Reason Code	PROOF of DELIVERY STATEMENTS
GDR01	The documentation does not include a proof of delivery. Refer to Medicare Program Integrity Manual 100-08, Chapter 4, Section 4.26 & Standard Documentation Requirements A55426.
GDR02	The beneficiary or designee signature and date indicating proof of delivery is after the date of service. Refer to Standard Documentation Requirements A55426.
GDR03	The beneficiary or designee signature and date indicating proof of delivery is prior to the date of service. Refer to Medicare Program Integrity Manual 100-08, Chapter 4, Section 4.26.1 & Standard Documentation Requirements A55426.
GDR04	The shipping date documented on the proof of delivery is after the date of service. Refer to Medicare Program Integrity Manual 100-08, Chapter 4, Section 4.26.1 & Standard Documentation Requirements A55426.
GDR05	The shipping date indicating proof of delivery is prior to the date of service. Refer to Medicare Program Integrity Manual 100-08, Chapter 4, Section 4.26.1 & Standard Documentation Requirements A55426.
GDR06	The proof of delivery is missing the beneficiary or designee's signature. Refer to Medicare Program Integrity Manual 100-08, Chapter 4, Section 4.26.1 & Standard Documentation Requirements A55426.
GDR07	The proof of delivery contains a beneficiary or designee's signature that is illegible. Refer to Medicare Program Integrity Manual 100-08, Chapter 4, Section 4.26.1 & Standard Documentation Requirements A55426.
GDR08	The proof of delivery is missing the beneficiary's name. Refer to Standard Documentation Requirements A55426.
GDR09	The proof of delivery is missing the delivery address. Refer to Standard Documentation Requirements A55426.
GDR10	The proof of delivery is missing the date delivered. Refer to Medicare Program Integrity Manual 4.26.1
GDR11	The proof of delivery is missing the quantity delivered. Refer to Standard Documentation Requirements A55426.
GDR12	The proof of delivery contains a description of contents not consistent with the item(s) billed. Refer to Standard Documentation Requirements A55426.
GDR13	The proof of delivery does not contain a sufficiently detailed description of contents. Refer to Standard Documentation Requirements A55426.

GDR14	The proof of delivery documentation is missing the date the item(s) was shipped or delivered. Refer to Medicare Program Integrity Manual 100-08, Chapter 4, Section 4.26.1 & Standard Documentation Requirements A55426.
GDR15	The shipping documentation does not contain the delivery service's package identification number, supplier invoice number or alternative method that links the supplier's delivery documents with the delivery service's records. Refer to Standard Documentation Requirements A55426.
GDR16	The shipping documentation does not contain proof or confirmation of delivery. Refer to Standard Documentation Requirements A55426.
GDR17	The documentation showing proof of delivery for the item(s) billed is prior to Medicare eligibility. Refer to Medicare Program Integrity Manual 100-08, Chapter 4, Section 4.26.3 & Standard Documentation Requirements A55426.
GDR18	The proof of delivery is illegible.
GDR19	There is no prescription number on any document to compare to the prescription number on the proof of delivery, therefore, the item(s) received cannot be determined. Refer to 42 CFR 424.57(c)(12)
GDR20	The proof of delivery does not contain a statement, signed and dated by the beneficiary (or beneficiary's designee), that the supplier has examined the item received prior to Medicare eligibility. Refer to Medicare Program Integrity Manual 100-08, Chapter 4, Section 4.26.3.
GDR21	The proof of delivery does not contain an attestation from the supplier to the fact that the item meets Medicare requirements. Refer to Medicare Program Integrity Manual 100-08, Chapter 4, Section 4.26.3 & Standard Documentation Requirements A55426.
GDR1Z	The proof of delivery contains an error for a reason not otherwise specified.

