

APPENDIX VIII - MCO Denied Claims, July 1, 2019 - June 30, 2020¹

by claims adjustment reason code (CARC), emergency vs. non-emergency²

CARC Code	Emergency							Non-Emergency						MCO Total
	ABH	ACLA	HB	LHC	UHC	Total	ABH	ACLA	HB	LHC	UHC	Total		
18	Exact duplicate claim/service	4,648	238	9,587	11,758	5,485	31,716	244,734	16,547	527,236	382,333	188,546	1,359,396	1,391,112
96	Non-covered charge(s).	.	2,272	52	107	5,316	7,747	9,825	251,251	70,776	510,487	356,709	1,199,048	1,206,795
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	3,663	450	518	164	3,199	7,994	210,678	49,846	249,957	100,372	238,195	849,048	857,042
16	Claim/service lacks information or has submission/billing error(s).	38	3,310	4,961	704	3,787	12,800	5,126	102,978	243,818	277,254	108,037	737,213	750,013
197	Precertification/authorization/notification/pre-treatment absent.	1	.	6	96	19	122	11,279	132,024	140,391	261,534	134,604	679,832	679,954
252	An attachment/other documentation is required to adjudicate this claim/service.	.	3,401	2,880	.	13,938	20,219	186	52,779	87,548	3,763	242,114	386,390	406,609
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	.	.	40	144	8	192	12	125,515	3,697	207,448	25,025	361,697	361,889
204	This service/equipment/drug is not covered under the patient's current benefit plan	1,580	.	101	4,325	.	6,006	120,675	2,027	51,733	155,006	2,705	332,146	338,152
133	The disposition of this service line is pending further review.	3,490	.	.	423	228	4,141	270,047	3,004	98	27,681	11,279	312,109	316,250
29	The time limit for filing has expired.	396	834	892	1,395	1,390	4,907	26,595	48,368	63,009	82,097	61,799	281,868	286,775
27	Expenses incurred after coverage terminated.	.	4,093	4,276	733	5,843	14,945	.	56,842	82,257	16,724	93,498	249,321	264,266
256	Service not payable per managed care contract.	.	.	23	.	375	398	.	722	180,119	130	50,938	231,909	232,307
147	Provider contracted/negotiated rate expired or not on file.	180	1	.	.	.	181	227,268	620	.	.	.	227,888	228,069
4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	240	51	152	217	97	757	39,771	19,375	82,614	15,860	23,993	181,613	182,370
22	This care may be covered by another payer per coordination of benefits.	126	.	.	7,411	3	7,540	5,072	38	.	143,621	6,193	154,924	162,464
P14	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day.	.	.	.	545	.	545	149	.	637	167,789	.	168,575	169,120
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	.	.	4,293	458	.	4,751	.	.	106,798	30,797	.	137,595	142,346

CARC Code		Emergency						Non-Emergency						MCO Total
		ABH	ACLA	HB	LHC	UHC	Total	ABH	ACLA	HB	LHC	UHC	Total	
222	Exceeds the contracted maximum number of hours/days/units by this provider for this period.	.	.	18	92	.	110	.	506	19,331	71,920	242	91,999	92,109
109	Claim/service not covered by this payer/contractor.	.	4	2,954	150	1,388	4,496	1	5,912	63,484	23,634	27,751	120,782	125,278
A1	Claim/Service denied. At least one Remark Code must be provided.	.	.	.	4,986	2	4,988	.	362	2	119,084	458	119,906	124,894
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	.	17	.	206	776	999	453	963	2,283	14,330	93,733	111,762	112,761
6	The procedure/revenue code is inconsistent with the patient's age.	.	.	57	1	.	58	10,378	2,044	21,043	59,552	970	93,987	94,045
119	Benefit maximum for this time period or occurrence has been reached.	.	.	244	1	.	245	6,927	9,161	35,712	54,479	239	106,518	106,763
26	Expenses incurred prior to coverage.	2,529	209	411	350	452	3,951	42,197	5,003	9,674	4,420	9,940	71,234	75,185
23	The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)	.	.	206	1,312	.	1,518	.	42	5,867	59,180	.	65,089	66,607
8	The procedure code is inconsistent with the provider type/specialty (taxonomy).	.	2	.	.	2	4	1,204	9,699	27,241	20,955	7,222	66,321	66,325
11	The diagnosis is inconsistent with the procedure.	.	.	88	4	.	92	4,488	17,768	8,361	18,375	8,617	57,609	57,701
5	The procedure code/type of bill is inconsistent with the place of service.	.	32	103	302	129	566	.	8,086	12,210	20,381	10,588	51,265	51,831
169	Alternate benefit has been provided.	.	42	.	.	.	42	.	961	.	.	.	961	1,003
198	Precertification/notification/authorization/pre-treatment exceeded.	.	.	.	.	.	-	1,254	9,102	18,304	17,650	4,928	51,238	51,238
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.	.	13	.	1	.	14	154	15,887	.	29,527	.	45,568	45,582
B8	Alternative services were available, and should have been utilized.	.	.	.	.	.	-	.	.	.	.	40,961	40,961	40,961
B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.	27	.	216	.	143	386	6,077	144	11,786	3,179	15,943	37,129	37,515
95	Plan procedures not followed.	.	38	.	.	.	38	.	31,999	4	.	.	32,003	32,041
39	Services denied at the time authorization/pre-certification was requested.	.	.	.	.	1	1	1,830	3,999	10,785	4,373	7,197	28,184	28,185
234	This procedure is not paid separately.	.	61	.	.	64	125	2	2,717	6,832	14,354	2,570	26,475	26,600

