APPENDIX VIII - MCO Denied Claims, July 1, 2018 - June 30, 2019[1]

by claims adjustment reason code (CARC), emergency vs. non-emergency[2]

CARC Code		Emergency						Non-Emergency						MCO Total
		ABH	ACLA	HB	LHC	UHC	Total	ABH	ACLA	HB	LHC	UHC	Total	
18	Exact duplicate claim/service	5,827	236	11,585	11,177	8,212	37,037	284,163	16,950	569,091	351,395	200,675	1,422,274	1,459,311
197	Precertification/authorization/notification/pre-treatment absent		4	7	330	8	349	20,499	193,734	253,152	752,646	234,381	1,454,412	1,454,761
96	Non-covered charge(s)		1,890	140	317	8,115	10,462	22,594	224,507	67,384	458,631	343,302	1,116,418	1,126,880
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	3,854	936	725	573	3,649	9,737	233,114	73,689	260,313	107,090	327,725	1,001,931	1,011,668
16	Claim/service lacks information or has submission/billing error(s)	45	5,594	570	1,428	2,336	9,973	6,343	198,676	318,018	341,423	91,215	955,675	965,648
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service			5	120	23	148		329,565	2,771	196,987	36,509	565,832	565,980
252	An attachment/other documentation is required to adjudicate this claim/service		4,459	3,534		14,362	22,355		93,258	99,052	2,174	257,682	452,166	474,521
133	The disposition of this service line is pending further review	8,435	1	3	137	72	8,648	295,916	1,452	62	9,776	5,420	312,626	321,274
27	Expenses incurred after coverage terminated		4,295	4,225	1,151	6,134	15,805		62,978	83,748	29,518	103,732	279,976	295,781
204	This service/equipment/drug is not covered under the patient's current benefit plan	1,575		21	4,614		6,210	84,388	330	28,094	161,175	3,868	277,855	284,065
29	The time limit for filing has expired	529	1,120	972	2,045	2,044	6,710	20,543	40,908	51,413	73,864	66,632	253,360	260,070
256	Service not payable per managed care contract		1	86		203	290		652	169,455	129	35,807	206,043	206,333
22	This care may be covered by another payer per coordination of benefits	953	2		8,223	4	9,182	29,215	22		150,577	5,146	184,960	194,142
4	The procedure code is inconsistent with the modifier used or a required modifier is missing	237	54	155	47	30	523	45,191	22,754	84,334	14,336	19,842	186,457	186,980
119	Benefit maximum for this time period or occurrence has been reached			168	14		182	6,793	6,297	47,445	82,817	798	144,150	144,332
147	Provider contracted/negotiated rate expired or not on file	128					128	142,656					142,656	142,784
A1	Claim/Service denied At least one Remark Code must be provided				2,977	3	2,980		162	2	128,848	93	129,105	132,085
222	Exceeds the contracted maximum number of hours/days/units by this provider for this period			5	54		59		4,390	31,920	83,433	775	120,518	120,577

CARC Code		Emergency						Non-Emergency						MCO Total
		ABH	ACLA	HB	LHC	UHC	Total	ABH	ACLA	HB	LHC	UHC	Total	
109	Claim/service not covered by this payer/contractor You must send the claim/service to the correct payer/contractor		5	2,947	254	1,437	4,643		2,303	57,803	29,266	19,774	109,146	113,789
B13	Previously paid Payment for this claim/service may have been provided in a previous payment		118		215	647	980		1,633	3,323	16,978	88,793	110,727	111,707
26	Expenses incurred prior to coverage	2,900	272	534	436	591	4,733	48,880	4,924	11,063	18,910	11,437	95,214	99,947
P14	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day				248		248			779	86,939		87,718	87,966
6	The procedure/revenue code is inconsistent with the patient's age			37	3	2	42	3,041	1,385	18,865	62,472	1,337	87,100	87,142
198	Precertification/notification/authorization/pre-treatment exceeded			1	1		2	1,877	11,037	25,270	36,789	3,188	78,161	78,163
8	The procedure code is inconsistent with the provider type/specialty (taxonomy)						-	4,841	12,455	30,332	16,352	3,249	67,229	67,229
B15	This service/procedure requires that a qualifying service/procedure be received and covered The qualifying other service/procedure has not been received/adjudicated	44		129	2	677	852	3,721	43	9,775	1,098	38,986	53,623	54,475
11	The diagnosis is inconsistent with the procedure			84	1		85	1,775	19,903	7,260	11,406	10,094	50,438	50,523
234	This procedure is not paid separately At least one Remark Code must be provided		110		221	50	381		3,810	6,256	36,418	2,365	48,849	49,230
150	Payer deems the information submitted does not support this level of service			72	58		130		3,263	12,128	23,105	4,450	42,946	43,076
B8	Alternative services were available, and should have been utilized						-					42,133	42,133	42,133
163	Attachment/other documentation referenced on the claim was not received						-		21,645		15,900	69	37,614	37,614
95	Plan procedures not followed		94	1			95		36,344	8			36,352	36,447
39	Services denied at the time authorization/pre-certification was requested					19	19	2,858	4,431	12,868	4,637	10,509	35,303	35,322
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement			7	207		214			3,035	28,459		31,494	31,708

