APPENDIX XVII - MCNA Denied Claims, July 1, 2019 - June 30, 2020[1]

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

CARC		Emergency	Non-Emergency	MCNA Total
169	Alternate benefit has been provided.	64	50,879	50,943
18	Exact duplicate claim/service	132	43,907	44,039
96	Non-covered charge(s).	21	35,866	35,887
222	Exceeds the contracted maximum number of hours/days/units by this provider for this period.	20	33,343	33,363
6	The procedure/revenue code is inconsistent with the patient's age.	9	21,106	21,115
252	An attachment/other documentation is required to adjudicate this claim/service.	48	14,608	14,656
22	This care may be covered by another payer per coordination of benefits.	43	13,939	13,982
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.	75	10,748	10,823
16	Claim/service lacks information or has submission/billing error(s).	82	9,740	9,822
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	21	7,575	7,596
272	Coverage/program guidelines were not met.	24	7,051	7,075
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.	2	5,604	5,606
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	28	5,349	5,377
27	Expenses incurred after coverage terminated.	2	4,739	4,741
242	Services not provided by network/primary care providers.	.	4,153	4,153
269	Anesthesia not covered for this service/procedure.	26	3,738	3,764
206	National Provider Identifier - missing.	3	2,811	2,814
29	The time limit for filing has expired.	6	1,686	1,692
261	The procedure or service is inconsistent with the patient's history.	2	1,526	1,528
B14	Only one visit or consultation per physician per day is covered.	7	1,443	1,450
226	Information requested from the Billing/Rendering Provider was not provided or not provided timely or was insufficient/incomplete.	8	1,300	1,308
56	Procedure/treatment has not been deemed 'proven to be effective' by the payer.	10	1,106	1,116
B20	Procedure/service was partially or fully furnished by another provider.	51	941	992
251	The attachment/other documentation that was received was incomplete or deficient. The necessary information is still needed to process the claim.	6	979	985

CARC		Emergency	Non-Emergency	MCNA Total
169	Alternate benefit has been provided.	64	50,879	50,943
18	Exact duplicate claim/service	132	43,907	44,039
9	The diagnosis is inconsistent with the patient's age.	.	885	885
181	Procedure code was invalid on the date of service.	12	842	854
50	These are non-covered services because this is not deemed a 'medical necessity' by the payer.	14	755	769
5	The procedure code/type of bill is inconsistent with the place of service.	1	765	766
233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.	16	655	671
40	Charges do not meet qualifications for emergent/urgent care.	79	391	470
200	Expenses incurred during lapse in coverage	6	440	446
216	Based on the findings of a review organization	10	435	445
193	Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.	1	406	407
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	.	236	236
149	Lifetime benefit maximum has been reached for this service/benefit category.	.	216	216
26	Expenses incurred prior to coverage.	.	206	206
152	Payer deems the information submitted does not support this length of service.	12	153	165
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.	.	107	107
185	The rendering provider is not eligible to perform the service billed.	.	95	95
58	Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.	.	89	89
B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.	.	78	78
95	Plan procedures not followed.	1	76	77
199	Revenue code and Procedure code do not match.	1	55	56
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	3	45	48
146	Diagnosis was invalid for the date(s) of service reported.	.	45	45
250	The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing.	.	30	30
14	The date of birth follows the date of service.	.	24	24
107	The related or qualifying claim/service was not identified on this claim.	.	21	21
133	The disposition of this service line is pending further review.	.	11	11
55	Procedure/treatment/drug is deemed experimental/investigational by the payer.	.	11	11
163	Attachment/other documentation referenced on the claim was not received.	.	9	9

CARC		Emergency	Non-Emergency	MCNA Total
169	Alternate benefit has been provided.	64	50,879	50,943
18	Exact duplicate claim/service	132	43,907	44,039
276	Services denied by the prior payer(s) are not covered by this payer.	.	9	9
254	Claim received by the dental plan, but benefits not available under this plan. Submit these services to the patient's medical plan for further consideration.	5	3	8
173	Service/equipment was not prescribed by a physician.	2	3	5
253	Sequestration - reduction in federal payment	.	5	5
197	Precertification/authorization/notification/pre-treatment absent.	.	4	4
39	Services denied at the time authorization/pre-certification was requested.	.	4	4
170	Payment is denied when performed/billed by this type of provider.	.	4	4
140	Patient/Insured health identification number and name do not match.	.	4	4
204	This service/equipment/drug is not covered under the patient's current benefit plan	.	3	3
8	The procedure code is inconsistent with the provider type/specialty (taxonomy).	.	3	3
273	Coverage/program guidelines were exceeded.	.	3	3
150	Payer deems the information submitted does not support this level of service.	.	3	3
31	Patient cannot be identified as our insured.	.	3	3
23	The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)	.	2	2
177	Patient has not met the required eligibility requirements.	.	2	2
109	Claim/service not covered by this payer/contractor.	.	1	1
119	Benefit maximum for this time period or occurrence has been reached.	.	1	1
19	This is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.	.	1	1
103	Provider promotional discount (e.g., Senior citizen discount).	.	1	1
166	These services were submitted after this payers responsibility for processing claims under this plan ended.	.	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).