CARC Code		Emergency					Non-Emergency						MCO Total	
		ABH	ACLA	HB	LHC	UHC	Total	ABH	ACLA	HB	LHC	UHC		Total
206	National Provider Identifier - missing.	.	.	15	.	.	15	.	218	18,676	2,553	163	21,610	21,625
9	The diagnosis is inconsistent with the patient's age.	.	9	.	43	17	69	.	413	92	10,612	9,234	20,351	20,420
107	The related or qualifying claim/service was not identified on this claim.	.	1	4	.	.	5	.	13,393	4,069	3,009	.	20,471	20,476
251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim.	.	314	13	1	.	328	.	4,513	3,466	4,557	4,147	16,683	17,011
242	Services not provided by network/primary care providers.	.	.	.	9	.	9	1,210	1,098	2,689	6,996	.	11,993	12,002
B23	Procedure billed is not authorized per your Clinical Laboratory Improvement Amendment (CLIA) proficiency test.	.	.	.	.	.	-	.	9,938	.	5,033	.	14,971	14,971
273	Coverage/program guidelines were exceeded.	.	29	.	11	.	40	.	181	11,701	2,398	.	14,280	14,320
272	Coverage/program guidelines were not met.	.	.	.	15	.	15	6	3,740	5	2,786	2	6,539	6,554
150	Payer deems the information submitted does not support this level of service.	.	.	34	.	.	34	.	2,251	6,883	165	4,229	13,528	13,562
58	Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.	.	106	.	.	11	117	.	4,624	131	6,569	1,621	12,945	13,062
246	This non-payable code is for required reporting only.	.	.	.	.	.	-	.	12,500	.	1	.	12,501	12,501
59	Processed based on multiple or concurrent procedure rules.	.	.	.	.	5	5	11	197	4,617	4	6,343	11,172	11,177
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.	.	.	.	.	.	-	.	.	.	195	.	195	195
216	Based on the findings of a review organization	.	.	.	8	.	8	.	.	2	10,494	.	10,496	10,504
128	Newborn's services are covered in the mother's Allowance.	.	.	.	.	1	1	.	2,432	2,327	.	5,759	10,518	10,519
B16	'New Patient' qualifications were not met.	.	.	.	.	.	-	.	45	6,443	1,095	2,853	10,436	10,436
226	Information requested from the Billing/Rendering Provider was not provided or not provided timely or was insufficient/incomplete.	.	.	48	.	.	48	.	139	8,048	.	.	8,187	8,235
60	Charges for outpatient services are not covered when performed within a period of time prior to or after inpatient services.	.	.	.	517	8	525	.	.	.	8,217	250	8,467	8,992
243	Mutually exclusive procedures cannot be done in the same day/setting.	.	1	10	.	.	11	1,682	919	5,428	89	125	8,243	8,254

CARC Code		Emergency					Non-Emergency						MCO Total	
		ABH	ACLA	HB	LHC	UHC	Total	ABH	ACLA	HB	LHC	UHC		Total
151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.	2	.	.	.	.	2	8,036	4	.	1	170	8,211	8,213
146	Diagnosis was invalid for the date(s) of service reported.	26	9	.	1	15	51	2,984	1,663	54	1,257	839	6,797	6,848
208	National Provider Identifier - Not matched.	.	1	.	.	.	1	.	5,006	276	262	29	5,573	5,574
50	These are non-covered services because this is not deemed a 'medical necessity' by the payer.	.	.	.	.	.	-	.	142	2,054	1,975	619	4,790	4,790
199	Revenue code and Procedure code do not match.	16	.	693	.	.	709	891	1,343	1,685	.	.	3,919	4,628
7	The procedure/revenue code is inconsistent with the patient's gender.	.	.	.	.	.	-	.	446	715	3,523	.	4,684	4,684
55	Procedure/treatment/drug is deemed experimental/investigational by the payer.	.	.	.	.	.	-	.	359	4,237	.	.	4,596	4,596
250	The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing.	.	.	36	.	.	36	20	2,781	1,626	.	.	4,427	4,463
185	The rendering provider is not eligible to perform the service billed.	.	.	.	4	.	4	.	3,649	11	545	.	4,205	4,209
31	Patient cannot be identified as our insured.	.	.	.	2	1	3	845	3,166	3	65	120	4,199	4,202
181	Procedure code was invalid on the date of service.	.	.	.	.	1	1	529	2,257	24	26	20	2,856	2,857
182	Procedure modifier was invalid on the date of service.	2	17	.	.	1	20	60	3,313	.	2	85	3,460	3,480
164	Attachment/other documentation referenced on the claim was not received in a timely fashion.	.	.	.	29	.	29	.	.	.	3,112	.	3,112	3,141
40	Charges do not meet qualifications for emergent/urgent care.	.	.	.	.	.	-	367	.	.	.	2,044	2,411	2,411
B14	Only one visit or consultation per physician per day is covered.	.	136	.	369	.	505	7	847	18	7	.	879	1,384
B20	Procedure/service was partially or fully furnished by another provider.	.	25	.	.	103	128	.	425	.	.	1,103	1,528	1,656
10	The diagnosis is inconsistent with the patient's gender.	.	27	42	.	.	69	.	1,026	1,408	13	1	2,448	2,517
54	Multiple physicians/assistants are not covered in this case.	.	.	.	.	.	-	224	452	722	.	917	2,315	2,315
163	Attachment/other documentation referenced on the claim was not received.	.	.	.	.	.	-	.	1,904	.	.	255	2,159	2,159
171	Payment is denied when performed/billed by this type of provider in this type of facility.	.	.	.	.	.	-	1,935	.	.	.	.	1,935	1,935
112	Service not furnished directly to the patient and/or not documented.	.	.	.	.	70	70	.	.	.	.	1,790	1,790	1,860

