and PROFESSIONAL (CMS) Providers

DENIED codes for FEP claims

Status:	Code:	Description:
DENIED	39	Services denied at the time authorization/pre-certification was requested.
DENIED	40	Charges do not meet qualifications for emergent/urgent care.
DENIED	41	Discount agreed to in Preferred Provider contract.
DENIED	42	Charges exceed our fee schedule or maximum allowable amount.
DENIED	43	Gramm-Rudman reduction.
DENIED	44	Prompt-pay discount.
DENIED	45	Charges exceed your contracted/ legislated fee arrangement.
DENIED	46	This (these) service(s) is (are) not covered.
DENIED	47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.
DENIED	48	This (these) procedure(s) is (are) not covered.
DENIED	49	These are non-covered services because this is a routine exam or screening done in conjunction with a routine exam.
DENIED	50	These are non-covered services because this is not deemed a `medical necessity' by the payer.
DENIED	51	These are non-covered services because this is a pre-existing condition
DENIED	52	The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.
DENIED	53	Services by an immediate relative or a member of the same household are not covered.
DENIED	54	Multiple physicians/assistants are not covered in this case .
DENIED	55	Claim/service denied because procedure/treatment is deemed experimental/investigational by the payer.

Status:	Code:	Description:
DENIED	56	Claim/service denied because procedure/treatment has not been deemed 'proven to be effective' by the payer.
DENIED	57	Payment denied/reduced because the payer deems the information submitted support this level of service, this many services, this length of service, or this day's supply.
DENIED	58	Payment adjusted because treatment was deemed by the payer to have been in an inappropriate or invalid place of service.
DENIED	59	Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules.
DENIED	60	Charges for outpatient services with this proximity to inpatient service
DENIED	61	Charges adjusted as penalty for failure to obtain second surgical opinion.
DENIED	62	Payment denied/reduced for absence of, or exceeded, precertification/authorization.
DENIED	63	Correction to a prior claim.
DENIED	64	Denial reversed per Medical Review.
DENIED	65	Procedure code was incorrect. This payment reflects the correct code.
DENIED	66	Blood Deductible.
DENIED	67	Lifetime reserve days. (Handled in QTY, QTY01=LA)
DENIED	68	DRG weight. (Handled in CLP12)
DENIED	69	Day outlier amount.
DENIED	70	Cost outlier - Adjustment to compensate for additional costs.
DENIED	71	Primary Payer amount.
DENIED	72	Coinsurance day. (Handled in QTY, QTY01=CD)
DENIED	73	Administrative days.
DENIED	74	Indirect Medical Education Adjustment.

Status:	Code:	Description:
DENIED	75	Direct Medical Education Adjustment.
DENIED	76	Disproportionate Share Adjustment.
DENIED	77	Covered days. (Handled in QTY, QTY01=CA)
DENIED	78	Non-Covered days/Room charge adjustment.
DENIED	79	Cost Report days. (Handled in MIA15)
DENIED	80	Outlier days. (Handled in QTY, QTY01=OU)
DENIED	81	Discharges.
DENIED	82	PIP days.
DENIED	83	Total visits.
DENIED	84	Capital Adjustment. (Handled in MIA)
DENIED	85	Interest amount.
DENIED	86	Statutory Adjustment.
DENIED	87	Transfer amount.
DENIED	88	Adjustment amount represents collection against receivable created in prior overpayment.
DENIED	89	Professional fees removed from charges.
DENIED	90	Ingredient cost adjustment.
DENIED	91	Dispensing fee adjustment.
DENIED	92	Claim Paid in full.
DENIED	93	No Claim level Adjustments.
DENIED	94	Processed in Excess of charges.