Reason Code	**REFILL REQUIREMENT STATEMENTS**
GDT01	There is no documentation of beneficiary contact and beneficiary affirmation that the refill is needed. Refer to 42 CFR 410.38, Medicare Program Integrity Manual 100-08, Chapter 5, Section 5.2.6. & Standard Documentation Requirements A55426.
GDT02	The documentation does not show contact with the beneficiary within 30 calendar days of the expected end of the current supply. Refer to 42 CFR 410.38, Medicare Program Integrity Manual 100-08, Chapter 5, Section 5.2.6. & Standard Documentation Requirements A55426.
GDT03	The documentation contains a retrospective attestation statement by the supplier or beneficiary for a refill request. Refer to 42 CFR 410.38 & Standard Documentation Requirements A55426.

GDT04	The refill documentation is missing the beneficiary's name. Refer to 42 CFR 410.38 & Standard Documentation Requirements A55426.
GDT05	The refill documentation is missing the description of each item that is being requested. Refer to 42 CFR 410.38 & Standard Documentation Requirements A55426.
GDT06	The refill documentation is missing the date of the refill request. Refer to 42 CFR 410.38 & Standard Documentation Requirements A55426.
GDT08	The refill documentation is illegible.
GDT11	The documentation does not contain a refill request as the delivery slip is not signed by the beneficiary or designee. Refer to Standard Documentation Requirements A55426
GDT1Z	The refill documentation contains an error for a reason not otherwise specified.

Reason Code	MEDICAL RECORDS STATEMENTS
GDU01	No medical record documentation was received. Refer to Medicare Program Integrity Manual 100-08, Chapter 3, Section 3.2.3.8.
GDU02	The medical record documentation is missing the beneficiary's name. Refer to Medicare Program Integrity Manual 100-08, Chapter 5, Section 5.9.
GDU03	Some or all of the medical record documentation is not applicable to this beneficiary. Refer to Medicare Program Integrity Manual 100-08, Chapter 5, Section 5.9.
GDU04	The medical record documentation is not authenticated (handwritten or electronic) by the author. Refer to Medicare Program Integrity Manual 100-08, Chapter 3, Section 3.3.2.4.
GDU05	The medical record documentation contains a practitioner’s signature which does not comply with the Centers for Medicare & Medicaid Services signature requirements. Refer to Medicare Program Integrity Manual 100-08, Chapter 3, Section 3.3.2.4.
GDU06	The medical record documentation contains an illegible signature and no signature log or attestation statement was submitted. Refer to Medicare Program Integrity Manual 100-08, Chapter 3, Section 3.3.2.4.
GDU07	The treating practitioner's order, Certificate of Medical Necessity, supplier prepared statement, or the practitioner's attestation, by itself, does not provide sufficient documentation of medical necessity. Refer to Medicare Program Integrity Manual 100-08, Chapter 5, Section 5.9.
GDU08	The medical record documentation does not clearly indicate the date of the amendment, correction or delayed entry. Refer to Medicare Program Integrity Manual 100-08, Chapter 3, Section 3.3.2.5.