CARC Code		Emergency					Non-Emergency						MCO Total	
		ABH	ACLA	HB	LHC	UHC	Total	ABH	ACLA	HB	LHC	UHC		Total
136	Failure to follow prior payer's coverage rules. (Use only with Group Code OA)	.	.	.	.	96	96	.	.	.	54	1,554	1,608	1,704
261	The procedure or service is inconsistent with the patient's history.	.	.	.	.	.	-	88	.	.	.	.	88	88
170	Payment is denied when performed/billed by this type of provider.	.	.	.	.	9	9	144	343	.	.	798	1,285	1,294
177	Patient has not met the required eligibility requirements.	.	.	9	.	.	9	1	.	655	521	.	1,177	1,186
56	Procedure/treatment has not been deemed 'proven to be effective' by the payer.	.	.	.	.	.	-	.	.	.	.	48	48	48
110	Billing date predates service date.	.	.	.	.	.	-	.	14	.	.	904	918	918
24	Charges are covered under a capitation agreement/managed care plan.	.	.	.	50	.	50	.	16	.	690	.	706	756
183	The referring provider is not eligible to refer the service billed.	.	.	9	.	.	9	5	.	636	.	.	641	650
209	Per regulatory or other agreement. The provider cannot collect this amount from the patient.	.	.	.	.	.	-	.	647	.	.	.	647	647
65	Procedure code was incorrect. This payment reflects the correct code.	.	.	.	.	.	-	.	607	.	.	.	607	607
189	'Not otherwise classified' or 'unlisted' procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service	.	.	.	.	.	-	.	593	1	7	.	601	601
193	Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.	.	.	.	.	.	-	.	.	.	51	.	51	51
200	Expenses incurred during lapse in coverage	.	.	.	.	.	-	5	.	.	.	.	5	5
129	Prior processing information appears incorrect.	.	7	.	.	1	8	.	297	.	.	77	374	382
260	Processed under Medicaid ACA Enhanced Fee Schedule	.	.	.	.	.	-	.	.	197	.	.	197	197
152	Payer deems the information submitted does not support this length of service.	.	.	.	.	.	-	.	23	.	.	.	23	23
B12	Services not documented in patient's medical records.	.	.	.	.	.	-	.	.	174	.	.	174	174
38	Services not provided or authorized by designated (network/primary care) providers.	.	.	.	.	.	-	.	.	.	157	.	157	157
35	Lifetime benefit maximum has been reached.	.	.	.	.	.	-	.	144	.	.	.	144	144
34	Insured has no coverage for newborns.	.	.	.	.	.	-	.	.	.	73	.	73	73
239	Claim spans eligible and ineligible periods of coverage. Rebill separate claims.	.	.	.	.	.	-	55	.	12	.	.	67	67

