APPENDIX VII - MCO Denied Claims, July 1, 2020 - June 30, 2021[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	4,160	263	10,254	7,369	4,711	26,757	214,559	11,559	555,724	425,947	176,145	1,383,934	1,410,691
96	Non-covered charge(s).	68	2,301	71	452	5,678	8,570	91,421	278,773	60,416	593,260	349,400	1,373,270	1,381,840
16	Claim/service lacks information or has submission/billing error(s).	18	3,417	6,178	667	5,983	16,263	1,847	138,516	238,645	497,718	101,944	978,670	994,933
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	3,854	268	412	409	2,535	7,478	197,977	32,172	228,003	193,990	273,166	925,308	932,786
197	Precertification/authorization/notification/pre-treatment absent.	2	.	13	119	22	156	27,985	108,182	180,372	156,391	160,726	633,656	633,812
252	An attachment/other documentation is required to adjudicate this claim/service.	.	3,144	419	1	13,260	16,824	100	70,327	43,044	5,598	328,058	447,127	463,951
4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	202	28	129	92	98	549	107,548	28,515	192,281	56,721	38,901	423,966	424,515
204	This service/equipment/drug is not covered under the patient's current benefit plan	1,424	.	11	4,393	.	5,828	166,836	98	33,084	191,650	1,868	393,536	399,364
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	.	2	36	21	50	109	19	63,594	1,193	282,083	36,424	383,313	383,422
133	The disposition of this service line is pending further review.	4,113	.	.	563	36	4,712	283,322	.	51	80,323	2,574	366,270	370,982
256	Service not payable per managed care contract.	.	.	670	.	1,510	2,180	.	183	254,518	63	99,364	354,128	356,308
147	Provider contracted/negotiated rate expired or not on file.	2,443	3	.	.	.	2,446	325,264	7,445	.	17	.	332,726	335,172
29	The time limit for filing has expired.	574	943	1,081	2,091	1,527	6,216	24,807	45,897	53,694	87,043	50,845	262,286	268,502
27	Expenses incurred after coverage terminated.	.	2,207	2,019	989	3,250	8,465	.	47,761	58,898	29,141	83,414	219,214	227,679
22	This care may be covered by another payer per coordination of benefits.	148	.	.	7,109	3	7,260	13,296	138	.	169,998	6,523	189,955	197,215
109	Claim/service not covered by this payer/contractor.	.	5	3,034	83	222	3,344	.	8,124	95,724	21,895	33,611	159,354	162,698
119	Benefit maximum for this time period or occurrence has been reached.	.	.	194	.	.	194	10,638	17,777	31,569	77,075	130	137,189	137,383
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	.	113	.	2,497	567	3,177	654	670	2,929	26,608	71,070	101,931	105,108
242	Services not provided by network/primary care providers.	.	.	.	4	.	4	1,354	210	94,749	7,621	.	103,934	103,938
A1	Claim/Service denied.	.	.	.	3,599	.	3,599	.	56	.	91,325	118	91,499	95,098

CARC Code		Emergency						Non-Emergency						MCO Total
		ABH	ACLA	HB	LHC	UHC	Total	ABH	ACLA	HB	LHC	UHC	Total	
6	The procedure/revenue code is inconsistent with the patient's age.	.	.	80	.	.	80	9,188	2,857	21,176	59,192	1,954	94,367	**94,447**
8	The procedure code is inconsistent with the provider type/specialty (taxonomy).	.	3	.	4	.	7	945	35,931	21,111	18,889	8,113	84,989	**84,996**
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	.	.	4	1,334	.	1,338	.	.	9,623	71,810	.	81,433	**82,771**
11	The diagnosis is inconsistent with the procedure.	.	1	36	1	.	38	2,483	25,072	19,519	20,827	9,653	77,554	**77,592**
26	Expenses incurred prior to coverage.	1,559	126	356	53	339	2,433	40,456	6,397	12,913	1,946	11,564	73,276	**75,709**
222	Exceeds the contracted maximum number of hours/days/units by this provider for this period.	.	.	3	876	.	879	.	120	10,107	55,362	957	66,546	**67,425**
5	The procedure code/type of bill is inconsistent with the place of service.	.	21	144	177	178	520	.	9,268	22,446	5,715	25,174	62,603	**63,123**
B23	Procedure billed is not authorized per your Clinical Laboratory Improvement Amendment (CLIA) proficiency test.	.	.	.	.	.	-	.	13,320	.	48,810	.	62,130	**62,130**