CARC Code		Emergency						Non-Emergency						MCO Total
		ABH	ACLA	HB	LHC	UHC	Total	ABH	ACLA	HB	LHC	UHC	Total	
236	This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/ fee schedule requirements		50		1		51	344	16,669		9,614		26,627	26,678
151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services	2					2	24,999	2			74	25,075	25,077
9	The diagnosis is inconsistent with the patient's age		16	3	51	30	100		313	111	10,291	8,398	19,113	19,213
59	Processed based on multiple or concurrent procedure rules (For example multiple surgery or diagnostic imaging, concurrent anesthesia)					2	2			5,542		12,322	17,864	17,866
5	The procedure code/type of bill is inconsistent with the place of service		31	90	20	70	211		4,608	2,332	5,495	5,170	17,605	17,816
199	Revenue code and Procedure code do not match	24		2,509			2,533	5,420	7,298	1,838			14,556	17,089
107	The related or qualifying claim/service was not identified on this claim		44	4			48		5,140	9,574	1,192		15,906	15,954
55	Procedure/treatment/drug is deemed experimental/investigational by the payer						-			15,608			15,608	15,608
58	Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service		46			15	61		4,226	174	8,561	612	13,573	13,634
242	Services not provided by network/primary care providers			1	6		7	2,594	4,996	2,873	2,884		13,347	13,354
251	The attachment/other documentation that was received was incomplete or deficient The necessary information is still needed to process the claim		298	4		1	303		5,091	675	5,129	1,726	12,621	12,924
272	Coverage/program guidelines were not met				23		23		9,710	12	2,736		12,458	12,481
185	The rendering provider is not eligible to perform the service billed		192		12		204	1	4,934		4,720	2,350	12,005	12,209
231	Mutually exclusive procedures cannot be done in the same day/setting	2					2	2,964	1,001	7,925	16	8	11,914	11,916
273	Coverage/program guidelines were exceeded		126				126		784	9,709	621		11,114	11,240
50	These are non-covered services because this is not deemed a 'medical necessity' by the payer						-		198	2,161	3,914	4,591	10,864	10,864
23	The impact of prior payer(s) adjudication including payments and/or adjustments			251	51		302		8	4,787	5,261		10,056	10,358

CARC Code		Emergency						Non-Emergency						MCO Total
		ABH	ACLA	HB	LHC	UHC	Total	ABH	ACLA	HB	LHC	UHC	Total	
226	Information requested from the Billing/Rendering Provider was not provided or not provided timely or was insufficient/incomplete			154			154		233	9,836			10,069	10,223
128	Newborn's services are covered in the mother's Allowance						-		2,336	2,610		5,269	10,215	10,215
B16	New Patient' qualifications were not met						-			4,050	1,577	4,055	9,682	9,682
181	Procedure code was invalid on the date of service		1			1	2	1,399	5,791	9	11	23	7,233	7,235
146	Diagnosis was invalid for the date(s) of service reported	22	30		1	11	64	3,342	1,939	1	764	1,011	7,057	7,121
208	National Provider Identifier - Not matched						-		6,821	274	18	5	7,118	7,118
182	Procedure modifier was invalid on the date of service	1	22		60	6	89	44	6,363		520	19	6,946	7,035
B23	Procedure billed is not authorized per your Clinical Laboratory Improvement Amendment (CLIA) proficiency test						-		6,768				6,768	6,768
49	This is a non-covered service because it is a routine/preventive exam or a diagnostic/screening procedure done in conjunction with a routine/preventive exam						-				6,575		6,575	6,575
40	Charges do not meet qualifications for emergent/urgent care						-	393				5,536	5,929	5,929
206	National Provider Identifier - missing			6			6		734	2,383	1,957	728	5,802	5,808
B5	Coverage/program guidelines were not met or were exceeded						-				5,238	50	5,288	5,288
250	The attachment/other documentation that was received was the incorrect attachment/document The expected attachment/document is still missing			34			34	17	2,831	1,758			4,606	4,640
60	Charges for outpatient services are not covered when performed within a period of time prior to or after inpatient services				177	2	179				3,226	136	3,362	3,541
B20	Procedure/service was partially or fully furnished by another provider		46			175	221		1,171		4	1,856	3,031	3,252
31	Patient cannot be identified as our insured				2	2	4	1,531	1,012	1	130	50	2,724	2,728
10	The diagnosis is inconsistent with the patient's gender		55	49			104		792	1,306	7	4	2,109	2,213
7	The procedure/revenue code is inconsistent with the patient's gender		1				1		859	1,016	263		2,138	2,139
54	Multiple physicians/assistants are not covered in this case						-	198	280	675		956	2,109	2,109
129	Prior processing information appears incorrect		30				30		1,700			100	1,800	1,830