CARC Code		Emergency						Non-Emergency						MCO Total
		ABH	ACLA	HB	LHC	UHC	Total	ABH	ACLA	HB	LHC	UHC	Total	
115	Procedure postponed, canceled, or delayed.	.	.	.	.	.	-	.	45	1	.	.	46	46
B1	Non-covered visits.	.	.	.	.	.	-	.	43	.	.	.	43	43
284	Precertification/authorization/notification/pre-treatment number may be valid but does not apply to the billed services.	.	.	.	.	.	-	6	.	35	.	.	41	41
20	This injury/illness is covered by the liability carrier.	.	.	.	.	.	-	.	40	.	.	.	40	40
167	This (these) diagnosis(es) is (are) not covered.	.	.	.	.	.	-	.	36	.	2	.	38	38
243	Services not authorized by network/primary care providers.	.	.	.	.	.	-	.	.	1	35	.	36	36
14	The date of birth follows the date of service.	.	.	.	.	.	-	.	.	4	.	.	4	4
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.	.	.	.	.	.	-	.	.	.	22	.	22	22
210	Payment adjusted because pre-certification/authorization not received in a timely fashion	.	.	.	.	.	-	.	.	.	21	.	21	21
184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	.	.	.	.	.	-	.	.	19	.	.	19	19
13	The date of death precedes the date of service.	.	.	.	.	.	-	.	.	.	14	.	14	14
63	Correction to a prior claim.	.	.	.	.	.	-	.	14	.	.	.	14	14
108	Rent/purchase guidelines were not met.	.	.	.	.	.	-	.	5	.	.	5	10	10
158	Service/procedure was provided outside of the United States.	.	.	.	.	.	-	.	.	7	.	.	7	7
P21	Payment denied based on the Medical Payments Coverage (MPC) and/or Personal Injury Protection (PIP) Benefits jurisdictional regulations, or payment policies.	.	.	.	.	.	-	.	7	.	.	.	7	7
101	Predetermination: anticipated payment upon completion of services or claim adjudication.	.	.	.	.	.	-	.	6	.	.	.	6	6
140	Patient/Insured health identification number and name do not match.	.	.	.	.	.	-	.	.	.	.	2	2	2
B11	The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.	.	.	.	.	.	-	.	.	.	.	5	5	5
135	Interim bills cannot be processed.	.	.	.	.	.	-	.	.	4	.	.	4	4

CARC Code		Emergency						Non-Emergency						MCO Total
		ABH	ACLA	HB	LHC	UHC	Total	ABH	ACLA	HB	LHC	UHC	Total	
111	Not covered unless the provider accepts assignment.	.	.	.	.	.	-	.	3	.	.	.	3	3
279	Services not provided by Preferred network providers.	.	.	.	.	.	-	.	3	.	.	.	3	3
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.	.	.	.	.	.	-	.	.	3	.	.	3	3
282	The procedure/revenue code is inconsistent with the type of bill.	.	.	.	.	.	-	.	.	3	.	.	3	3
186	Level of care change adjustment.	.	.	.	.	.	-	.	2	.	.	.	2	2
19	This is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.	.	.	.	.	.	-	.	.	.	1	.	1	1
21	This injury/illness is the liability of the no-fault carrier.	.	.	.	.	.	-	.	.	.	.	2	2	2
249	This claim has been identified as a readmission. (Use only with Group Code CO)	.	.	.	.	.	-	.	.	.	2	.	2	2
3	Co-payment Amount	.	.	.	.	.	-	.	.	.	.	2	2	2
69	Day outlier amount.	.	.	.	.	.	-	.	.	.	.	2	2	2
212	Administrative surcharges are not covered	.	.	.	.	.	-	.	1	.	.	.	1	1
91	Dispensing fee adjustment.	.	.	.	.	.	-	1	.	.	.	.	1	1

Source: 173 Denied Claims Report

¹Inpatient 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.

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

APPENDIX VIII - MCO Denied Pharmacy Claims, July 1, 2019 - June 30, 2020¹

by National Council for Prescription Drug Program (NCPDP) reject code, emergency vs non-emergency²