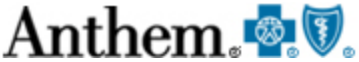
ANTHEM SOUTHEAST REMITTANCE REMARK CODE REPORT

For use by FACILITY (UB) and PROFESSIONAL (CMS) Providers

DENIED codes for FEP claims

Status:	Code:	Description:
DENIED	95	Benefits adjusted. Plan procedures not followed.
DENIED	96	Non-covered charge(s).
DENIED	97	Payment is included in the allowance for another service/procedure.
DENIED	98	The hospital must file the Medicare claim for this inpatient non- physician service.
DENIED	99	Medicare Secondary Payer Adjustment Amount.
DENIED	100	Payment made to patient/insured/responsible party.
DENIED	101	Predetermination: anticipated payment upon completion of services or claim adjudication.
DENIED	102	Major Medical Adjustment.
DENIED	103	Provider promotional discount (e.g., Senior citizen discount).
DENIED	104	Managed care withholding.
DENIED	105	Tax withholding.
DENIED	106	Patient payment option/election not in effect.
DENIED	107	Claim/service denied because the related or qualifying claim/service was identified on the claim.
DENIED	108	Payment reduced because rent/purchase guidelines were not met.
DENIED	109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.
DENIED	110	Billing date predates service date.
DENIED	111	Not covered unless the provider accepts assignment.
DENIED	112	Payment adjusted as not furnished directly to the patient and/or not documented.

Status:	Code:	Description:
DENIED	113	Payment denied because service/procedure was provided outside the United States or as a result of war.
DENIED	114	Procedure/product not approved by the Food and Drug Administration.
DENIED	115	Payment adjusted as procedure postponed or canceled.
DENIED	116	Payment denied. The advance indemnification notice signed by the patient did not comply with requirements.
DENIED	117	Payment adjusted because transportation is only covered to the closest facility that can provide the necessary care.
DENIED	118	Charges reduced for ESRD network support.
DENIED	119	Benefit maximum for this time period has been reached.
DENIED	120	Patient is covered by a managed care plan.
DENIED	121	Indemnification adjustment.
DENIED	122	Psychiatric reduction.
DENIED	123	Payer refund due to overpayment.
DENIED	124	Payer refund amount - not our patient.
DENIED	125	Payment adjusted due to a submission/billing error(s).
DENIED	126	Deductible -- Major Medical
DENIED	127	Coinsurance -- Major Medical
DENIED	128	Newborn's services are covered in the mother's Allowance.
DENIED	129	Payment denied - Prior processing information appears incorrect.
DENIED	130	Claim submission fee.
DENIED	131	Claim specific negotiated discount.



ANTHEM SOUTHEAST REMITTANCE REMARK CODE REPORT

For use by FACILITY (UB) and PROFESSIONAL (CMS) Providers

DENIED codes for FEP claims

Status:	Code:	Description:
DENIED	132	Prearranged demonstration project adjustment.
DENIED	133	The disposition of this claim/service is pending further review.
DENIED	134	Technical fees removed from charges.
DENIED	135	Claim denied. Interim bills cannot be processed.
DENIED	136	Claim Adjusted. Plan procedures of a prior payer were not followed.
DENIED	137	Payment/Reduction for Regulatory Surcharges, Assessments, Allowances or Health Related Taxes.
DENIED	138	Claim/service denied. Appeal procedures not followed or time limits not met.
DENIED	139	Contracted funding agreement - Subscriber is employed by the provider of services.
DENIED	140	Patient/Insured health identification number and name do not match.
DENIED	141	Claim adjustment because the claim spans eligible and ineligible periods of coverage.
DENIED	142	Claim adjusted by the monthly Medicaid patient liability amount.
DENIED	143	Portion of payment deferred.
DENIED	144	Incentive adjustment, e.g. preferred product/service.
DENIED	634	Benefits for these services are included in the allowed amount for another covered service rendered on the same date of service. Therefore, no additional payment can be made.
DENIED	A0	Patient refund amount.
DENIED	A1	Claim denied charges.
DENIED	A2	Contractual adjustment.
DENIED	A3	Medicare Secondary Payer liability met.
DENIED	A4	Medicare Claim PPS Capital Day Outlier Amount.