GDU09	The medical record documentation does not clearly indicate the author of the amendment, correction or delayed entry. Refer to Medicare Program Integrity Manual 100-08, Chapter 3, Section 3.3.2.5.
GDU10	The medical record documentation does not clearly identify all original content of the amendment, correction or delayed entry. Refer to Medicare Program Integrity Manual 100-08, Chapter 3, Section 3.3.2.5.
GDU11	The medical record documentation is dated after the date of service. Refer to Medicare Program Integrity Manual 100-08, Chapter 5, Section 5.9 & Standard Documentation Requirements A55426.
GDU12	The medical record documentation is illegible.
GDU13	The documentation was not timely (within the preceding 12 months) to support continued use by the beneficiary. Refer to Standard Documentation Requirements A55426
GDU14	The documentation was not timely (within the preceding 12 months) to support continued need by the beneficiary. Refer to Standard Documentation Requirements A55426
GDU15	The telehealth visit does not comply with the Medicare prescribed telehealth requirements. Refer to 42 CFR 414.65, 42 CFR 410.78, & 42 CFR 410.38.
GDU16	The medical record documentation does not indicate the date of service or date of visit. Refer to Standard Documentation Requirements A55426.
GDU17	The medical record documentation appears to be missing pages.
GDU18	The medical record documentation indicates the item is needed for post-operative recovery, this item is expected to be included in the Diagnostic Related Group (DRG) or Prospective Payment System (PPS) rates. Refer to Claims Processing Manual Pub. 100-04 Chapter 1, Section 10.1.5.1
GDU19	The medical record documentation indicates the item is needed during post-operative recovery; however, the surgery has not yet taken place. Refer to Medicare Benefit Policy Manual Chapter 15, Section 110.1, Section C.
GDU20	The item provided is not clearly noted in the beneficiary's record for a treating practitioner who is also the supplier. Refer to Medicare Program Integrity Manual 100-08, Chapter 5, Section 5.2 and Standard Documentation Article A55426.
GDU1Z	The medical record documentation contains an error not otherwise specified.
GDU21	***The face-to-face encounter does not contain a treating practitioner's signature required to resolve authenticity concerns related to legitimacy or falsity of the documentation. Refer to Social Security Act §1815(a) and §1833(e), 42 Code of Federal Regulations 410.38 (c), & Medicare Program Integrity Manual 100- 08, Chapter 3, Section 3.3.2.4.***

GDU22	***The medical record documentation does not contain a treating practitioner's signature required to resolve authenticity concerns related to legitimacy or falsity of the documentation. Refer to Social Security Act §1815(a) and §1833(e) & Medicare Program Integrity Manual 100- 08, Chapter 3, Section 3.3.2.4.***

Reason Code	UTILIZATION STATEMENTS
GDV01	The date of service for item(s) billed has been paid. Refer to Medicare Benefit Policy Manual 100-02, Chapter 15, Section 50.5.1-50.6 & 110-140.
GDV02	The date of service for item(s) billed has paid to another supplier. Refer to Medicare Benefit Policy Manual 100-02, Chapter 15, Section 50.5.1-50.6 & 110-140.
GDV03	The date of service for item(s) billed has been partially paid. Refer to Medicare Benefit Policy Manual 100-02, Chapter 15, Section 50.5.1-50.6 & 110-140.
GDV04	The date of service for item(s) billed has been partially paid to another supplier. Refer to Medicare Benefit Policy Manual 100-02, Chapter 15, Section 50.5.1-50.6 & 110-140.
GDV05	The claim is billed for greater quantity than the order indicates. Refer to Medicare Program Integrity Manual 100-08, Chapter 5, Section 5.2 & applicable Local Coverage Determination/Policy Article.
GDV06	The claim is billed for greater quantity than the proof of delivery indicates. Refer to Medicare Program Integrity Manual 4.26.1

Reason Code	MISCELLANEOUS STATEMENTS
GDW01	The beneficiary was not enrolled in Medicare fee for service on the date of service.
GDW02	Claims history indicates same or similar durable medical equipment within the last five years. Refer to Medicare Claims Processing Manual 100-04, Chapter 20, Section 50.1.
GDW03	The documentation does not include verification that the equipment was lost, stolen, or irreparably damaged in a specific incident. Refer to Medicare Claims Processing Manual 100-04, Chapter 20, Section 50 & Standard Documentation Requirements A55426.
GDW04	The claim was submitted with an incorrect modifier. Refer to Medicare Claims Processing Manual 100-04, Chapter 20 & LCDs.
GDW05	The claim was submitted without a required modifier. Refer to Medicare Claims Processing Manual 100-04, Chapter 20 & LCDs.
GDW06	The documentation submitted indicates the item(s) were returned by the beneficiary.