198	Precertification/notification/authorization/pre-treatment exceeded.	.	.	.	.	.	-	1,554	5,856	22,612	21,774	4,015	55,811	**55,811**
23	The impact of prior payer(s) adjudication including payments and/or adjustments.	.	.	192	1,144	.	1,336	13	514	9,790	42,364	.	52,681	**54,017**
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	.	62	.	114	203	5,559	1,137	18,172	1,593	16,251	42,712	**42,915**
95	Plan procedures not followed.	.	29	.	.	.	29	.	40,695	260	325	1,360	42,640	**42,669**
234	This procedure is not paid separately.	.	30	.	141	41	212	.	2,337	7,284	27,696	2,373	39,690	**39,902**
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.	.	10	.	4	.	14	406	8,567	9	29,735	.	38,717	**38,731**
B8	Alternative services were available, and should have been utilized.	.	.	.	.	.	-	.	.	.	.	37,712	37,712	**37,712**
P14	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day.	.	.	.	.	.	-	233	.	1,077	34,583	.	35,893	**35,893**
107	The related or qualifying claim/service was not identified on this claim.	.	5	7	.	.	12	.	21,607	4,994	2,408	5,014	34,023	**34,035**
75	Direct Medical Education Adjustment.	.	.	.	.	.	-	33,810	.	.	.	.	33,810	**33,810**
251	The attachment/other documentation that was received was incomplete or deficient.	.	226	5	.	.	231	.	4,077	9,028	5,726	6,224	25,055	**25,286**

CARC Code		Emergency						Non-Emergency						MCO Total
		ABH	ACLA	HB	LHC	UHC	Total	ABH	ACLA	HB	LHC	UHC	Total	
60	Charges for outpatient services are not covered when performed within a period of time prior to or after inpatient services.	.	.	.	1,590	4	1,594	.	.	.	21,929	148	22,077	**23,671**
9	The diagnosis is inconsistent with the patient's age.	.	18	3	57	62	140	.	569	130	9,929	9,779	20,407	**20,547**
39	Services denied at the time authorization/pre-certification was requested.	.	.	.	1	4	5	2,389	2,490	5,995	3,640	4,553	19,067	**19,072**
246	This non-payable code is for required reporting only.	.	.	.	.	.	-	.	18,130	7	1	4	18,142	**18,142**
206	National Provider Identifier - missing.	.	.	22	.	.	22	.	42	13,765	859	2,776	17,442	**17,464**
151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.	2	.	.	.	.	2	16,318	11	.	.	105	16,434	**16,436**
273	Coverage/program guidelines were exceeded.	.	.	.	.	.	-	.	.	11,244	4,540	.	15,784	**15,784**
59	Processed based on multiple or concurrent procedure rules.	.	.	.	.	2	2	79	611	6,880	1	6,058	13,629	**13,631**
150	Payer deems the information submitted does not support this level of service.	.	.	.	.	1	1	.	2,011	3,921	1,256	5,529	12,717	**12,718**
B16	'New Patient' qualifications were not met.	.	.	.	.	.	-	.	197	7,168	879	4,061	12,305	**12,305**
58	Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.	.	45	.	.	34	79	.	3,844	151	5,137	2,484	11,616	**11,695**
146	Diagnosis was invalid for the date(s) of service reported.	15	5	.	15	2	37	3,147	1,501	435	5,198	494	10,775	**10,812**
128	Newborn's services are covered in the mother's Allowance.	.	.	1	.	.	1	.	2,267	3,969	.	4,476	10,712	**10,713**
199	Revenue code and Procedure code do not match.	45	.	498	.	.	543	1,355	2,847	5,364	.	.	9,566	**10,109**
231	Mutually exclusive procedures cannot be done in the same day/setting.	4	.	20	.	.	24	2,116	968	6,750	58	116	10,008	**10,032**
170	Payment is denied when performed/billed by this type of provider.	.	.	.	.	103	103	2,117	340	5,835	.	785	9,077	**9,180**
216	Based on the findings of a review organization	.	.	.	29	.	29	.	1	46	6,201	.	6,248	**6,277**
169	Alternate benefit has been provided.	.	25	.	.	.	25	.	5,805	.	.	.	5,805	**5,830**
226	Information requested from the Billing/Rendering Provider was not provided or not provided timely or was insufficient/incomplete.	.	.	.	.	.	-	.	.	5,400	.	.	5,400	**5,400**
