Reason Code	DUPLICATES
GBA01	This is a duplicate service previously submitted by the same provider. Refer to IOM, Pub 100-04, Medicare Claims Processing Manual Chapter 1 section 120-120.3
GBA02	This is a duplicate service previously submitted by a different provider. Refer to IOM, Pub 100-04, Medicare Claims Processing Manual Chapter 1 section 120-120.3

Reason Code	INSUFFICIENT DOCUMENTATION
GBB01	The requested records were not received. Refer to 42 CFR 424.5(a)(6), Social Security Act 1862(a)(1)(A), Social Security Act 1833(e).
GBB02	The documentation submitted was incomplete and/or insufficient. Refer to 42 CFR 424.5(a)(6), Social Security Act 1862(a)(1)(A), Social Security Act 1833(e).
GBB03	The documentation submitted does not support services were rendered as billed. Refer to IOM-Pub 100-08, Medicare Program Integrity Manual, Chapter 3, Section 3.6.2.5, A
GBB04	The documentation submitted did not include a physician order. Refer to IOM, Pub 100-08, Chapter 3, Section 3.6.2.2
GBB05	The documentation submitted was missing patient identifiers. Refer to Standards for Adequacy of Medical Records; Section 1833 (e), Title XVIII, of the Social Security Act.
GBB06	The documentation submitted was for the incorrect date of service. Refer to Medicare Program Integrity Manual Chapter 3, Section 3.6.2.2
GBB07	The documentation submitted does not support the modifiers billed. Refer to Medicare Program Integrity Manual Chapter 3, IOM Pub 100-04, Medicare Claims Processing Manual Chapter 1
GBB08	The Advanced Beneficiary Notice (ABN) of Noncoverage is invalid, incomplete or missing. Refer to Internet Only Manual, Pub 100-04, Medicare Claims Processing Manual, Chapter 30, Section 50
GBB09	The documentation submitted was for the incorrect beneficiary. Refer to Social Security Act 1833€, 1862(a)(1)(A) Internet Only Manual, Pub 100-08, Medicare Program Integrity Manual, Chapter 3, Section 3.2.3.8, 3.6.2.2.
GBB10	The documentation submitted is not legible. Refer to Medicare Program Integrity Manual, Chapter 3 Section 3.3.2.1

GBB11	The documentation submitted does not support the number of units billed. Refer to IOM, 100-08, Medicare Program Integrity Manual Chapter 3, Section 3.6.2.4 and Section 3.6.2.5, Medicare Claims Processing Manual Chapter 23
GBB12	The documentation submitted is for a Prior Authorization (PA) program that excludes a Railroad Board (RRB) beneficiary.
GBB14	The documentation submitted did not include a signed physician order or documentation to support intent to order. Refer to 42 CFR 410.32, Social Security Act 1842(p)(4), Internet Only Manual (IOM), Pub 100-08, Medicare Program Integrity Manual, Chapter 3, Section 3.3.2.4, IOM, Pub 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 80.6

Reason Code	MEDICAL NECESSITY
GBC01	The documentation submitted does not support medical necessity as listed in coverage requirements in the National Coverage Determination or Local Coverage Determination. Refer to Social Security Act 1862, Internet Only Manual, Pub 100-08, Medicare Program Integrity Manual, Chapter 3, Section 3.6.2.2
GBC02	The documentation submitted does not support medical necessity. Refer to SSA 1862, IOM, Medicare Program Integrity Manual, Pub 100-08, Chapter 3, Section 3.6.2.1, 3.6.2.2
GBC03	The service billed is not a covered Medicare benefit or is an excluded service. Refer to 42 CFR 411.15. Medicare Benefit Policy Manual Chapter 16; CFR title 42, Chapter IV, subchapter B, part 411
GBC04	The documentation provided does not support the medical necessity for this number of services or items within this timeframe. Refer to SSA 1862, IOM, 100-08, MPIM Chapter 3, Section 3.6.2.2
GBC05	The maximum benefit has been reached for this service. Refer to Internet Only Manual, Pub 100-08, Medicare Program Integrity Manual, Chapter 3, Section 3.6.2.5, A
GBC06	The documentation indicates that the service was performed for routine/screening purposes but is not covered under Medicare's Screening Benefit. Refer to Medicare Claims Processing Manual Chapter 18.

Reason Code	MISCELLANEOUS STATEMENTS
GBD03	Bundled or included in another code billed (NCCI). Refer to Internet Only Manual, Pub 100-04, Medicare Claims Processing Manual, Chapter 12, Section 20.3; National Correct Coding Initiative Coding Policy Manual for Medicare Services.