NCPDP Code	Emergency						Non-Emergency						Total
	ABH	ACLA	HB	LHC	UHC	Total	ABH	ACLA	HB	LHC	UHC	Total	
79 Refill Too Soon	20,847	.	10	78	1	20,936	217,974	206,632	460,971	622,805	143,985	1,652,367	1,673,303
70 Product/Service Not Covered – Plan/Benefit Exclusion	8,058	.	7	23	19	8,107	69,706	134,652	237,974	244,980	440,547	1,127,859	1,135,966
88 DUR Reject Error	2,871	.	4	161	12	3,048	30,125	116,261	145,920	192,817	580,835	1,065,958	1,069,006
75 Prior Authorization Required	21,588	.	24	180	3	21,795	225,135	96,083	248,447	397,129	72,927	1,039,721	1,061,516
76 Plan Limitations Exceeded	14,232	.	2	78	317	14,629	138,744	20,712	70,573	247,952	323,564	801,545	816,174
MR Product Not On Formulary	5,498	.	2	10	.	5,510	39,120	121,469	130,165	67,887	.	358,641	364,151
69 Filled After Coverage Terminated	7,806	.	2	.	1	7,809	71,571	9,406	99,305	.	110,132	290,414	298,223
41 Submit Bill To Other Processor Or Primary Payer	689	.	.	29	7	725	9,363	23,645	29,867	107,427	124,634	294,936	295,661
7X Days Supply Exceeds Plan Limitation	1	.	1	.	.	2	25	130,079	155,460	77	.	285,641	285,643
39 M/I Diagnosis Code	4,059	.	.	.	.	4,059	42,490	122,048	59,403	.	3	223,944	228,003
65 Patient Is Not Covered	.	.	.	.	.	.	.	.	11	.	117,456	117,467	117,467
19 M/I Days Supply	8,212	.	.	.	.	8,212	69,266	88	172	.	32,605	102,131	110,343
AC Product Not Covered Non-Participating Manufacturer	.	.	.	.	.	.	.	73,409	2	.	.	73,411	73,411
9G Quantity Dispensed Exceeds Maximum Allowed	.	.	.	.	.	.	.	64,117	.	.	.	64,117	64,117
77 Discontinued Product/Service ID Number	441	.	1	8	.	450	6,583	.	10,582	18,618	23,697	59,480	59,930
22 M/I Dispense As Written (DAW)/Product Selection Code	1,204	.	.	28	.	1,232	13,094	11,439	6	31,326	7	55,872	57,104
50 Non-Matched Pharmacy Number	26	.	1	.	.	27	426	1,665	5,498	.	38,993	46,582	46,609
80 Drug-Diagnosis Mismatch	.	.	.	.	.	.	37	.	33	.	42,440	42,510	42,510
83 Duplicate Paid/Captured Claim	273	.	.	6	.	279	3,564	.	23,114	7,842	6,552	41,072	41,351
13 M/I Other Coverage Code	1,765	.	.	.	.	1,765	20,435	3,240	7,440	.	270	31,385	33,150
44 Plan's Prescriber data base indicates the associated DEA to submitted Prescriber ID is not found	571	.	.	.	.	571	5,368	3,267	9,078	.	14,149	31,862	32,433
40 Pharmacy Not Contracted With Plan On Date Of Service	403	.	.	.	.	403	1,915	5,413	11,362	8,003	.	26,693	27,096
606 Brand Drug / Specific Labeler Code Required	.	.	.	.	.	.	.	19,733	.	.	.	19,733	19,733
04 M/I Processor Control Number	21	.	.	.	.	21	173	.	18,773	.	.	18,946	18,967
09 M/I Date Of Birth	352	.	.	.	.	352	3,317	28	7,683	.	7,014	18,042	18,394
DV M/I Other Payer Amount Paid	92	.	.	.	.	92	1,319	10,411	3,982	.	.	15,712	15,804
E7 M/I Quantity Dispensed	56	.	.	2	.	58	777	500	1,340	2,404	10,388	15,409	15,467
21 M/I Product/Service ID	199	.	.	.	1	200	1,472	240	2,938	.	9,272	13,922	14,122
CB M/I Patient Last Name	.	.	.	.	.	.	33	.	4	.	13,604	13,641	13,641
7M Discrepancy Between Other Coverage Code And Other Coverage Information On File	185	.	.	.	.	185	1,787	.	4,643	6,009	.	12,439	12,624
890 Pharmacy Not Enrolled in State Medicaid Program	.	.	.	.	.	.	12,423	.	.	.	.	12,423	12,423
99 Host Processing Error	3	.	.	.	.	3	61	11,322	32	.	.	11,415	11,418
95 Time Out	.	.	.	.	.	.	.	10,313	.	.	.	10,313	10,313
10 M/I Patient Gender Code	.	.	.	.	.	.	.	.	1	.	10,076	10,077	10,077
34 M/I Submission Clarification Code	.	.	.	.	.	.	220	8,160	744	.	159	9,283	9,283
60 Product/Service Not Covered For Patient Age	.	.	.	.	.	.	2,625	3,385	.	3,153	.	9,163	9,163