182	Procedure modifier was invalid on the date of service.	3	43	.	.	5	51	1,182	4,075	.	5	83	5,345	**5,396**
171	Payment is denied when performed/billed by this type of provider in this type of facility.	1	.	.	.	.	1	5,069	.	.	.	.	5,069	**5,070**

CARC Code		Emergency						Non-Emergency						MCO Total
		ABH	ACLA	HB	LHC	UHC	Total	ABH	ACLA	HB	LHC	UHC	Total	
209	Per regulatory or other agreement. The provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to patient if collected.	.	.	.	.	.	-	.	4,214	.	.	.	4,214	**4,214**
7	The procedure/revenue code is inconsistent with the patient's gender.	.	.	.	69	.	69	.	261	535	3,108	.	3,904	**3,973**
50	These are non-covered services because this is not deemed a 'medical necessity' by the payer.	.	.	.	.	.	-	.	71	1,206	1,844	339	3,460	**3,460**
55	Procedure/treatment/drug is deemed experimental/investigational by the payer.	.	.	.	.	.	-	.	114	2,869	.	.	2,983	**2,983**
185	The rendering provider is not eligible to perform the service billed.	.	.	.	13	.	13	.	2,554	.	320	4	2,878	**2,891**
208	National Provider Identifier - Not matched.	.	.	1	.	.	1	.	2,716	122	4	30	2,872	**2,873**
10	The diagnosis is inconsistent with the patient's gender.	.	30	73	.	.	103	.	558	2,121	15	1	2,695	**2,798**
31	Patient cannot be identified as our insured.	.	1	.	.	8	9	1,105	1,274	188	30	136	2,733	**2,742**
54	Multiple physicians/assistants are not covered in this case.	.	.	.	.	.	-	545	307	778	2	1,097	2,729	**2,729**
12	The diagnosis is inconsistent with the provider type.	.	.	.	.	.	-	2,657	.	.	.	.	2,657	**2,657**
181	Procedure code was invalid on the date of service.	.	.	.	.	2	2	688	1,194	.	47	47	1,976	**1,978**
B20	Procedure/service was partially or fully furnished by another provider.	.	44	.	.	109	153	.	547	.	.	1,243	1,790	**1,943**
250	The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing.	1	.	26	.	.	27	96	.	1,803	.	.	1,899	**1,926**
B14	Only one visit or consultation per physician per day is covered.	.	184	.	399	.	583	6	1,073	56	8	.	1,143	**1,726**
272	Coverage/program guidelines were not met.	.	.	.	.	.	-	.	132	3	1,579	.	1,714	**1,714**
136	Failure to follow prior payer's coverage rules.	.	.	.	.	61	61	.	.	.	106	1,177	1,283	**1,344**
112	Service not furnished directly to the patient and/or not documented.	.	.	.	.	.	-	.	.	.	.	1,199	1,199	**1,199**
177	Patient has not met the required eligibility requirements.	3	.	.	.	.	3	26	.	351	597	.	974	**977**
24	Charges are covered under a capitation agreement/managed care plan.	.	.	.	32	.	32	.	15	.	900	.	915	**947**
189	'Not otherwise classified' or 'unlisted' procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service	.	.	.	.	.	-	.	847	.	7	.	854	**854**

CARC Code		Emergency						Non-Emergency						MCO Total
		ABH	ACLA	HB	LHC	UHC	Total	ABH	ACLA	HB	LHC	UHC	Total	
129	Prior processing information appears incorrect.	.	1	1	.	.	2	.	571	7	2	113	693	695
108	Rent/purchase guidelines were not met.	.	.	.	.	.	-	.	1	.	.	565	566	566
163	Attachment/other documentation referenced on the claim was not received.	.	4	.	.	.	4	.	378	.	.	.	378	382
183	The referring provider is not eligible to refer the service billed.	.	.	.	.	.	-	1	.	263	.	.	264	264
297	Claim received by the medical plan, but benefits not available under this plan. Submit these services to the patient's vision plan for further consideration.	.	.	.	.	.	-	.	.	257	.	.	257	257
184	The prescribing/ordering provider is not eligible to prescribe/order the service billed.	.	.	.	.	.	-	.	.	231	.	.	231	231
243	Services not authorized by network/primary care providers.	.	.	.	.	.	-	.	.	223	2	.	225	225
40	Charges do not meet qualifications for emergent/urgent care.	.	.	.	.	.	-	154	.	.	.	70	224	224
149	Lifetime benefit maximum has been reached for this service/benefit category.	.	.	.	.	.	-	28	1	157	.	.	186	186
261	The procedure or service is inconsistent with the patient's history.	.	.	.	.	.	-	170	.	.	.	.	170	170