GBD04	The documentation does not support the service was performed as billed. Refer to IOM, 100-08, Medicare Program Integrity Manual Chapter 3, Section 3.6.2.4 and Section 3.6.2.5, Medicare Claims Processing Manual Chapter 23
GBD05	The documentation does not support the diagnosis code billed. Refer to Internet Only Manual, Pub 100-08, Medicare Program Integrity Manual, Chapter 3
GBD06	Payment for this service is compensated in the global surgical period. Refer to Medicare Claims Processing Manual Chapter 12 Section 30.6.6
GBD07	Payment is included in another service received on the same date (bundled). Refer to Medicare Claims Processing Manual Chapter 12, Section 30 & 40
GBD08	This service or procedure is considered investigational and, therefore, not covered by Medicare. Refer to IOM, 100-08, Medicare Program Integrity Manual Chapter 3, Section 3.6.2.2
GBD09	The documentation submitted does not support the ordered service. Refer to IOM- Pub 100-08, Medicare Program Integrity Manual, Chapter 3, Section 3.6.2.5, A
GBD10	The documentation does not support that a separately identifiable service was performed. Refer to IOM Medicare Claims Processing Manual Chapter 12, Section 30.6; Section 1833 (e), Title XVIII, of the Social Security Act
GBD11	The appropriate primary code has not been billed or paid. Refer to IOM-Pub 100-08, Medicare Program Integrity Manual, Chapter 3, Section 3.6.2.4
GBD12	The documentation submitted indicates the service was performed for cosmetic purposes. Refer to Medicare Benefit Policy Manual Chapter 16, Section 120
GBD13	The documentation submitted contains cloned or altered information. Refer to Pub 100-8, Medicare Program Integrity Manual, Chapter 3, Section 3.3.2.5; Chapter 4.3
GBD14	The provider indicated services were billed in error. Refer to Section 1833 (e), Title XVIII, of the Social Security Act
GBD15	The documentation contains conflicting information. Refer to Medicare Program Integrity Manual Chapter 4.3
GBD16	The service or device was not FDA approved. Refer to SSA 1862; Medicare Benefit Policy Manual Chapter 14
GBD17	The service billed is statutorily excluded. Refer to Medicare Claims Processing Manual Chapter 30, Section 20.1.1, Social Security Act 1862 (a), 12 CFR 411.15, Medicare Benefit Policy Manual Chapter 16
GBD18	***The documentation submitted supports the performing and billing providers are different. Refer to IOM, Medicare Claims Processing Manual, Pub 100-04, Chapter 12, Section 230.1***

Reason Code	DOWNCODED/RECODED BASED ON LEVEL OF SERVICE PROVIDED
GBE01	The documentation submitted does not support the medical necessity of the level of service billed. Refer to IOM, 100-08, Medicare Program Integrity Manual Chapter 3, Section 3.6.2.4 and Section 3.6.2.5, Medicare Claims Processing Manual Chapter 23
GBE02	The documentation submitted does not support the level of service billed. Refer to IOM, Medicare Program Integrity Manual, Pub 100-08, Chapter 3, Section 3.6.2.4

Reason Code	SIGNATURE DENIALS
GBF01	The documentation submitted did not include a valid signature and/or credentials. Refer to IOM, Medicare Program Integrity Manual, Pub 100-08, Chapter 3, Section 3.3.2.4 and CFR Part 482.24
GBF02	The documentation submitted did not include a valid signature and a response to attestation or signature log request was not received. Refer to IOM, Medicare Program Integrity Manual, Pub 100-08, Chapter 3, Section 3.3.2.4 and CFR Part 482.24
GBF03	***Stamped signatures without proof of disability inhibiting them to sign and requiring the need for a rubber-stamped signature are not accepted. Refer to IOM Pub 100-08, Medicare Program Integrity Manual, Chapter 3, Section 3.3.2.4.***

Reason Code	CERTIFICATION REQUIREMENTS
GBG01	The documentation submitted did not include the required certifications or recertifications for outpatient therapy services. Refer to Internet Only Manual, Pub 100-02, Medicare Benefit Policy Manual, Chapter 15, 220.1.3
GBG02	The documentation submitted did not include the required certifications or recertifications for the skilled nursing facility. Refer to Internet Only Manual (IOM) Pub100-2, Medicare Benefit Policy Manual, Chapter 8, Section 40 and IOM, Pub 100-01 Medicare General Information, Eligibility and Entitlement Manual, Chapter 4, Section 40.
GBG03	The documentation submitted did not include the required certifications or recertifications for inpatient psychiatric facility services. Refer to Internet Only Manual (IOM), Pub 100-2, Medicare Benefit Policy Manual, Chapter 2, Section 30.2.1 and IOM, Pub 100-01, Medicare General Information, Eligibility and Entitlement Manual, Chapter 4, Section 10.9

Reason Code	OTHER
GBH01	The claim did not include a valid NPI. Refer to IOM, Pub 100-04, Medicare Claims Processing Manual Chapter 1, Section 80.3.1
GBH02	The claim submitted did not contain required information.