CARC Code		Emergency						Non-Emergency						MCO Total
		ABH	ACLA	HB	LHC	UHC	Total	ABH	ACLA	HB	LHC	UHC	Total	
216	Based on the findings of a review organization						-			1	1,821		1,822	1,822
35	Lifetime benefit maximum has been reached						-		1,801				1,801	1,801
136	Failure to follow prior payer's coverage rules (Use only with Group Code OA)					125	125				33	1,621	1,654	1,779
170	Payment is denied when performed/billed by this type of provider					12	12	947	245			44	1,236	1,248
B14	Only one visit or consultation per physician per day is covered		133		273		406		604	48	49		701	1,107
246	This non-payable code is for required reporting only						-		966		9		975	975
171	Payment is denied when performed/billed by this type of provider in this type of facility						-	915				5	920	920
46	This (these) service(s) is (are) not covered						-	805	4	3			812	812
24	Charges are covered under a capitation agreement/managed care plan		2		12		14		471		297		768	782
169	Alternate benefit has been provided		24				24		726	1			727	751
177	Patient has not met the required eligibility requirements			6			6	13		590	119		722	728
282	The procedure/revenue code is inconsistent with the type of bill			715			715			4			4	719
164	Attachment/other documentation referenced on the claim was not received in a timely fashion				8		8				507		507	515
110	Billing date predates service date						-		1			431	432	432
189	'Not otherwise classified' or 'unlisted' procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service						-		394	3	5		402	402
243	Services not authorized by network/primary care providers						-			46	287		333	333
193	Original payment decision is being maintained Upon review, it was determined that this claim was processed properly						-				238		238	238
B12	Services not documented in patient's medical records						-			199	1		200	200
112	Service not furnished directly to the patient and/or not documented					38	38		2			107	109	147
D20	Claim/Service missing service/product information							66	77				143	143
249	This claim has been identified as a readmission (Use only with Group Code CO)										138		138	138

CARC Code		Emergency						Non-Emergency						MCO Total
		ABH	ACLA	HB	LHC	UHC	Total	ABH	ACLA	HB	LHC	UHC	Total	
261	The procedure or service is inconsistent with the patient's history						-	127					127	127
210	Payment adjusted because pre-certification/authorization not received in a timely fashion										63		63	63
167	This (these) diagnosis(es) is (are) not covered Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present								38				38	38
28	Coverage not in effect at the time the service was provided									38			38	38
239	Claim spans eligible and ineligible periods of coverage Rebill separate claims							20		11		3	34	34
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										30		30	30
20	This injury/illness is covered by the liability carrier								29				29	29
284	Precertification/authorization/notification/pre-treatment number may be valid but does not apply to the billed services									27			27	27
260	Processed under Medicaid ACA Enhanced Fee Schedule									26			26	26
223	Adjustment code for mandated federal, state or local law/regulation that is not already covered by another code and is mandated before a new code can be created										24		24	24
B11	The claim/service has been transferred to the proper payer/processor for processing Claim/service not covered by this payer/processor											24	24	24
56	Procedure/treatment has not been deemed 'proven to be effective' by the payer						-			3		15	18	18
52	The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed									18			18	18
34	Insured has no coverage for newborns										17		17	17
108	Rent/purchase guidelines were not met								1			15	16	16
149	Lifetime benefit maximum has been reached for this service/benefit category								2		3	10	15	15

CARC Code		Emergency						Non-Emergency						MCO Total
		ABH	ACLA	HB	LHC	UHC	Total	ABH	ACLA	HB	LHC	UHC	Total	
15	The authorization number is missing, invalid, or does not apply to the billed services or provider									12			12	12
183	The referring provider is not eligible to refer the service billed									12			12	12
70	Cost outlier - Adjustment to compensate for additional costs											12	12	12
19	This is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier								3		2		5	5
200	Expenses incurred during lapse in coverage						-	4					4	4
258	Claim/service not covered when patient is in custody/incarcerated Applicable federal, state or local authority may cover the claim/service									4			4	4
280	Claim received by the medical plan, but benefits not available under this plan Submit these services to the patient's Pharmacy plan for further consideration									4			4	4
D16	Claim lacks prior payer payment information								3				3	3
212	Administrative surcharges are not covered								2				2	2
91	Dispensing fee adjustment									2			2	2
233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error						-					1	1	1
14	The date of birth follows the date of service									1			1	1
1	Deductible Amount										1		1	1
13	The date of death precedes the date of service										1		1	1
267	Claim/service spans multiple months											1	1	1
275	Prior payer's (or payers') patient responsibility (deductible, coinsurance, co-payment) not covered									1			1	1
47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid									1			1	1
51	These are non-covered services because this is a pre-existing condition										1		1	1

Source: 173 Denied Claims Report

[1]Inpatient hospital denied claim counts are reported at the header level. Denied claims counts for all other provider types are reported at the line level. Excludes pharmacy claims which are reported in the second table this appendix.

[2]Each claim denied may have mutliple CARC codes therefore totals includes duplication. Emergency services are defined as claim type 03 with revenue codes 450, 459, or 981 (outpatient hosptial) and claim type 04 with procedure codes 99281 through 99285 (professional).

APPENDIX VIII - MCO Denied Pharmacy Claims, July 1, 2018 - June 30, 2019[1]

by National Council for Prescription Drug Program (NCPDP) reject code, emergency vs non-emergency[2]