GDW07	The supplier indicates the item(s) were billed in error.
GDW08	The beneficiary was in an acute care hospital or skilled nursing facility on this date of service. Refer to Medicare Claims Processing Manual 100-04, Chapter 20, Sections 210-212.
GDW09	The medical record documentation does not demonstrate a change in the patient's medical condition necessitating a different item. Refer to Medicare Claims Processing Manual 100-04, Chapter 20, Section 50 & applicable Local Coverage Determination/Policy Article.
GDW10	The claim submitted is a duplicate to another claim billed.
GDW11	The beneficiary does not reside in this jurisdiction.
GDW12	The claim submitted is a duplicate to another claim processed through medical record review.
GDW13	The date of service on the claim is after the beneficiary's date of death. Refer to Medicare Claims Processing Manual 100-04, Chapter 20.
GDW14	The time limit for filing claims has expired. Refer to 42 CFR 424.44 & Medicare Claims Processing Manual 100-04, Chapter 1, Section 70.
GDW15	The claim was billed with an incorrect Medicare Beneficiary Identifier. Refer to Medicare Claims Processing Manual 100-04, Chapter 1, Section 70.2.3.1.
GDW16	The item was provided prior to an inpatient hospital admission or Part A covered skilled nursing facility stay and its use began during the stay.
GDW17	The item was provided during an inpatient hospital or Part A covered skilled nursing facility stay prior to the day of discharge and the use began during the stay.
GDW18	The payment for this item(s) is included in the payment of another as it bundles.
GDW19	The item billed is not specified in the Product Classification List on the Pricing, Data Analysis and coding (PDAC) contractor web site. Refer to applicable Local Coverage Determination/Policy Article.
GDW20	The claim is billed for items which are not billable to the DME MAC.
GDW21	The supply or accessory is denied as the base equipment is denied. Refer to applicable Local Coverage Determination/Policy Article.
GDW22	The documentation submitted is for a Prior Authorization (PA) program that excludes a Railroad Board (RRB) beneficiary.
GDW23	The beneficiary resides in a state that is not eligible for Prior Authorization.
GDW24	This is a duplicate Prior Authorization Request.
GDW25	An error occurred during the fax transmission of the Prior Authorization request and it is unable to be processed.

GDW26	The documentation does not specify the procedure code of the requested item, therefore eligibility for Prior Authorization cannot be determined.
GDW27	The requested item is not eligible for Prior Authorization.
GDW28	The date of the treating physician/practitioner order is prior to the implementation of Prior Authorization.
GDW29	The documentation does not include a valid Medicare Beneficiary Identifier (MBI) number.
GDW30	The documentation does not include a Medicare Beneficiary Identifier (MBI) number.
GDW31	The documentation demonstrates the requested item has been delivered and is therefore not eligible for Prior Authorization.
GDW32	The beneficiary is excluded for Prior Authorization as there is a Representative Payee on file; therefore, claims billed are not subject to the Prior Authorization program.
GDW33	The Prior Authorization request has been cancelled per the supplier's request
GDW34	The Prior Authorization resubmission does not include all required documentation.
GDW35	The Prior Authorization submission does not include a beneficiary name.
GDW36	The Prior Authorization request documentation indicates the beneficiary is deceased.
GDW37	A previously affirmative determination has been made on the Prior Authorized item requested for this beneficiary.
GDW38	The Prior Authorization request coversheet does not include the ordering physician's contact information.
GDW39	The Prior Authorization request {Explanation-of-Problem}.
GDW40	No documentation was received in response to the additional documentation request (ADR) letter. Refer to Social Security Act (SSA) Title XVIII, Section 1815(a), 1833(e), & 1862(a)(1)(A).
GDW1Z	The documentation contains an error not otherwise specified.

Reason Code	**ABN STATEMENTS**
GDY01	The GA modifier was removed as no Advance Beneficiary Notice was provided. Refer to ABN Instructions & Medicare Claims Processing Manual 100-04, Chapter 30, Section 50.
GDY02	Section A of the Advance Beneficiary Notice is not properly completed.
GDY03	Section B of the Advance Beneficiary Notice is not properly completed.