NCPDP Code	Emergency						Non-Emergency						Total	
	ABH	ACLA	HB	LHC	UHC	Total	ABH	ACLA	HB	LHC	UHC	Total		
38	M/I Basis Of Cost Determination	.	.	.	.	.	.	8,016	.	.	.	8,016	8,016	
922	Morphine Milligram Equivalent (MME)Exceeds Limits*	239	.	.	3	.	242	1,421	.	2,144	3,019	.	6,584	6,826
33	M/I Prescription Origin Code	123	.	.	.	.	123	1,170	39	2,549	.	2,904	6,662	6,785
M2	Recipient Locked In	.	.	1	.	.	1	309	.	2,685	2	3,301	6,297	6,298
818	Medication Administration Not Covered, Plan Benefit Exclusion.	650	.	.	.	.	650	2,377	.	2,791	233	.	5,401	6,051
17	M/I Fill Number	129	.	.	.	.	129	1,453	2	1,985	4	2,364	5,808	5,937
R2	Other Payer Reject Count Does Not Match Number Of Repetitions	.	.	.	.	1	1	.	.	.	.	5,808	5,808	5,809
85	Claim Not Processed	.	.	.	.	1	1	33	.	690	.	4,977	5,700	5,701
54	Non-Matched Product/Service ID Number	.	.	.	.	.	.	.	5,554	2	1	.	5,557	5,557
25	M/I Prescriber ID	120	.	.	.	.	120	1,108	1,350	1,770	.	883	5,111	5,231
G4	Physician must contact plan	.	.	.	3	.	3	.	.	2,126	2,968	.	5,094	5,097
DN	M/I Basis Of Cost Determination	.	.	.	6	.	6	998	.	367	1,569	1,061	3,995	4,001
78	Cost Exceeds Maximum	.	.	.	.	1	1	.	375	.	.	3,510	3,885	3,886
557	COB Segment Present On A Non-COB Claim	52	.	.	.	.	52	560	58	445	2,564	.	3,627	3,679
82	Claim Is Post-Dated	.	.	.	.	.	.	.	3,445	.	.	155	3,600	3,600
DQ	M/I Usual And Customary Charge	34	.	.	.	.	34	277	835	850	.	1,436	3,398	3,432
6E	M/I Other Payer Reject Code	.	.	.	.	.	.	.	.	3,350	.	.	3,350	3,350
8W	Discrepancy Between Other Coverage Code and Other Payer Amount Paid	23	.	.	.	.	23	343	.	2,440	494	.	3,277	3,300
46	Plan's Prescriber data base indicates associated DEA to submitted Prescriber ID does not allow this drug DEA Schedule	4	.	.	.	.	4	119	240	162	.	2,561	3,082	3,086
56	Non-Matched Prescriber ID	42	.	.	.	.	42	533	89	763	.	1,613	2,998	3,040
545	Prescription Origin Code Value Not Supported	.	.	.	.	.	.	.	2,991	.	.	.	2,991	2,991
8R	Submission Clarification Code Value Not Supported	1	.	.	.	.	1	346	222	257	1,824	.	2,649	2,650
7D	Non-Matched DOB	.	.	.	.	.	.	.	2,397	.	.	.	2,397	2,397
619	Prescriber Type 1 NPI Required	.	.	.	.	.	.	13	.	824	.	1,334	2,171	2,171
645	Repackaged product is not covered by the contract.	.	.	.	.	.	.	.	1,914	.	.	.	1,914	1,914
7W	Refills Exceed allowable Refills	.	.	.	.	.	.	.	1,708	3	.	.	1,711	1,711
81	Claim Too Old	43	.	.	.	.	43	110	2	1,078	.	224	1,414	1,457
EV	M/I Prior Authorization Number Submitted	.	.	.	.	.	.	.	225	38	.	1,097	1,360	1,360
E5	M/I Professional Service Code	57	.	.	.	.	57	111	68	322	339	218	1,058	1,115
43	Plan's Prescriber data base indicates the associated DEA to submitted Prescriber ID is inactive	22	.	.	.	.	22	227	274	426	.	139	1,066	1,088
67	Filled Before Coverage Effective	20	.	.	.	.	20	211	95	324	.	438	1,068	1,088
NQ	M/I Other Payer-Patient Responsibility Amount	68	.	.	.	.	68	783	1	178	.	.	962	1,030
7C	M/I Other Payer ID	6	.	.	.	.	6	34	.	570	69	259	932	938
GE	M/I Percentage Sales Tax Amount Submitted	.	.	.	.	.	.	.	.	22	.	849	871	871
61	Product/Service Not Covered For Patient Gender	104	.	.	.	.	104	592	.	3	.	87	682	786
543	Prescriber ID Qualifier Value Not Supported	.	.	.	.	.	.	.	715	.	.	.	715	715
42	Plan's Prescriber data base indicates the Prescriber ID Submitted is inactive or expired	7	.	.	.	.	7	108	90	329	.	163	690	697