19	This is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.	.	.	.	14	.	14	.	.	.	150	.	150	164
110	Billing date predates service date.	.	.	.	.	.	-	.	.	.	.	145	145	145
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.	.	.	.	.	.	-	.	.	.	137	.	137	137
35	Lifetime benefit maximum has been reached.	.	.	.	.	.	-	.	121	.	.	.	121	121
193	Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.	.	.	.	.	.	-	.	2	.	98	.	100	100
B1	Non-covered visits.	.	.	.	.	.	-	.	95	.	.	.	95	95
B12	Services not documented in patient's medical records.	.	.	.	.	.	-	.	.	92	.	.	92	92
284	Precertification/authorization/notification/pre-treatment number may be valid but does not apply to the billed services.	.	.	.	.	.	-	15	1	68	.	.	84	84
167	This (these) diagnosis(es) is (are) not covered.	.	.	.	.	.	-	.	76	.	2	.	78	78

CARC Code		Emergency						Non-Emergency						MCO Total
		ABH	ACLA	HB	LHC	UHC	Total	ABH	ACLA	HB	LHC	UHC	Total	
164	Attachment/other documentation referenced on the claim was not received in a timely fashion.	.	.	.	.	.	-	.	.	.	73	.	73	73
152	Payer deems the information submitted does not support this length of service.	.	.	.	.	.	-	.	69	.	.	.	69	69
34	Insured has no coverage for newborns.	.	.	.	.	.	-	.	.	.	69	.	69	69
56	Procedure/treatment has not been deemed 'proven to be effective' by the payer.	.	.	.	.	.	-	.	.	4	.	64	68	68
186	Level of care change adjustment.	.	.	.	.	.	-	.	66	.	.	.	66	66
13	The date of death precedes the date of service.	.	.	.	.	.	-	.	.	.	30	30	60	60
282	The procedure/revenue code is inconsistent with the type of bill.	.	.	4	.	.	4	.	.	45	.	.	45	49
260	Processed under Medicaid ACA Enhanced Fee Schedule	.	.	.	.	.	-	.	.	41	.	.	41	41
2	Coinsurance Amount	.	.	.	.	.	-	.	2	.	.	36	38	38
1	Deductible Amount	.	.	.	.	.	-	.	.	.	.	36	36	36
3	Co-payment Amount	.	.	.	.	.	-	.	.	.	.	36	36	36
57	Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.	.	.	.	.	.	-	.	.	.	24	.	24	24
239	Claim spans eligible and ineligible periods of coverage. Rebill separate claims.	.	.	.	.	.	-	20	.	1	.	.	21	21
258	Claim/service not covered when patient is in custody/incarcerated. Applicable federal, state or local authority may cover the claim/service.	.	.	.	.	.	-	.	.	21	.	.	21	21
131	Claim specific negotiated discount.	.	.	.	.	.	-	.	.	12	.	.	12	12
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.	.	.	.	.	.	-	.	.	.	11	.	11	11
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.	.	.	.	.	.	-	.	.	10	.	.	10	10
P21	Payment denied based on the Medical Payments Coverage (MPC) and/or Personal Injury Protection (PIP) Benefits jurisdictional regulations, or payment policies.	.	.	.	.	.	-	.	9	.	.	.	9	9
111	Not covered unless the provider accepts assignment.	.	.	.	.	.	-	.	7	.	.	.	7	7

CARC Code		Emergency						Non-Emergency						MCO Total
		ABH	ACLA	HB	LHC	UHC	Total	ABH	ACLA	HB	LHC	UHC	Total	
279	Services not provided by Preferred network providers.	.	.	.	.	.	-	.	7	.	.	.	7	7
14	The date of birth follows the date of service.	.	.	.	.	.	-	.	.	5	.	.	5	5
233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.	.	.	.	.	.	-	.	.	4	.	.	4	4
268	The Claim spans two calendar years. Please resubmit one claim per calendar year.	.	.	.	.	.	-	.	4	.	.	.	4	4
212	Administrative surcharges are not covered	.	.	.	.	.	-	.	3	.	.	.	3	3
271	Prior contractual reductions related to a current periodic payment as part of a contractual payment schedule when deferred amounts have been previously reported.	.	.	.	.	.	-	.	3	.	.	.	3	3
B11	The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.	.	.	.	.	.	-	.	.	.	.	3	3	3
165	Referral absent or exceeded.	.	.	.	.	.	-	.	.	.	2	.	2	2
20	This injury/illness is covered by the liability carrier.	.	.	.	.	.	-	.	2	.	.	.	2	2
200	Expenses incurred during lapse in coverage	.	.	.	.	.		1	1	.	.	.	2	2