Reason Code	EVALUATION AND MANAGEMENT (E&M)
GBI01	The documentation submitted does not support the medical necessity of the level of service billed. Refer to SSA 1862; Internet Only Manual (IOM), Pub 100-08, Medicare Program Integrity Manual Chapter 3, Section 3.6.2.4 and Section 3.6.2.5; IOM, Pub 100-04, Medicare Claims Processing Manual Chapter 23; IOM, Pub 100-04, Medicare Claims Processing Manual, Chapter 12, Section 30.6.1 A
GBI02	***The documentation submitted supported the key elements and/or reasonable necessity of a lower level of service. Refer to Internet Only Manual (IOM), Pub 100-04, Medicare Claims Processing Manual, Chapter 12, Section 30.6; 1995 Documentation Guidelines For Evaluation and Management Services; 1997 Documentation Guidelines For Evaluation and Management Services; AMA's 2021 and 2023 changes to office, outpatient, and other E/M visits; IOM, Pub 100-08, Medicare Program Integrity Manual Chapter 3, Section 3.6.2.4 and Section 3.6.2.5, IOM, Pub 100-04, Medicare Claims Processing Manual Chapter 23.***
GBI03	***The documentation submitted supported the key elements and/or reasonable necessity of a higher level of service. Refer to Internet Only Manual (IOM), Pub 100-04, Medicare Claims Processing Manual, Chapter 12, Section 30.6; 1995 Documentation Guidelines For Evaluation and Management Services; 1997 Documentation Guidelines For Evaluation and Management Services; AMA's 2021 and 2023 changes to office, outpatient, and other E/M visits; IOM, Pub 100-08, Medicare Program Integrity Manual Chapter 3, Section 3.6.2.4; IOM, Pub 100-04, Medicare Claims Processing Manual Chapter 23.***
GBI04	The documentation supported there was another evaluation and management service paid to the same physician on the same day and documentation did not support a separately identifiable evaluation and management service. Refer to SSA 1862; Internet Only Manual (IOM), Pub 100-08, Medicare Program Integrity Manual Chapter 3, Section 3.6.2.5; IOM, Pub 100-04, Medicare Claims Processing Manual, Chapter 12, Section 30.6.
GBI05	The documentation submitted does not support the medical necessity of the frequency of service(s) billed. Refer to SSA 1862; Internet Only Manual (IOM), Pub 100-08, Medicare Program Integrity Manual Chapter 3, Section 3.6.2.4 and Section 3.6.2.5;

	IOM, Pub 100-04, Medicare Claims Processing Manual Chapter 23; IOM, Pub 100-04, Medicare Claims Processing Manual, Chapter 12, Section 30.6.1
GBI06	The documentation submitted did not support incident-to criteria were met. Refer to SSA 1862; Internet Only Manual (IOM), Pub 100-08, Medicare Program Integrity Manual Chapter 3, Section 3.6.2.5; IOM, Pub 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 60.1-60.3; IOM, Pub 100-04, Medicare Claims Processing Manual, Chapter 12, Section 30.6.4, 30.6.1 B.
GBI07	The documentation submitted did not support shared service criteria were met. Refer to SSA 1862; Internet Only Manual (IOM), Pub 100-08, Medicare Program Integrity Manual Chapter 3, Section 3.6.2.5; IOM, Pub 100-04, Medicare Claims Processing Manual, Chapter 12, Section 30.6.1 B; IOM, Pub 100-02, Medicare Benefit Policy Manual, Chapter 15, Sections 60.1-60.3.
GBI08	The documentation submitted did not support all of the requirements of an initial preventative physical examination. Refer to SSA 1861 (s)(2)(w) and 1861(ww); 42 CFR 410.16, 411.15 (a)(1), 411.15 (k)(11); Internet Only Manual (IOM), Pub 100-04, Medicare Claims Processing Manual, Chapter 12, Section 30.6.1.1; IOM, Pub 100-08, Medicare Program Integrity Manual Chapter 3, Section 3.6.2.5.
GBI09	The documentation submitted did not support all of the requirements of an annual wellness visit. Refer to SSA 1861 (s)(2)(FF) and 1861 (hhh); 42 CFR 410.15; Internet Only Manual (IOM), Pub 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 280.5; IOM, Pub 100-04, Medicare Claims Processing Manual Chapter 12, Section 30.6.1.1; IOM, Pub 100-08, Medicare Program Integrity Manual Chapter 3, Section 3.6.2.5.
GBI10	The submitted documentation supported the annual wellness visit billed occurred within twelve months from the previous annual wellness visit. Refer to 42 CFR 410.15; Internet Only Manual (IOM), Pub 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 280.5; IOM, Pub 100-04, Medicare Claims Processing Manual, Chapter 12, Section 30.6.1.1; IOM, Pub 100-08, Medicare Program Integrity Manual Chapter 3, Section 3.6.2.5.
GBI11	The documentation submitted support the annual wellness visit occurred within twelve months from Part B Entitlement. Medicare [only] pays for an AWV for a beneficiary who is no longer within 12 months after the effective date of his/her first Medicare Part B coverage period. Refer to 42 CFR 410.15; Internet Only Manual (IOM), Pub 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 280.5; IOM, Pub 100-04, Medicare Claims Processing Manual, Chapter 12, Section 30.6.1.1.
GBI12	The documentation submitted supports an Annual Wellness Visit; however, the beneficiary has had a previous initial Annual Wellness Visit billed. Refer to 42 CFR 410.15; Internet Only Manual (IOM), Pub 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 280.5; IOM, Pub 100-04, Medicare Claims Processing Manual,