NCPDP Code		Emergency						Non-Emergency						Total
		ABH	ACLA	HB	LHC	UHC	Total	ABH	ACLA	HB	LHC	UHC	Total	
6C	M/I Other Payer ID Qualifier	6	.	.	.	.	6	34	.	574	78	2	688	694
H9	M/I Other Amount Claimed Submitted	16	.	.	.	.	16	151	.	430	6	.	587	603
EZ	M/I Prescriber ID Qualifier	4	.	.	.	.	4	12	.	9	.	520	541	545
1V	Multiple Transactions Not Supported	.	.	.	.	.	.	.	477	.	.	.	477	477
A1	ID Submitted is associated with a Sanctioned Prescriber	.	.	.	.	.	.	28	238	18	38	69	391	391
R6	Product/Service Not Appropriate For This Location	.	.	.	.	.	.	.	.	297	51	.	348	348
6T	Compound Segment Required For Adjudication	6	.	.	1	.	7	77	.	92	167	.	336	343
01	M/I Bin Number	.	.	.	.	.	.	.	331	9	.	.	340	340
EU	M/I Prior Authorization Type Code	.	.	.	.	.	.	.	.	7	.	330	337	337
52	Non-Matched Cardholder ID	.	.	.	.	.	.	.	.	329	.	.	329	329
05	M/I Service Provider Number	.	.	.	.	.	.	8	.	11	.	271	290	290
RE	M/I Compound Product ID Qualifier	8	.	.	.	.	8	100	.	176	.	.	276	284
AD	Billing Provider Not Eligible To Bill This Claim Type	.	.	.	.	.	.	.	.	280	3	.	283	283
28	M/I Date Prescription Written	1	.	.	.	.	1	8	1	5	.	245	259	260
CP	M/I Patient Zip/Postal Zone	.	.	.	.	.	.	58	.	95	94	.	247	247
E3	M/I Incentive Amount Submitted	7	.	.	.	.	7	13	.	57	70	71	211	218
PE	M/I Request Coordination Of Benefits/Other Payments Segment	.	.	.	.	.	.	.	106	102	.	.	208	208
92	System Unavailable/Host Unavailable	.	.	.	.	.	.	.	.	.	.	203	203	203
HE	M/I Percentage Sales Tax Rate Submitted	.	.	.	.	.	.	.	73	116	.	13	202	202
7J	Patient Relationship Code Value Not Supported	.	.	.	.	.	.	.	.	189	.	.	189	189
30	Reversal request outside processor reversal window.	.	.	.	.	.	.	.	.	179	.	.	179	179
HB	M/I Other Payer Amount Paid Count	.	.	.	.	.	.	.	2	33	.	143	178	178
35	M/I Primary Care Provider ID	.	.	.	.	.	.	.	.	.	.	174	174	174
6Z	Provider Not Eligible To Perform Service/Dispense Product	.	.	.	.	.	.	.	165	.	.	.	165	165
9M	Minimum Of Two Ingredients Required	.	.	.	.	.	.	.	.	.	.	157	157	157
JE	M/I Percentage Sales Tax Basis Submitted	.	.	.	.	.	.	.	.	99	.	46	145	145
891	Days Supply Is Less Than Plan Minimum	1	.	.	.	.	1	.	.	134	1	.	135	136
E8	M/I Other Payer Date	.	.	.	.	.	.	9	86	28	7	.	130	130
8A	Compound Requires At Least One Covered Ingredient	.	.	.	.	.	.	.	125	.	.	.	125	125
23	M/I Ingredient Cost Submitted	.	.	.	.	.	.	37	21	61	.	.	119	119
8N	Future Date Prescription Written Not Allowed,	.	.	.	.	.	.	.	108	8	.	.	116	116
5C	M/I Other Payer Coverage Type	.	.	.	.	.	.	3	.	37	.	73	113	113
HC	M/I Other Payer Amount Paid Qualifier	.	.	.	.	.	.	16	33	60	.	3	112	112
600	Coverage Outside Submitted Date Of Service	.	.	.	.	.	.	.	101	.	.	.	101	101
609	COB Claim Not Required, Patient Liability Amount Submitted Was Zero	.	.	.	.	.	.	.	.	98	.	.	98	98
11	M/I Patient Relationship Code	.	.	.	.	.	.	.	.	86	.	1	87	87
E6	M/I Result Of Service Code	.	.	.	.	.	.	.	.	10	.	77	87	87
4C	M/I Coordination Of Benefits/Other Payments Count	.	.	.	.	.	.	.	.	.	.	77	77	77
06	M/I Group ID	.	.	.	.	.	.	51	.	23	.	.	74	74
05	HBL only: PRESCRIBER NOT ALLOWED	.	.	.	.	.	.	.	.	73	.	.	73	73