NCPDP Code		Emergency						Non-Emergency						Total
		ABH	ACLA	HB	LHC	UHC	Total	ABH	ACLA	HB	LHC	UHC	Total	
79	Refill Too Soon	3	1	3	63	53	123	218,244	268,687	360,929	566,971	185,529	1,600,360	1,600,483
76	Plan Limitations Exceeded	23	3		113	249	388	202,722	200,322	132,518	362,946	339,592	1,238,100	1,238,488
70	Product/Service Not Covered – Plan/Benefit Exclusion	29	2	1	88	910	1,030	136,501	215,164	91,770	371,874	374,442	1,189,751	1,190,781
88	DUR Reject Error	20	5		24	435	484	34,966	93,435	249,222	50,363	564,053	992,039	992,523
75	Prior Authorization Required	62		3	89	85	239	121,721	30,267	262,632	128,255	115,099	657,974	658,213
41	Submit Bill To Other Processor Or Primary Payer				36	374	410	10,967	27,104	26,375	138,190	99,470	302,106	302,516
69	Filled After Coverage Terminated	5				641	646	74,290	2,050	59,911		120,889	257,140	257,786
MR	Product Not On Formulary								18,245	205,470		.	223,715	223,715
39	M/I Diagnosis Code		1				1	23,674	167,971	6,266		16	197,927	197,928
65	Patient Is Not Covered					506	506	740	82,040	2,304	1	96,110	181,195	181,701
7X	Days Supply Exceeds Plan Limitation							33	22,544	141,110	67	.	163,754	163,754
19	M/I Days Supply	2					2	86,547	23	3,084		247	89,901	89,903
80	Drug-Diagnosis Mismatch					28	28	523		57		68,151	68,731	68,759
AC	Product Not Covered Non-Participating Manufacturer								15,220	49,299		.	64,519	64,519
77	Discontinued Product/Service ID Number				6	32	38	9,425	4,871	13,137	11,014	18,280	56,727	56,765
50	Non-Matched Pharmacy Number					134	134	579	11,697	1,874		36,033	50,183	50,317
83	Duplicate Paid/Captured Claim				4		4	4,791	2,074	14,622	7,597	9,855	38,939	38,943
AG	Days Supply Limitation For Product/Service				6		6	894		34	35,946	.	36,874	36,880
44	Plan's Prescriber data base indicates the associated DEA to submitted Prescriber ID Is not found					42	42	7,165	8,076	1,654		17,217	34,112	34,154
54	Non-Matched Product/Service ID Number								15,706	15,135	1	.	30,842	30,842
13	M/I Other Coverage Code	1					1	22,439	532	3,317		200	26,488	26,489
46	Plan's Prescriber data base indicates associated DEA to submitted Prescriber ID does not allow this drug DEA Schedule					2	2	155	20,195	31		3,130	23,511	23,513
22	M/I Dispense As Written (DAW)/Product Selection Code				1		1	1,292	17,514	160	4,208	14	23,188	23,189
40	Pharmacy Not Contracted With Plan On Date Of Service							2,850	924	11,463	7,628	.	22,865	22,865
09	M/I Date Of Birth					13	13	4,630	5,156	652		8,463	18,901	18,914
21	M/I Product/Service ID					12	12	3,251	53	928		11,418	15,650	15,662
85	Claim Not Processed					6	6	54		15,700		1,295	17,049	17,055
CB	M/I Patient Last Name					35	35			47		16,005	16,052	16,087
E7	M/I Quantity Dispensed				2	1	3	642	1,215	296	3,297	3,852	9,302	9,305
9G	Quantity Dispensed Exceeds Maximum Allowed								14,874	102		.	14,976	14,976
10	M/I Patient Gender Code					8	8	181		8		13,890	14,079	14,087
78	Cost Exceeds Maximum					3	3		10,225	581		1,736	12,542	12,545
96	Scheduled Downtime									12,209		.	12,209	12,209
04	M/I Processor Control Number							239		11,219		.	11,458	11,458

NCPDP Code		Emergency						Non-Emergency						Total
		ABH	ACLA	HB	LHC	UHC	Total	ABH	ACLA	HB	LHC	UHC	Total	
7C	M/I Other Payer ID									10,368		154	10,522	10,522
6C	M/I Other Payer ID Qualifier							3		10,302		1	10,306	10,306
R9	Value In Gross Amount Due Does Not Follow Pricing Formulae									9,661		.	9,661	9,661
M2	Recipient Locked In					12	12			5,388		3,069	8,457	8,469
DV	M/I Other Payer Amount Paid							1,021	1,807	5,035		.	7,863	7,863
EV	M/I Prior Authorization Number Submitted					1	1	3		6,554		1,151	7,708	7,709
9E	Quantity Does Not Match Dispensing Unit									7,627		.	7,627	7,627
8W	Discrepancy Between Other Coverage Code and Other Payer Amount Paid							393		6,445	436	.	7,274	7,274
7M	Discrepancy Between Other Coverage Code And Other Coverage Information On File				1		1	1,854		933	4,012	.	6,799	6,800
JE	M/I Percentage Sales Tax Basis Submitted									6,728		50	6,778	6,778
HE	M/I Percentage Sales Tax Rate Submitted								13	6,310		.	6,323	6,323
7J	Patient Relationship Code Value Not Supported									6,209		.	6,209	6,209
777	Plan's Prescriber data base not able to verify active state license with prescriptive authority for Prescriber ID Submitted									5,858		.	5,858	5,858
E6	M/I Result Of Service Code			2		1	3			5,674		87	5,761	5,764
621	This Medicaid Patient Is Medicare Eligible									5,688		.	5,688	5,688
E5	M/I Professional Service Code			2			2	27		5,211	169	240	5,647	5,649
922	Morphine Milligram Equivalent (MME)Exceeds Limits*	2			1		3	1,075	2,099	318	1,871	.	5,363	5,366
PE	M/I Request Coordination Of Benefits/Other Payments Segment								38	4,857		.	4,895	4,895
620	This Product/Service May Be Covered Under Medicare Part D									4,765		.	4,765	4,765
33	M/I Prescription Origin Code					1	1	1,208	9	487		2,867	4,571	4,572
R2	Other Payer Reject Count Does Not Match Number Of Repetitions									26		4,536	4,562	4,562
446	COB/Other Payments Segment Incorrectly Formatted								4,578			.	4,578	4,578
25	M/I Prescriber ID							1,549	582	936		1,069	4,136	4,136
56	Non-Matched Prescriber ID					7	7	545	141	57		2,850	3,593	3,600
818	Medication Administration Not Covered, Plan Benefit Exclusion	3					3	3,112		532	76	.	3,720	3,723
NR	M/I Other Payer-Patient Responsibility Amount Count									3,667		9	3,676	3,676
DQ	M/I Usual And Customary Charge					4	4	254	816	896		1,195	3,161	3,165
8K	DAW Code Value Not Supported									3,031		.	3,031	3,031
1V	Multiple Transactions Not Supported								2,992			.	2,992	2,992
11	M/I Patient Relationship Code									2,928		2	2,930	2,930
5E	M/I Other Payer Reject Count							1		2,762		.	2,763	2,763
17	M/I Fill Number					5	5	1,877	1	274		541	2,693	2,698
816	Pharmacy Benefit Exclusion, May Be Covered Under Patient's Medical Benefit									2,586		.	2,586	2,586