GDY04	Section C of the Advance Beneficiary Notice contains a Medicare or Social Security number.
GDY05	Section D of the Advance Beneficiary Notice is not properly completed.
GDY06	Section E of the Advance Beneficiary Notice is not properly completed.
GDY07	Section E of the Advance Beneficiary Notice indicates a reason Medicare may not pay which is unrelated to the denial.
GDY08	Section E of the Advance Beneficiary Notice does not contain a genuine reason that denial by Medicare is expected.
GDY09	Section E of the Advance Beneficiary Notice is not completed using beneficiary friendly language.
GDY10	Section F of the Advance Beneficiary Notice is not properly completed.
GDY11	Section G of the Advance Beneficiary Notice is not properly completed.
GDY12	Section I of the Advance Beneficiary Notice is not signed by the beneficiary (or representative).
GDY13	Section J of the Advance Beneficiary Notice is not properly completed.
GDY14	The Advance Beneficiary Notice is dated after the date of service.
GDY15	Generic Advance Beneficiary Notices which do no more than state that Medicare denial of payment is possible are not considered to be acceptable.
GDY16	The Advance Beneficiary Notice is not the most current version of the Centers for Medicare & Medicaid Services approved form.
GDY17	The Advance Beneficiary Notice contains an amendment, correction or delayed entry that does not comply with accepted record keeping principles.
GDY18	Some or all of the Advance Beneficiary Notice is illegible.
GDY19	The file does not contain a valid Advance Beneficiary Notice.
GDY1Z	The Advance Beneficiary Notice contains an error not otherwise specified.

Reason Code	**FACE-TO-FACE**
GDB02	The face-to-face encounter is greater than six months prior to the date of the standard written order (SWO) required prior to delivery. Refer to 42 CFR 410.38(d)(2) & Standard Documentation Requirements A55426.
GDB03	The documentation does not include a face-to-face encounter within six months prior to the order. Refer to 42 Code of Federal Regulations 410.38 (c) and Standard Documentation Requirements A55426.

GDB04	The face-to-face encounter was completed on a limited space template with insufficiently detailed or incomplete narrative to support medical necessity from the physician/practitioner. Refer to Medicare Program Integrity Manual 3.3.2.1.1.
GDB05	The face-to-face encounter contains an amendment, correction or delayed entry that does not comply with accepted record keeping principles. Refer to 42 Code of Federal Regulations 410.38 (c) & Medicare Program Integrity Manual 100-08, Chapter 3, Section 3.3.2.5.
GDB06	The face-to-face encounter contains a practitioner's signature which does not comply with the Centers for Medicare & Medicaid Services signature requirements. Refer to 42 Code of Federal Regulations 410.38 (c) & Medicare Program Integrity Manual 100-08, Chapter 3, Section 3.3.2.4.
GDB07	The face-to-face encounter is not authenticated (handwritten or electronic) by the author. Refer to 42 Code of Federal Regulations 410.38 (c) & Medicare Program Integrity Manual 100-08, Chapter 3, Section 3.3.2.4.
GDB08	The face-to-face encounter is illegible.
GDB09	The face-to-face encounter is missing the beneficiary's name. Refer to Medicare Program Integrity Manual 100-08, Chapter 3, Section 5.9.
GDB10	The face-to-face encounter does not indicate the date of service or date of visit. Refer to 42 Code of Federal Regulations 410.38 (c) & Standard Documentation Requirements A55426.
GDB11	The face-to-face encounter contains an error not otherwise specified.

Reason Code	**STANDARD WRITTEN ORDER (SWO)**
GDX01	The documentation does not include a standard written order (SWO). Refer to 42 CFR 410.38(d)(1), Medicare Program Integrity Manual 100-08, Chapter 5, Section 5.2.1 & Standard Documentation Requirements A55426.
GDX02	The standard written order (SWO) is missing the beneficiary's name or Medicare Beneficiary Identifier (MBI). Refer to 42 CFR 410.38(d)(1), Medicare Program Integrity Manual 100-08, Chapter 5, Section 5.2.2 & Standard Documentation Requirements A55426.
GDX03	The standard written order (SWO) is not applicable to this beneficiary. Refer to 42 CFR 410.38(d)(1), Medicare Program Integrity Manual 100-08, Chapter 5, Section 5.2.2 & Standard Documentation Requirements A55426.
GDX04	The standard written order (SWO) is missing a description of the item. Refer to 42 CFR 410.38(d)(1), Medicare Program Integrity Manual 100-08, Chapter 5, Section 5.2.2 & Standard Documentation Requirements A55426.