21	This injury/illness is the liability of the no-fault carrier.	.	.	.	.	.		.	.	.	.	2	2	2
32	Our records indicate the patient is not an eligible dependent.	.	.	.	.	.		.	1	.	.	1	2	2
B5	Coverage/program guidelines were not met or were exceeded.	.	.	.	.	.		.	.	.	.	2	2	2
115	Procedure postponed, canceled, or delayed.	.	.	.	.	.		.	.	1	.	.	1	1
153	Payer deems the information submitted does not support this dosage.	.	.	.	.	.		.	1	.	.	.	1	1
210	Payment adjusted because pre-certification/authorization not received in a timely fashion	.	.	.	.	.		.	.	.	1	.	1	1
B9	Patient is enrolled in a Hospice.	.	.	.	.	.		.	.	.	.	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 VII - MCO Denied Pharmacy Claims, July 1, 2020 - June 30, 2021[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	52	.	12	128	.	192	266,063	286,670	529,094	725,945	193,298	2,001,070	2,001,262
88	DUR Reject Error	1	.	6	181	3	191	38,086	137,817	300,139	211,275	792,696	1,480,013	1,480,204
70	Product/Service Not Covered – Plan/Benefit Exclusion	.	.	9	44	8	61	86,230	139,847	208,955	264,420	480,395	1,179,847	1,179,908
75	Prior Authorization Required	32	.	12	208	2	254	268,605	79,215	261,153	361,681	86,322	1,056,976	1,057,230
76	Plan Limitations Exceeded	24	.	2	403	378	807	155,849	49,845	115,418	287,565	384,717	993,394	994,201
41	Submit Bill To Other Processor Or Primary Payer	.	.	.	44	7	51	14,922	34,897	43,199	125,068	154,079	372,165	372,216
39	M/I Diagnosis Code	5	.	3	.	.	8	65,235	147,633	110,529	.	25,837	349,234	349,242
MR	Product Not On Formulary	.	.	1	29	.	30	54,218	97,511	17,142	71,207	.	240,078	240,108
7X	Days Supply Exceeds Plan Limitation	.	.	1	.	.	1	20	104,711	92,869	60	.	197,660	197,661
69	Filled After Coverage Terminated	2	.	3	.	.	5	45,812	7,478	55,113	.	50,316	158,719	158,724
AC	Product Not Covered Non-Participating Manufacturer	.	.	.	.	.		.	78,924	.	.	.	78,924	78,924
50	Non-Matched Pharmacy Number	.	.	.	.	.		158	707	1,064	.	73,048	74,977	74,977
65	Patient Is Not Covered	.	.	.	.	1	1	.	.	.	.	70,796	70,796	70,797
77	Discontinued Product/Service ID Number	1	.	1	8	1	11	7,689	.	18,519	17,781	26,008	69,997	70,008
19	M/I Days Supply	6	.	.	.	.	6	55,853	183	1,285	.	356	57,677	57,683
22	M/I Dispense As Written (DAW)/Product Selection Code	.	.	.	16	.	16	12,385	14,989	.	29,474	9	56,857	56,873
9G	Quantity Dispensed Exceeds Maximum Allowed	.	.	.	.	.		.	50,794	2	.	.	50,796	50,796
44	Plan's Prescriber data base indicates the associated DEA to submitted Prescriber ID Is not found	4	.	.	.	.	4	6,245	8,985	8,501	.	16,329	40,060	40,064
13	M/I Other Coverage Code	.	.	.	.	.		28,346	2,522	6,084	.	251	37,203	37,203
DN	M/I Basis Of Cost Determination	.	.	.	1	.	1	4,934	333	2,168	22,276	4,193	33,904	33,905
40	Pharmacy Not Contracted With Plan On Date Of Service	.	.	.	.	.		1,969	6,215	17,184	4,365	.	29,733	29,733
83	Duplicate Paid/Captured Claim	.	.	.	2	.	2	2,210	6,878	4,629	8,457	7,416	29,590	29,592
56	Non-Matched Prescriber ID	.	.	2	.	.	2	375	747	17,572	.	2,231	20,925	20,927
'04	M/I Processor Control Number	.	.	.	.	.		201	.	20,123	.	.	20,324	20,324
21	M/I Product/Service ID	1	.	1	.	.	2	2,223	300	4,224	.	13,224	19,971	19,973
890	Pharmacy Not Enrolled in State Medicaid Program	3	.	.	.	.	3	19,582	.	.	.	.	19,582	19,585
60	Product/Service Not Covered For Patient Age	5	.	.	31	.	36	4,926	1,996	61	11,746	.	18,729	18,765
'09	M/I Date Of Birth	.	.	.	.	.		4,040	13	7,740	.	5,888	17,681	17,681
606	Brand Drug / Specific Labeler Code Required	.	.	.	.	.		.	17,273	.	.	.	17,273	17,273
80	Drug-Diagnosis Mismatch	.	.	.	.	.		5	.	11	.	15,849	15,865	15,865
7M	Discrepancy Between Other Coverage Code And Other Coverage Information On File	.	.	.	5	.	5	1,963	.	5,239	7,444	.	14,646	14,651
34	M/I Submission Clarification Code	.	.	.	.	.		1,558	7,039	2,403	.	2,597	13,597	13,597
CB	M/I Patient Last Name	.	.	.	.	.		.	.	.	.	12,503	12,503	12,503