NCPDP Code		Emergency						Non-Emergency						Total
		ABH	ACLA	HB	LHC	UHC	Total	ABH	ACLA	HB	LHC	UHC	Total	
7W	Refills Exceed allowable Refills								314	2,071		.	2,385	2,385
G4	Physician must contact plan				1		1			318	1,865	.	2,183	2,184
GE	M/I Percentage Sales Tax Amount Submitted									1,305		818	2,123	2,123
A1	ID Submitted is associated with a Sanctioned Prescriber					2	2	210	1,507	106	50	239	2,112	2,114
8R	Submission Clarification Code Value Not Supported							1		2,059		.	2,060	2,060
443	Other Payer-Patient Responsibility Amount Grouping Incorrect									1,947		.	1,947	1,947
7V	Duplicate Refills									1,870		.	1,870	1,870
HB	M/I Other Payer Amount Paid Count									1,731		47	1,778	1,778
99	Host Processing Error							20	1,689	15		.	1,724	1,724
52	Non-Matched Cardholder ID									1,695		.	1,695	1,695
95	Time Out								1,593			.	1,593	1,593
EU	M/I Prior Authorization Type Code					1	1			931		591	1,522	1,523
619	Prescriber Type 1 NPI Required							8	1,300	191		.	1,499	1,499
9V	Prescriber ID Qualifier Submitted Not Covered									1,487		.	1,487	1,487
81	Claim Too Old							140	161	749		463	1,513	1,513
645	Repackaged product is not covered by the contract								354	1,056		.	1,410	1,410
67	Filled Before Coverage Effective							297	9	267		717	1,290	1,290
8E	M/I DUR/PPS Level Of Effort					1	1			1,227		12	1,239	1,240
43	Plan's Prescriber data base indicates the associated DEA to submitted Prescriber ID is inactive					1	1	447	622	55		106	1,230	1,231
609	COB Claim Not Required, Patient Liability Amount Submitted Was Zero									1,159		.	1,159	1,159
DU	M/I Gross Amount Due								1,028	22		.	1,050	1,050
E1	M/I Product/Service ID Qualifier					1	1			950		44	994	995
60	Product/Service Not Covered For Patient Age								982	9		.	991	991
EZ	M/I Prescriber ID Qualifier							12		469		403	884	884
BB	Diagnosis Code Qualifier Submitted Not Covered									898		.	898	898
557	COB Segment Present On A Non-COB Claim				1		1	196	5	83	599	.	883	884
545	Prescription Origin Code Value Not Supported								808			.	808	808
15	M/I Date of Service								13	781		.	794	794
28	M/I Date Prescription Written							33		384		368	785	785
NQ	M/I Other Payer-Patient Responsibility Amount							731	1	20		.	752	752
7D	Non-Matched DOB								711			.	711	711
42	Plan's Prescriber data base indicates the Prescriber ID Submitted is inactive or expired							239	84	316		.	639	639
34	M/I Submission Clarification Code							4		621		13	638	638
82	Claim Is Post-Dated								182			445	627	627
DN	M/I Basis Of Cost Determination									556		62	618	618
E4	M/I Reason For Service Code									540		52	592	592
6E	M/I Other Payer Reject Code							1		525		.	526	526
EW	M/I Intermediary Authorization Type ID									491		.	491	491
35	M/I Primary Care Provider ID									158		250	408	408