	Chapter 12, Section 30.6.1.1; IOM, Pub 100-04, Medicare Claims Processing Manual Chapter 23.
GBI14	The documentation does not support a separate E&M service was performed during a global surgery period. Refer to Social Security Act 1862; Internet Only Manual, Pub 100-04, Medicare Claims Processing Manual, Chapter 12, Section 30.6.6.
GBI15	The documentation submitted did not support teaching service criteria were met. Refer to 42 CFR §415.172; Internet Only Manual (IOM), Pub 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 30.2B; IOM, Pub 100-04, Medicare Claims Processing Manual Chapter 12 Section 100.1.
GBI16	The submitted documentation does not support that the billing physician is the physician who ordered the observation services and was responsible for the patient during his/her observation care. Refer to Internet Only Manual (IOM), Pub 100-04, Medicare Claims Processing Manual, Chapter 12, Section 30.6.8; IOM, Pub 100-04, Medicare Claims Processing Manual Chapter 23.
GBI17	The documentation submitted does not support the required elements for the service billed. Refer to Internet Only Manual (IOM), Pub 100-04, Medicare Claims Processing Manual, Chapter 12, Section 30.6; IOM, Pub 100-04, Medicare Claims Processing Manual Chapter 23.
GBI18	The documentation submitted and claim history do not support the reasonable necessity of an additional physicians visit. Refer to Social Security Act 1862; Internet Only Manual (IOM), Pub 100-04, Medicare Claims Processing Manual, Chapter 12, Section 30.6.9; IOM, Pub 100-04, Medicare Claims Processing Manual Chapter 23.
GBI19	The documentation submitted supports the billing physician billing the initial nursing facility service is not the ordering physician. Refer to Internet Only Manual (IOM), Pub 100-04, Medicare Claims Processing Manual, Chapter 12, Section 30.6.13; IOM, Pub 100-04, Medicare Claims Processing Manual Chapter 23.

Reason Code	**ADMINISTRATIVE/OTHER** *(For Transmission via esMD)*
GEX04	Other
GEX05	The system used to retrieve the Subscriber/Insured details using the given MBI is temporarily unavailable.
GEX06	The documentation submitted is incomplete
GEX07	This submission is an unsolicited response
GEX08	The documentation submitted cannot be matched to a case/claim
GEX09	This is a duplicate of a previously submitted transaction
GEX10	The date(s) of service on the cover sheet received is missing or invalid.

GEX11	The NPI on the cover sheet received is missing or invalid.
GEX12	The state where services were provided is missing or invalid on the cover sheet received.
GEX13	The Medicare ID on the cover sheet received is missing or invalid.
GEX14	The billed amount on the cover sheet received is missing or invalid.
GEX15	The contact phone number on the cover sheet received is missing or invalid.
GEX16	The Beneficiary name on the cover sheet received is missing or invalid
GEX17	The Claim number on the cover sheet received is missing or invalid
GEX18	The ACN on the coversheet received is missing or invalid
GEX19 (Effective 10/01/2021)	Provider is exempted from submitting this PA request