ANTHEM SOUTHEAST REMITTANCE REMARK CODE REPORT

For use by FACILITY (UB) and PROFESSIONAL (CMS) Providers

DENIED codes for FEP claims

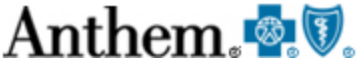
Status:	Code:	Description:
DENIED	A5	Medicare Claim PPS Capital Cost Outlier Amount.
DENIED	A6	Prior hospitalization or 30 day transfer requirement not met.
DENIED	A7	Presumptive Payment Adjustment
DENIED	A8	Claim denied; ungroupable DRG
DENIED	B1	Non-covered visits.
DENIED	B10	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.
DENIED	B11	The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.
DENIED	B12	Services not documented in patients' medical records.
DENIED	B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.
DENIED	B14	Payment denied because only one visit or consultation per physician per day is covered.
DENIED	B15	Payment adjusted because this procedure/service is not paid separately.
DENIED	B16	Payment adjusted because 'New Patient' qualifications were not met.
DENIED	B17	Payment adjusted because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incompleted or the prescription is not current.
DENIED	B18	Payment denied because this procedure code/modifier was invalid on the date of service or claim submission.
DENIED	B19	Claim/service adjusted because of the finding of a Review Organization.
DENIED	B2	Covered visits.
DENIED	B20	Payment adjusted because procedure/service was partially or fully furnished by another provider.

ANTHEM SOUTHEAST REMITTANCE REMARK CODE REPORT

For use by FACILITY (UB) and PROFESSIONAL (CMS) Providers

DENIED codes for FEP claims

Status:	Code:	Description:
DENIED	B21	The charges were reduced because the service/care was partially furnished by another physician.
DENIED	B22	This payment is adjusted based on the diagnosis.
DENIED	B23	Payment denied because this provider has failed an aspect of a proficiency testing program.
DENIED	B3	Covered charges.
DENIED	B4	Late filing penalty.
DENIED	B5	Payment adjusted because coverage/program guidelines were not met or were exceeded.
DENIED	B6	This payment is adjusted when performed/billed by this type of provider, by this type of provider in this type of facility, or by a provider of t his specialty.
DENIED	B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.
DENIED	B8	Claim/service not covered/reduced because alternative services were available, and should have been utilized.
DENIED	B9	Services not covered because the patient is enrolled in a Hospice.
DENIED	D01	Processing of this claim has been suspended pending review by a medical consultant. Processing of this claim will resume when the review is completed.
DENIED	D02	The procedure code submitted on this claim is not approved in an ambulatory surgery setting. If the incorrect procedure code was submitted, please refile a corrected claim.
DENIED	D03	To process this claim, we need the hospital admission and discharge dates for the patient. Please resubmit the claim with this information.
DENIED	D04	Admission review is required for this claim and the process was not completed. Processing of this claim will resume with receipt of medical documentation for inpatient care.
DENIED	D05	In order to process this claim we must have the name, strength and dosage of the drug charge submitted. Please refile the claim withthis information.