NCPDP Code		Emergency						Non-Emergency						Total
		ABH	ACLA	HB	LHC	UHC	Total	ABH	ACLA	HB	LHC	UHC	Total	
R0	Professional Service Code of "MA" required for Vaccine Incentive Fee Submitted								137	313		.	450	450
30	Reversal request outside processor reversal window									440		.	440	440
E3	M/I Incentive Amount Submitted				2		2	22	130	57	72	116	397	399
73	Refills Are Not Covered								340	9		.	349	349
E9	M/I Provider ID									339		8	347	347
6T	Compound Segment Required For Adjudication							80		55	205	.	340	340
E2	M/I Route of Administration									322		.	322	322
O5										317		.	317	317
23	M/I Ingredient Cost Submitted							25	34	249		3	311	311
R6	Product/Service Not Appropriate For This Location									238	31	.	269	269
600	Coverage Outside Submitted Date Of Service								264			.	264	264
05	M/I Service Provider Number							5		9		247	261	261
61	Product/Service Not Covered For Patient Gender							250		3		.	253	253
08	M/I Person Code									250		.	250	250
895	Allowed Number of Overrides Exhausted									226		.	226	226
AB	Date Written Is After Date Filled									207		.	207	207
E8	M/I Other Payer Date								16	190		.	206	206
543	Prescriber ID Qualifier Value Not Supported								200			.	200	200
5C	M/I Other Payer Coverage Type					2	2	7		119		47	173	175
4Y	Patient Residence Value Not Supported									175		.	175	175
7Q	Other Payer ID Qualifier Value Not Supported									170		.	170	170
20	M/I Compound Code								3	154		11	168	168
HA	M/I Flat Sales Tax Amount Submitted											157	157	157
92	System Unavailable/Host Unavailable											166	166	166
RE	M/I Compound Product ID Qualifier							120		40		.	160	160
A6	This Product/Service May Be Covered Under Medicare Part B									155		.	155	155
HC	M/I Other Payer Amount Paid Qualifier							14	5	126		3	148	148
8N	Future Date Prescription Written Not Allowed,								16	113		.	129	129
6Z	Provider Not Eligible To Perform Service/Dispense Product								3	122		.	125	125
C2										124		.	124	124
47	Reserved for future use									116		.	116	116
H9	M/I Other Amount Claimed Submitted									113		.	113	113
EF	M/I Compound Dosage Form Description Code					2	2			66		41	107	109
9M	Minimum Of Two Ingredients Required					1	1					103	103	104
CX	M/I Patient ID Qualifier									70		40	110	110
71	Prescriber ID Is Not Covered									74		19	93	93
C1										89		.	89	89
DY	M/I Date Of Injury									84		.	84	84
PT	M/I Request Worker's Compensation Segment									84		.	84	84
55	Non-Matched Product Package Size								77			.	77	77
H8	M/I Other Amount Claimed Submitted Qualifier									72		.	72	72
465	Patient ID Qualifier Does Not Precede Patient ID									68		.	68	68

NCPDP Code		Emergency						Non-Emergency						Total
		ABH	ACLA	HB	LHC	UHC	Total	ABH	ACLA	HB	LHC	UHC	Total	
NX	M/I Submission Clarification Code Count									1		63	64	64
4C	M/I Coordination Of Benefits/Other Payments Count											62	62	62
8Z	Product/Service ID Qualifier Value Not Supported									63		.	63	63
XF										56		.	56	56
831	Product Service ID Carve-Out, Bill Medicaid Fee For Service									50		.	50	50
SG	Submission Clarification Code Count Does Not Match Number of Repetitions									39		7	46	46
2N	M/I Prescriber State/Province Address							2		46		.	48	48
WE	M/I Diagnosis Code Qualifier									14		31	45	45
XH										48		.	48	48
CA	M/I Patient First Name									41		6	47	47
29	M/I Number Of Refills Authorized								45			.	45	45
827	Pharmacy Service Provider Is Temporarily Suspended From Processing Claims By Payer/Processor									45		.	45	45
3M	M/I Prescriber Phone Number									40		.	40	40
NP	M/I Other Payer-Patient Responsibility Amount Qualifier							4	1	31		.	36	36
EK	M/I Scheduled Prescription ID Number									35		.	35	35
EG	M/I Compound Dispensing Unit Form Indicator									33		.	33	33
PF	M/I Request Compound Segment									33		.	33	33
442	Other Payer Amount Paid Grouping Incorrect									32		.	32	32
478	Other Payer ID Qualifier Does Not Precede Other Payer ID									31		.	31	31
AD	Billing Provider Not Eligible To Bill This Claim Type							1		28		.	29	29
FC										29		.	29	29
8D	Compound Segment Present On A Non-Compound Claim									28		.	28	28
YE	Submission Clarification Code Count Exceeds Number of Occurrences Supported									24		.	24	24
CY	M/I Patient ID									10		13	23	23
EX	M/I Intermediary Authorization ID									23		.	23	23
51	Non-Matched Group ID									22		.	22	22
7P	Coordination Of Benefits/Other Payments Count Exceeds Number of Supported Payers									22		.	22	22
P3	Compound Ingredient Component Count Does Not Match Number Of Repetitions									22		.	22	22
SF	Other Payer Amount Paid Count Does Not Match Number Of Repetitions									20	2	.	22	22
XJ										17		.	17	17
G1	M/I Compound Type									16		.	16	16
7B	Service Provider ID Qualifier Value Not Supported For Processor/Payer								11	4		.	15	15
J9	M/I DUR Co-Agent ID Qualifier									8		9	17	17
614	Uppercase Character(s) Required									14		.	14	14