6E	M/I Other Payer Reject Code	.	.	.	.	.		.	.	10,466	.	.	10,466	10,466
25	M/I Prescriber ID	.	.	.	.	.		964	3,497	4,848	.	760	10,069	10,069
10	M/I Patient Gender Code	.	.	.	.	.		.	.	.	.	9,874	9,874	9,874
DV	M/I Other Payer Amount Paid	.	.	.	.	.		1,618	1,633	4,759	.	854	8,864	8,864

NCPDP Code		Emergency						Non-Emergency						Total
		ABH	ACLA	HB	LHC	UHC	Total	ABH	ACLA	HB	LHC	UHC	Total	
E7	M/I Quantity Dispensed	.	.	.	2	.	2	587	211	1,175	1,950	3,453	7,376	7,378
33	M/I Prescription Origin Code	4	.	.	.	.	4	1,292	50	2,701	.	3,272	7,315	7,319
R2	Other Payer Reject Count Does Not Match Number Of Repetitions	.	.	.	.	.		.	.	.	.	7,170	7,170	7,170
17	M/I Fill Number	.	.	.	.	.		1,594	1	2,032	2	2,772	6,401	6,401
99	Host Processing Error	.	.	.	.	.		152	4,370	1,847	.	.	6,369	6,369
922	Morphine Milligram Equivalent (MME)Exceeds Limits*	.	.	2	4	.	6	1,148	.	1,601	3,567	.	6,316	6,322
54	Non-Matched Product/Service ID Number	.	.	.	.	.		.	6,029	.	1	.	6,030	6,030
G4	Physician must contact plan	.	.	2	4	.	6	.	.	1,576	3,550	.	5,126	5,132
818	Medication Administration Not Covered, Plan Benefit Exclusion.	23	.	2	5	.	30	1,834	.	1,851	1,373	.	5,058	5,088
DQ	M/I Usual And Customary Charge	.	.	.	.	.		422	2,109	1,029	.	1,519	5,079	5,079
980	Patient Locked Into Specific Pharmacy(s)	.	.	.	.	.		872	.	1,590	2,033	456	4,951	4,951
82	Claim Is Post-Dated	.	.	.	.	.		.	4,410	.	.	277	4,687	4,687
38	M/I Basis Of Cost Determination	.	.	.	.	.		.	4,620	.	.	10	4,630	4,630
E5	M/I Professional Service Code	.	.	.	.	.		440	1,810	804	555	212	3,821	3,821
557	COB Segment Present On A Non-COB Claim	.	.	.	.	.		615	19	587	2,565	.	3,786	3,786
95	Time Out	.	.	.	.	.		.	3,511	.	.	.	3,511	3,511
78	Cost Exceeds Maximum	.	.	.	.	2	2	.	132	.	.	3,102	3,234	3,236
645	Repackaged product is not covered by the contract.	.	.	.	.	.		.	2,838	.	.	.	2,838	2,838
8W	Discrepancy Between Other Coverage Code and Other Payer Amount Paid	.	.	.	1	.	1	386	.	1,423	609	.	2,418	2,419
ET	M/I Quantity Prescribed	.	.	.	.	.		327	573	726	282	373	2,281	2,281
545	Prescription Origin Code Value Not Supported	.	.	.	.	.		.	2,250	.	.	.	2,250	2,250
46	Plan's Prescriber data base indicates associated DEA to submitted Prescriber ID does not allow this drug DEA Schedule	.	.	.	.	.		76	319	104	.	1,696	2,195	2,195
619	Prescriber Type 1 NPI Required	.	.	.	.	.		6	.	890	.	1,279	2,175	2,175
E3	M/I Incentive Amount Submitted	.	.	.	.	.		53	1,124	373	116	328	1,994	1,994
EV	M/I Prior Authorization Number Submitted	.	.	.	.	.		5	394	.	.	1,504	1,903	1,903
M2	Recipient Locked In	.	.	.	.	.		158	.	1,012	.	611	1,781	1,781
7W	Refills Exceed allowable Refills	.	.	.	.	.		.	1,613	.	.	.	1,613	1,613
979	Patient Locked Into Specific Prescriber(s)	.	.	.	.	.		437	.	329	633	187	1,586	1,586
A1	ID Submitted is associated with a Sanctioned Prescriber	.	.	.	.	.		175	430	308	224	357	1,494	1,494
42	Plan's Prescriber data base indicates the Prescriber ID Submitted is inactive or expired	.	.	.	.	.		156	214	424	.	490	1,284	1,284
H9	M/I Other Amount Claimed Submitted	.	.	.	.	.		355	.	737	4	.	1,096	1,096
67	Filled Before Coverage Effective	.	.	.	.	.		307	108	326	.	348	1,089	1,089
23	M/I Ingredient Cost Submitted	.	.	.	.	.		454	268	336	.	1	1,059	1,059
EZ	M/I Prescriber ID Qualifier	.	.	.	.	.		245	.	1	4	750	1,000	1,000
61	Product/Service Not Covered For Patient Gender	.	.	.	.	.		957	.	.	.	.	957	957
GE	M/I Percentage Sales Tax Amount Submitted	.	.	.	.	.		.	.	.	.	927	927	927
NQ	M/I Other Payer-Patient Responsibility Amount	.	.	.	.	.		735	4	159	.	.	898	898

NCPDP Code		Emergency						Non-Emergency						Total
		ABH	ACLA	HB	LHC	UHC	Total	ABH	ACLA	HB	LHC	UHC	Total	
43	Plan's Prescriber data base indicates the associated DEA to submitted Prescriber ID is inactive	.	.	.	.	.		199	417	261	.	12	889	889