NCPDP Code		Emergency						Non-Emergency						Total
		ABH	ACLA	HB	LHC	UHC	Total	ABH	ACLA	HB	LHC	UHC	Total	
NR	M/I Other Payer-Patient Responsibility Amount Count	.	.	.	.	.	.	.	.	64	.	7	71	71
29	M/I Number Of Refills Authorized	.	.	.	.	.	.	.	60	.	.	.	60	60
E1	M/I Product/Service ID Qualifier	.	.	.	.	.	.	.	6	17	.	37	60	60
AG	Days Supply Limitation For Product/Service	3	.	.	.	.	3	53	.	.	.	.	53	56
5E	M/I Other Payer Reject Count	.	.	.	.	.	.	.	.	54	.	.	54	54
02	M/I Version/Release Number	2	.	.	.	.	2	26	4	.	12	.	42	44
NX	M/I Submission Clarification Code Count	.	.	.	.	.	.	.	.	.	.	44	44	44
96	Scheduled Downtime	.	.	.	.	.	.	.	.	43	.	.	43	43
EF	M/I Compound Dosage Form Description Code	.	.	.	.	.	.	.	.	3	.	38	41	41
E4	M/I Reason For Service Code	.	.	.	.	.	.	.	.	3	.	33	36	36
R9	Value In Gross Amount Due Does Not Follow Pricing Formulae	.	.	.	.	.	.	.	.	33	.	.	33	33
71	Prescriber ID Is Not Covered	.	.	.	.	.	.	.	4	7	.	21	32	32
CX	M/I Patient ID Qualifier	.	.	.	.	.	.	.	.	2	.	30	32	32
608	Step Therapy, Alternate Drug Therapy Required Prior To Use Of Submitted Product Service ID	.	.	.	.	.	.	.	30	.	.	.	30	30
E9	M/I Provider ID	.	.	.	.	.	.	.	.	19	.	10	29	29
R0	Professional Service Code of "MA" required for Vaccine Incentive Fee Submitted	.	.	.	.	.	.	.	.	26	.	.	26	26
BB	Diagnosis Code Qualifier Submitted Not Covered	.	.	.	.	.	.	.	.	25	.	.	25	25
20	M/I Compound Code	.	.	.	.	.	.	.	22	1	.	.	23	23
8S	Basis Of Cost Determination Value Not Supported	.	.	.	.	.	.	.	22	.	.	.	22	22
47		.	.	.	.	.	.	.	.	20	.	.	20	20
RK	Partial Fill Transaction Not Supported	.	.	.	.	.	.	.	7	.	.	13	20	20
816	Pharmacy Benefit Exclusion, May Be Covered Under Patient's Medical Benefit	.	.	.	.	.	.	.	19	.	.	.	19	19
A2	ID Submitted is associated to a Deceased Prescriber	.	.	.	.	.	.	.	18	.	.	.	18	18
7B	Service Provider ID Qualifier Value Not Supported For Processor/Payer	.	.	.	.	.	.	.	17	.	.	.	17	17
AB	Date Written Is After Date Filled	.	.	.	.	.	.	.	.	17	.	.	17	17
H6	M/I DUR Co-Agent ID	.	.	.	.	.	.	.	.	.	.	16	16	16
6N	Prescriber Segment Required For Adjudication	.	.	.	.	.	.	.	14	.	.	.	14	14
WE	M/I Diagnosis Code Qualifier	.	.	.	.	.	.	.	.	.	.	13	13	13
2N	M/I Prescriber State/Province Address	3	.	.	.	.	3	6	.	3	.	.	9	12
E2	M/I Route of Administration	.	.	.	.	.	.	.	.	12	.	.	12	12
7V	Duplicate Refills,	.	.	.	.	.	.	.	.	11	.	.	11	11
NP	M/I Other Payer-Patient Responsibility Amount Qualifier	.	.	.	.	.	.	4	3	3	.	.	10	10
08	M/I Person Code	.	.	.	.	.	.	.	.	9	.	.	9	9
CA	M/I Patient First Name	.	.	.	.	.	.	.	.	2	.	7	9	9
CY	M/I Patient ID	.	.	.	.	.	.	.	.	.	.	9	9	9
7Q	Other Payer ID Qualifier Value Not Supported	.	.	.	.	.	.	.	.	8	.	.	8	8
C1	HBL only: MEM/DEP COVERED BY ANOTHER CARRIER	.	.	.	.	.	.	.	.	8	.	.	8	8
3M	M/I Prescriber Phone Number	.	.	.	.	.	.	.	.	7	.	.	7	7

NCPDP Code	Emergency						Non-Emergency						Total	
	ABH	ACLA	HB	LHC	UHC	Total	ABH	ACLA	HB	LHC	UHC	Total		
7G	Future Date Not Allowed For DOB											7	7	7
AK	M/I Software Vendor/Certification ID								7				7	7
J9	M/I DUR Co-Agent ID Qualifier										7		7	7
SG	Submission Clarification Code Count Does Not Match Number of Repetitions										6		6	6
443	Other Payer-Patient Responsibility Amount Grouping Incorrect								5				5	5
MV	M/I Benefit Stage Qualifier										5		5	5
P8	DUR/PPS Code Counter Out Of Sequence										5		5	5
SF	Other Payer Amount Paid Count Does Not Match Number Of Repetitions								3	2			5	5
XF									5				5	5
12	M/I Place of Service								4				4	4
32	M/I Level Of Service										4		4	4
8E	M/I DUR/PPS Level Of Effort										4		4	4
8Z	Product/Service ID Qualifier Value Not Supported								4				4	4
P4	Coordination Of Benefits/Other Payments Count Does Not Match Number Of Repetitions						1		3				4	4
73	Refills Are Not Covered								3				3	3
7P	Coordination Of Benefits/Other Payments Count Exceeds Number of Supported Payers								3				3	3
8B	Compound Segment Missing On A Compound Claim							3					3	3
8F									3				3	3
PF	M/I Request Compound Segment								3				3	3
U7	M/I Pharmacy Service Type										3		3	3
465	Patient ID Qualifier Does Not Precede Patient ID								2				2	2
7Y	Compounds Not Covered,									2			2	2
FC									2				2	2
H7	M/I Other Amount Claimed Submitted Count										2		2	2
H8	M/I Other Amount Claimed Submitted Qualifier										2		2	2
-											1		1	1
16	M/I Prescription/Service Reference Number							1					1	1
2K	M/I Prescriber Street Address								1				1	1
37									1				1	1
CO	M/I Patient State/Province Address								1				1	1
DU	M/I Gross Amount Due								1				1	1
EJ	M/I Originally Prescribed Product/Service ID Qualifier										1		1	1
MU	M/I Benefit Stage Count										1		1	1
P3	Compound Ingredient Component Count Does Not Match Number Of Repetitions								1				1	1
VE	M/I Diagnosis Code Count										1		1	1

Source: 173 Denied Claims Report

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

²Each claim denied may have multiple NCPDP codes and are therefore totals includes duplication