NCPDP Code		Emergency						Non-Emergency						Total
		ABH	ACLA	HB	LHC	UHC	Total	ABH	ACLA	HB	LHC	UHC	Total	
480	Other Payer Amount Paid Qualifier Does Not Precede Other Payer Amount Paid									13		.	13	13
YC	Other Payer Reject Count Exceeds Number Of Occurrences Supported									13		.	13	13
01	M/I Bin Number									11		.	11	11
26	M/I Unit Of Measure									11		.	11	11
CM	M/I Patient Street Address									11		.	11	11
CO	M/I Patient State/Province Address									10		.	10	10
SH	Other Payer-Patient Responsibility Amount Count Does Not Match Number of Repetitions									10		.	10	10
32	M/I Level Of Service									3		3	6	6
AK	M/I Software Vendor/Certification ID									9		.	9	9
H6	M/I DUR Co-Agent ID									3		7	10	10
P4	Coordination Of Benefits/Other Payments Count Does Not Match Number Of Repetitions									9		.	9	9
A2	ID Submitted is associated to a Deceased Prescriber								8			.	8	8
CP	M/I Patient Zip/Postal Zone							1		6	1	.	8	8
6N	Prescriber Segment Required For Adjudication								7			.	7	7
6P	Pricing Segment Required For Adjudication									7		.	7	7
7G	Future Date Not Allowed For DOB											7	7	7
H7	M/I Other Amount Claimed Submitted Count									1		7	8	8
MV	M/I Benefit Stage Qualifier									4		3	7	7
P8	DUR/PPS Code Counter Out Of Sequence									5		3	8	8
PH	M/I Request DUR/PPS Segment									7		.	7	7
RK	Partial Fill Transaction Not Supported								4			3	7	7
02	M/I Version/Release Number							1	4		1	.	6	6
1W	Multi-Ingredient Compound Must Be A Single Transaction									6		.	6	6
441	Other Amount Claimed Submitted Grouping Incorrect									6		.	6	6
469	Submission Clarification Code Count Does Not Precede Submission Clarification Code									6		.	6	6
488	DUR/PPS Code Counter Does Not Precede DUR Data Fields									6		.	6	6
489	DUR Co-Agent ID Qualifier Does Not Precede DUR Co-Agent ID									6		.	6	6
PC	M/I Request Claim Segment									6		.	6	6
12	M/I Place of Service							1				4	5	5
37										5		.	5	5
474	Prescriber Id Qualifier Does Not Precede Prescriber ID									5		.	5	5
DR	M/I Prescriber Last Name									5		.	5	5
EE	M/I Compound Ingredient Drug Cost									5		.	5	5
TS	M/I Pay To Qualifier											4	4	4
2K	M/I Prescriber Street Address									4		.	4	4

NCPDP Code		Emergency						Non-Emergency						Total
		ABH	ACLA	HB	LHC	UHC	Total	ABH	ACLA	HB	LHC	UHC	Total	
472	Other Amount Claimed Submitted Qualifier Does Not Precede Other Amount Claimed Submitted									4		.	4	4
9J	Future Other Payer Date Not Allowed									4		.	4	4
9Z	Duplicate Product ID In Compound									4		.	4	4
MW	M/I Benefit Stage Amount									4		.	4	4
06	M/I Group ID							2		1		.	3	3
616	Submission Clarification Code 8 Required When Compound Ingredient Quantity Is 0									3		.	3	3
8F										3		.	3	3
U7	M/I Pharmacy Service Type											2	2	2
VE	M/I Diagnosis Code Count											5	5	5
14	M/I Eligibility Clarification Code									1		1	2	2
2P	M/I Prescriber Zip/Postal Zone									2		.	2	2
444	Benefit Stage Amount Grouping Incorrect									2		.	2	2
445	Diagnosis Code Grouping Incorrect									2		.	2	2
483	Other Payer-Patient Responsibility Amount Qualifier Does Not Precede Other Payer-Patient Responsibility Amount									2		.	2	2
519	DUR/PPS Level Of Effort Value Not Supported									2		.	2	2
66	Patient Age Exceeds Maximum Age									2		.	2	2
7E	M/I DUR/PPS Code Counter									2		.	2	2
7Y	Compounds Not Covered,							1			1	.	2	2
87	Reversal Not Processed									2		.	2	2
876	Prescriptive Authority Restrictions Apply, Criteria Not Met									2		.	2	2
B2	M/I Service Provider ID Qualifier									2		.	2	2
CN	M/I Patient City Address									2		.	2	2
ED	M/I Compound Ingredient Quantity									2		.	2	2
EY	M/I Provider ID Qualifier									2		.	2	2
MX	Benefit Stage Count Does Not Match Number Of Repetitions									2		.	2	2
RJ	Associated Partial Fill Transaction Not On File								2			.	2	2
07	M/I Cardholder ID									1		.	1	1
16	M/I Prescription/Service Reference Number									1		.	1	1
2E	M/I Primary Care Provider ID Qualifier									1		.	1	1
2M	M/I Prescriber City Address									1		.	1	1
470	Originally Prescribed Product/Service ID Qualifier Does Not Precede Originally Prescribed Product/Service Code									1		.	1	1
481	Other Payer Reject Count Does Not Precede Other Payer Reject Code									1		.	1	1
485	Benefit Stage Qualifier Does Not Precede Benefit Stage Amount									1		.	1	1
494	Diagnosis Code Qualifier Does Not Precede Diagnosis Code									1		.	1	1

NCPDP Code		Emergency						Non-Emergency						Total
		ABH	ACLA	HB	LHC	UHC	Total	ABH	ACLA	HB	LHC	UHC	Total	
7R	Other Payer Amount Paid Count Exceeds Number of Supported Groupings									1		.	1	1
8Q	Excessive Refills Authorized									1		.	1	1
CQ	M/I Patient Phone Number									1		.	1	1
EB	M/I Originally Prescribed Quantity											1	1	1
EJ	M/I Originally Prescribed Product/Service ID Qualifier											1	1	1
HF	M/I Quantity Intended To Be Dispensed									1		.	1	1
HG	M/I Days Supply Intended To Be Dispensed									1		.	1	1
M9										1		.	1	1
O1										1		.	1	1
P7	Diagnosis Code Count Does Not Match Number Of Repetitions									1		.	1	1
PD	M/I Request Clinical Segment									1		.	1	1
R1	Other Amount Claimed Submitted Count Does Not Match Number Of Repetitions									1		.	1	1
X9	Diagnosis Code Count Exceeds Number Of Occurrences Supported									1		.	1	1