543	Prescriber ID Qualifier Value Not Supported	.	.	.	.	.		.	838	.	.	.	838	838
81	Claim Too Old	.	.	.	.	.		96	36	461	.	190	783	783
85	Claim Not Processed	.	.	.	.	.		49	.	33	.	541	623	623
6T	Compound Segment Required For Adjudication	.	.	.	.	.		52	.	147	199	78	476	476
92	System Unavailable/Host Unavailable	.	.	.	.	.		.	.	.	.	461	461	461
816	Pharmacy Benefit Exclusion, May Be Covered Under Patient's Medical Benefit	.	.	.	.	.		.	446	.	.	.	446	446
R6	Product/Service Not Appropriate For This Location	.	.	.	.	.		.	.	379	51	.	430	430
7C	M/I Other Payer ID	.	.	.	.	.		26	.	100	72	230	428	428
981	Date of Service for Incremental Fill Exceeds Regulatory	.	.	.	.	.		1	370	5	1	2	379	379
EU	M/I Prior Authorization Type Code	.	.	.	.	.		.	20	.	.	346	366	366
RE	M/I Compound Product ID Qualifier	.	.	.	.	.		123	.	214	.	.	337	337
8A	Compound Requires At Least One Covered Ingredient	.	.	.	.	.		.	329	.	.	.	329	329
'05	M/I Service Provider Number	.	.	.	.	.		4	3	10	.	227	244	244
28	M/I Date Prescription Written	.	.	.	.	.		5	3	6	.	219	233	233
649	Cumulative Quantity For This CII Rx Number Exceeds Quantity Prescribed	.	.	.	.	.		12	.	89	87	27	215	215
6C	M/I Other Payer ID Qualifier	.	.	.	.	.		28	.	104	75	4	211	211
35	M/I Primary Care Provider ID	.	.	.	.	.		.	.	.	.	204	204	204
891	Days Supply Is Less Than Plan Minimum	.	.	.	.	.		13	.	176	11	.	200	200
PE	M/I Request Coordination Of Benefits/Other Payments Segment	.	.	.	.	.		.	184	.	.	.	184	184
771	Compound contains unidentifiable ingredient(s); Submission Clarification Code override not allowed	.	.	.	.	.		.	.	.	.	175	175	175
HB	M/I Other Payer Amount Paid Count	.	.	.	.	.		.	.	4	.	167	171	171
8R	Submission Clarification Code Value Not Supported	.	.	.	.	.		.	89	40	38	.	167	167
AG	Days Supply Limitation For Product/Service	.	.	.	.	.		109	.	.	49	.	158	158
4C	M/I Coordination Of Benefits/Other Payments Count	.	.	.	.	.		.	.	.	.	139	139	139
9M	Minimum Of Two Ingredients Required	.	.	.	.	.		.	.	.	.	135	135	135
G1	M/I Compound Type	.	.	.	.	.		.	116	.	.	.	116	116
EF	M/I Compound Dosage Form Description Code	.	.	.	.	.		.	74	.	.	41	115	115
6Z	Provider Not Eligible To Perform Service/Dispense Product	.	.	.	.	.		.	109	.	.	.	109	109
8N	Future Date Prescription Written Not Allowed,	.	.	.	.	.		.	107	.	.	.	107	107
5C	M/I Other Payer Coverage Type	.	.	.	.	.		6	.	20	.	61	87	87
AD	Billing Provider Not Eligible To Bill This Claim Type	.	.	.	.	.		7	.	1	77	.	85	85
7Z	Compound Requires Two Or More Ingredients,	.	.	.	.	.		.	81	.	.	.	81	81
'06	M/I Group ID	.	.	.	.	.		.	38	30	.	.	68	68
8S	Basis Of Cost Determination Value Not Supported	.	.	.	.	.		.	66	.	.	.	66	66
E8	M/I Other Payer Date	.	.	.	.	.		7	43	7	6	.	63	63
NX	M/I Submission Clarification Code Count	.	.	.	.	.		.	.	.	.	60	60	60
HE	M/I Percentage Sales Tax Rate Submitted	.	.	.	.	.		.	56	1	.	.	57	57

NCPDP Code		Emergency						Non-Emergency						Total
		ABH	ACLA	HB	LHC	UHC	Total	ABH	ACLA	HB	LHC	UHC	Total	
E6	M/I Result Of Service Code	.	.	.	.	.		.	.	.	.	56	56	56
51	Non-Matched Group ID	.	.	.	.	.		.	52	.	.	.	52	52
HC	M/I Other Payer Amount Paid Qualifier	.	.	.	.	.		8	1	39	.	4	52	52
E1	M/I Product/Service ID Qualifier	.	.	.	.	.		.	31	.	.	20	51	51
608	Step Therapy, Alternate Drug Therapy Required Prior To Use Of Submitted Product Service ID	.	.	.	.	.		.	42	.	.	.	42	42
2N	M/I Prescriber State/Province Address	.	.	.	.	.		8	.	31	.	.	39	39
JE	M/I Percentage Sales Tax Basis Submitted	.	.	.	.	.		.	.	1	.	38	39	39
E4	M/I Reason For Service Code	.	.	.	.	.		.	.	.	.	38	38	38
20	M/I Compound Code	.	.	.	.	.		.	29	.	.	1	30	30
1V	Multiple Transactions Not Supported	.	.	.	.	.		.	27	.	.	.	27	27
RM	Completion Transaction Not Permitted With Same 'Date Of Service' As Partial Transaction	.	.	.	.	.		.	25	.	.	.	25	25
6N	Prescriber Segment Required For Adjudication	.	.	.	.	.		.	21	.	.	.	21	21
7G	Future Date Not Allowed For DOB	.	.	.	.	.		.	.	.	.	21	21	21