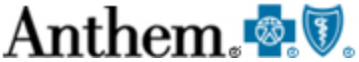


ANTHEM SOUTHEAST REMITTANCE REMARK CODE REPORT

For use by FACILITY (UB) and PROFESSIONAL (CMS) Providers

DENIED codes for FEP claims

Status:	Code:	Description:
DENIED	D06	In order to process this claim we must have a complete description of all unlisted and 99070 charges. Please refile this claim with this information.
DENIED	D07	The HCPCS billed on this claim are not compatible with the revenue code
DENIED	D08	The HCPCS date on the provider file indicates that a HCPCS is required for this revenue code
DENIED	D09	The HCPCS/revenue code combination has been cancelled on the OHAS table
DENIED	D1	Claim/service denied. Level of subluxation is missing or inadequate.
DENIED	D10	The admission date on the claim does not fall between a valid effective cancelation date range for this HCPCS/revenue code combination on the OHAS table
DENIED	D11	This claim is within 3 days of discharge of a previous claim and is considered a continuous stay. Please rebill for the entire confinement. we will complete processing as soon as it is received.
DENIED	D12	In order to properly apply outpatient facility benefits it will be necessary for us to have a breakdown of charges by date of service. please resubmit claim with this information or resubmit each date of service as a separate claim.
DENIED	D13	A specific procedure code is required to process this charge. The procedure code submitted was invalid or missing. Please resubmit with the correct procedure code.
DENIED	D14	The modifier was invalid or missing. Please resubmit.
DENIED	D15	Before we can consider this charge, we need the office notes to determine if benefits should be provided for this charge. Please refile the claim with this information.
DENIED	D17	The explanation of Medicare benefits submitted with this claim does not match the information on the claim. Please resubmit with the correct explanation of Medicare benefits.
DENIED	D18	So that we may process this claim for ambulance services, please provide us with a copy of the ambulance report. We will review the claim as soon as the information is received.
DENIED	D19	In order to process this charge we need the name of the specific test performed and/or the test results. Please refile the claim with this information.
DENIED	D2	Claim lacks the name, strength, or dosage of the drug furnished.

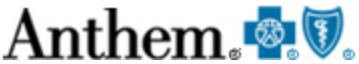


ANTHEM SOUTHEAST REMITTANCE REMARK CODE REPORT

For use by FACILITY (UB) and PROFESSIONAL (CMS) Providers

DENIED codes for FEP claims

Status:	Code:	Description:
DENIED	D20	We need additional medical information before we can complete the processing of this claim. The office or hospital progress notes and documentation concerning the additional time spent with the patient is required.
DENIED	D21	This service could not be covered. The modifier submitted on the claim indicates that the service was performed by another provider. Therefore, the claim should be submitted by that provider.
DENIED	D22	We need additional medical information before we can complete the processing of this claim. The medical or surgical report and/or an explanation for the use of the modifier(s) is required.
DENIED	D23	Operative reports and itemized bills are required from all providers for this date of service. once all information is received, we will complete the processing of your claim.
DENIED	D24	The dates on the I.V. Therapy plan of treatment do not match the date(s) of service on the claim.
DENIED	D25	The claim was billed with per diem charges for I.V. Therapy, but no drug charges were submitted.
DENIED	D26	The plan of treatment for I.V. Infusion services are incomplete. Therefore, the claim cannot be processed.
DENIED	D27	Payment for this service was based on the per diem allowance for hospice services.
DENIED	D28	Iv therapy claims must be filed in accordance with the guidelines that became effective 010199. Please resubmit a corrected claim with the corrected plan of treatment.
DENIED	D29	The place of treatment and/or the type of service are not compatible with the procedure code filed.
DENIED	D3	Claim/service denied because information to indicate if the patient owns the equipment that requires the part or supply was missing.
DENIED	D31	The partial day psychiatric claim we received has multiple levels of care authorized by hospital admission review. Please resubmit this claim with the correct date span per level of care.
DENIED	D33	Claims for partial day psychiatric services must contain revenue code 100 or 101. Please resubmit a corrected claim.



ANTHEM SOUTHEAST REMITTANCE REMARK CODE REPORT

For use by FACILITY (UB) and PROFESSIONAL (CMS) Providers

DENIED codes for FEP claims

Status:	Code:	Description:
DENIED	D34	Inpatient claims must contain at least one of the following revenue codes 110-179 or 190-219. Please send a corrected claim.
DENIED	D36	So that we may process this claim for ambulance services, please provide us with a copy of the ambulance report. We will review the claim as soon as the information is received.
DENIED	D4	Claim/service does not indicate the period of time for which this will be needed.
DENIED	D5	Claim/service denied. Claim lacks individual lab codes included in the test.
DENIED	D6	Claim/service denied. Claim did not include patient's medical record for the service.
DENIED	D7	Claim/service denied. Claim lacks date of patient's most recent physician visit.
DENIED	D8	Claim/service denied. Claim lacks indicator that 'x-ray is available for review.'
DENIED	D9	Claim/service denied. Claim lacks invoice or statement certifying the actual cost off the lens, less discounts or the type of intraocular lens used.
DENIED	W1	Workers Compensation State Fee Schedule Adjustment