Source: 173 Denied Claims Report

[1]Denied claim counts for pharmacy are reported at the line level

[2] Each claim denied may have mutliple NCPDP codes and are therefore totals includes duplication

APPENDIX VIII - MCNA Denied Claims, July 1, 2018 - June 30, 2019[1]

by claims adjustment reason code (CARC), emergency vs. non-emergency[2]

CARC		Emergency	Non-Emergency	MCNA Total
169	Alternate benefit has been provided.	43	59,577	59,620
18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	69	51,001	51,070
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	6	31,338	31,344
222	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	5	29,552	29,557
6	The procedure/revenue code is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	4	24,321	24,325
22	This care may be covered by another payer per coordination of benefits.	26	13,037	13,063
49	This is a non-covered service because it is a routine/preventive exam or a diagnostic/screening procedure done in conjunction with a routine/preventive exam. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	32	11,348	11,380
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	9	9,913	9,922
16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	29	9,613	9,642
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	8	9,442	9,450
272	Coverage/program guidelines were not met.	7	6,792	6,799

CARC		Emergency	Non-Emergency	MCNA Total
236	This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/ fee schedule requirements.		5,011	5,011
27	Expenses incurred after coverage terminated.		4,488	4,488
242	Services not provided by network/primary care providers.		4,178	4,178
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	5	3,569	3,574
269	Anesthesia not covered for this service/procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	9	3,500	3,509
29	The time limit for filing has expired.	3	2,401	2,404
226	Information requested from the Billing/Rendering Provider was not provided or not provided timely or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	4	1,960	1,964
206	National Provider Identifier - missing.		1,810	1,810
261	The procedure or service is inconsistent with the patient's history.		1,356	1,356
B20	Procedure/service was partially or fully furnished by another provider.	2	1,338	1,340
233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.	10	1,079	1,089
181	Procedure code was invalid on the date of service.	1	944	945
B14	Only one visit or consultation per physician per day is covered.		815	815
40	Charges do not meet qualifications for emergent/urgent care. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	40	751	791
56	Procedure/treatment has not been deemed 'proven to be effective' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	6	742	748
251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).		649	649
5	The procedure code/type of bill is inconsistent with the place of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		643	643
193	Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.	1	560	561
216	Based on the findings of a review organization		486	486

CARC		Emergency	Non-Emergency	MCNA Total
50	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	4	386	390
152	Payer deems the information submitted does not support this length of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	14	355	369
200	Expenses incurred during lapse in coverage		290	290
58	Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		242	242
185	The rendering provider is not eligible to perform the service billed. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		124	124
P14	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. To be used for Property and Casualty only.		110	110
26	Expenses incurred prior to coverage.		74	74
95	Plan procedures not followed.	2	62	64
223	Adjustment code for mandated federal, state or local law/regulation that is not already covered by another code and is mandated before a new code can be created.	4	43	47
9	The diagnosis is inconsistent with the patient's age. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		40	40
199	Revenue code and Procedure code do not match.		35	35
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		34	34
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability)		34	34
55	Procedure/treatment/drug is deemed experimental/investigational by the payer. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		33	33
146	Diagnosis was invalid for the date(s) of service reported.		32	32
31	Patient cannot be identified as our insured.		32	32

CARC		Emergency	Non-Emergency	MCNA Total
14	The date of birth follows the date of service.		31	31
39	Services denied at the time authorization/pre-certification was requested.		29	29
150	Payer deems the information submitted does not support this level of service.		8	8
204	This service/equipment/drug is not covered under the patient's current benefit plan		7	7
149	Lifetime benefit maximum has been reached for this service/benefit category.		4	4
140	Patient/Insured health identification number and name do not match.		4	4
170	Payment is denied when performed/billed by this type of provider. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		3	3
177	Patient has not met the required eligibility requirements.		3	3
253	Sequestration - reduction in federal payment		3	3
133	The disposition of this service line is pending further review. (Use only with Group Code OA). Usage: Use of this code requires a reversal and correction when the service line is finalized (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 837).		2	2
35	Lifetime benefit maximum has been reached.		2	2
P7	The applicable fee schedule/fee database does not contain the billed code. Please resubmit a bill with the appropriate fee schedule/fee database code(s) that best describe the service(s) provided and supporting documentation if required. To be used for Property and Casualty only.		2	2
23	The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)		1	1
182	Procedure modifier was invalid on the date of service.		1	1
167	This (these) diagnosis(es) is (are) not covered. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.		1	1
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.		1	1
15	The authorization number is missing, invalid, or does not apply to the billed services or provider.		1	1
19	This is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.		1	1
144	Incentive adjustment, e.g. preferred product/service.		1	1
173	Service/equipment was not prescribed by a physician.		1	1

Source: 173 Denied Claims Report

[1]Inpatient hospital denied claim counts are reported at the header level. Denied claims counts for all other provider types are reported at the line level. Excludes pharmacy claims which are reported in the second table this appendix.

[2]Each claim denied may have mutliple CARC codes therefore totals includes duplication. Emergency services are defined as claim type 03 with revenue codes 450, 459, or 981 (outpatient hosptial) and claim type 04 with procedure codes 99281 through 99285 (professional).