CX	M/I Patient ID Qualifier	.	.	.	.	.		.	.	.	.	21	21	21
J9	M/I DUR Co-Agent ID Qualifier	.	.	.	.	.		.	.	.	.	20	20	20
7B	Service Provider ID Qualifier Value Not Supported For Processor/Payer	.	.	.	.	.		.	17	.	.	.	17	17
8E	M/I DUR/PPS Level Of Effort	.	.	.	.	.		.	.	.	.	17	17	17
12	M/I Place of Service	.	.	.	.	.		.	.	.	.	15	15	15
WE	M/I Diagnosis Code Qualifier	.	.	.	.	.		.	.	.	.	14	14	14
CP	M/I Patient Zip/Postal Zone	.	.	.	.	.		.	.	.	13	.	13	13
EW	M/I Intermediary Authorization Type ID	.	.	.	.	.		.	13	.	.	.	13	13
32	M/I Level Of Service	.	.	.	.	.		.	4	.	.	8	12	12
29	M/I Number Of Refills Authorized	.	.	.	.	.		.	11	.	.	.	11	11
CY	M/I Patient ID	.	.	.	.	.		.	.	.	.	11	11	11
MV	M/I Benefit Stage Qualifier	.	.	.	.	.		.	.	.	1	10	11	11
NP	M/I Other Payer-Patient Responsibility Amount Qualifier	.	.	.	.	.		5	2	3	.	1	11	11
SH	Other Payer-Patient Responsibility Amount Count Does Not Match Number of Repetitions	.	.	.	.	.		.	.	1	.	10	11	11
600	Coverage Outside Submitted Date Of Service	.	.	.	.	.		.	10	.	.	.	10	10
'02	M/I Version/Release Number	.	.	.	.	.		6	.	.	3	.	9	9
7Y	Compounds Not Covered,	.	.	.	.	.		.	.	8	1	.	9	9
CA	M/I Patient First Name	.	.	.	.	.		.	.	.	.	9	9	9
H6	M/I DUR Co-Agent ID	.	.	.	.	.		.	.	.	.	9	9	9
NR	M/I Other Payer-Patient Responsibility Amount Count	.	.	.	.	.		.	.	.	.	9	9	9
RK	Partial Fill Transaction Not Supported	.	.	.	.	.		.	2	.	.	6	8	8
16	M/I Prescription/Service Reference Number	.	.	.	.	.		.	7	.	.	.	7	7
55	Non-Matched Product Package Size	.	.	.	.	.		.	.	.	.	6	6	6
DT	M/I Special Packaging Indicator	.	.	.	.	.		.	6	.	.	.	6	6
30	Reversal request outside processor reversal window.	.	.	.	.	.		.	.	5	.	.	5	5

NCPDP Code		Emergency						Non-Emergency						Total
		ABH	ACLA	HB	LHC	UHC	Total	ABH	ACLA	HB	LHC	UHC	Total	
648	Quantity Prescribed Does Not Match Quantity Prescribed On Original CII Dispensing	.	.	.	.	.		1	2	.	2	.	5	5
828	Plan/Beneficiary Case Management Restriction In Place	.	.	.	.	.		.	.	.	.	5	5	5
9E	Quantity Does Not Match Dispensing Unit	.	.	.	.	.		.	.	5	.	.	5	5
A2	ID Submitted is associated to a Deceased Prescriber	.	.	.	.	.		.	5	.	.	.	5	5
EM	M/I Prescription/Service Reference Number Qualifier	.	.	.	.	.		.	3	.	.	2	5	5
11	M/I Patient Relationship Code	.	.	.	.	.		.	.	.	2	2	4	4
8B	Compound Segment Missing On A Compound Claim	.	.	.	.	.		.	4	.	.	.	4	4
P8	DUR/PPS Code Counter Out Of Sequence	.	.	.	.	.		.	.	.	.	4	4	4
SG	Submission Clarification Code Count Does Not Match Number of Repetitions	.	.	.	.	.		.	.	.	.	4	4	4
1W	Multi-Ingredient Compound Must Be A Single Transaction	.	.	.	.	.		.	2	.	.	.	2	2
2E	M/I Primary Care Provider ID Qualifier	.	.	.	.	.		.	.	1	.	1	2	2
650	Fill Date Greater Than 60 Days From CII Date Prescription Written (414-DE).	.	.	.	.	.		.	.	.	2	.	2	2
E9	M/I Provider ID	.	.	.	.	.		.	.	.	.	2	2	2
EB	M/I Originally Prescribed Quantity	.	.	.	.	.		.	.	.	.	2	2	2
EC	M/I Compound Ingredient Component Count	.	.	.	.	.		.	.	.	.	2	2	2
EG	M/I Compound Dispensing Unit Form Indicator	.	.	.	.	.		.	2	.	.	.	2	2
FC	Non-Formulary	.	.	.	.	.		.	.	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
P4	Coordination Of Benefits/Other Payments Count Does Not Match Number Of Repetitions	.	.	.	.	.		.	.	2	.	.	2	2
SF	Other Payer Amount Paid Count Does Not Match Number Of Repetitions	.	.	.	.	.		.	.	.	2	.	2	2
TS	M/I Pay To Qualifier	.	.	.	.	.		.	.	.	.	2	2	2
U7	M/I Pharmacy Service Type	.	.	.	.	.		.	.	.	.	2	2	2
26	M/I Unit Of Measure	.	.	.	.	.		.	1	.	.	.	1	1
EJ	M/I Originally Prescribed Product/Service ID Qualifier	.	.	.	.	.		.	.	.	.	1	1	1
MU	M/I Benefit Stage Count	.	.	.	.	.		.	.	.	.	1	1	1
NV	M/I Delay Reason Code	.	.	.	.	.		.	1	.	.	.	1	1
TE	Missing/Invalid Compound Product ID	.	.	.	.	.		.	.	.	.	1	1	1
VE	M/I Diagnosis Code Count	.	.	.	.	.		.	.	.	.	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