GDX05	The standard written order (SWO) is missing the treating practitioner's signature. Refer to 42 CFR 410.38(d)(1), Medicare Program Integrity Manual 100-08, Chapter 5, Section 5.2.2 & Standard Documentation Requirements A55426.
GDX06	The standard written order (SWO) contains a treating practitioner's signature which does not comply with the Centers for Medicare & Medicaid Services signature requirements. Refer to Medicare Program Integrity Manual 100-08, Chapter 3, Section 3.3.2.4 & Standard Documentation Requirements A55426.
GDX07	The standard written order (SWO) is signed after the claim was submitted. Refer to 42 CFR 410.38(d)(1), Medicare Program Integrity Manual 100-08, Chapter 5, Section 5.2.4 & Standard Documentation Requirements A55426.
GDX08	The standard written order (SWO) is missing the order date. Refer to 42 CFR 410.38(d)(1), Medicare Program Integrity Manual 100-08, Chapter 5, Section 5.2.2 & Standard Documentation Requirements A55426.
GDX09	The standard written order (SWO) is dated after the claim was submitted. Refer to 42 CFR 410.38(d)(1), Medicare Program Integrity Manual 100-08, Chapter 5, Section 5.2.4 & Standard Documentation Requirements A55426.
GDX11	The standard written order (SWO) contains an amendment, correction or delayed entry that does not comply with accepted record keeping principles. Refer to Medicare Program Integrity Manual 100-08, Chapter 3, Section 3.3.2.5.
GDX12	The standard written order (SWO) is illegible.
GDX13	The standard written order (SWO) is missing the quantity to be dispensed. Refer to 42 CFR 410.38(d)(1), Medicare Program Integrity Manual 100-08, Chapter 5, Section 5.2.2 & Standard Documentation Requirements A55426.
GDX15	The standard written order (SWO) does not identify the item to be ordered. Refer to 42 CFR 410.38(d)(1) and Standard Documentation Requirements A55426.
GDX16	The standard written order (SWO) contains an error for a reason not otherwise specified.
GDX18	The standard written order (SWO) was signed prior to the date of the in-person visit with the treating practitioner. Refer to applicable Local Coverage Determination (LCD).
GDX19	The standard written order (SWO) is missing the treating practitioner's name or National Provider Identifier (NPI). Refer to 42 CFR 410.38(d)(1) & Standard Documentation Requirements A55426.
GDX22	The standard written order (SWO) is expired per length of need.
GDX23	The standard written order (SWO) required prior to delivery is dated after delivery of the item(s). Refer to Standard Documentation Requirements A55426.

GDX24	The standard written order (SWO) required prior to delivery was written before the completion date of the face-to-face encounter. Refer to 42 CFR 410.38(d)(1), CMS-1713-F, Standard Documentation Requirements A55426 & applicable Local Coverage Determination/ Policy Article.
GDX25	The standard written order (SWO) required prior to delivery was not completed by the treating practitioner that performed the face-to-face encounter. Refer to Social Security Act 1834(a)(1)(E)(iv), 42 CFR 410.38(d)(1) & Standard Documentation Requirements A55426.
GDX26	The standard written order (SWO) does not specify the type of supplies needed in such a manner that the supplier may calculate the necessary disbursement and assess the continued need for refill with the beneficiary. Refer to Medicare Program Integrity Manual 100-08, Chapter 5, Section 5.11.

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 is incomplete***
GEX07	This submission is an unsolicited response
GEX08	***The documentation cannot be matched to a case/claim***
GEX09	***This is a duplicate of a previous 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