APPENDIX VIII - Total Number of Denied Claims, July 1, 2017 - June 30, 2018[1]

by Claims Adjustment Reason Code (CARC), Emergency vs. Non-Emergency[2]

CARC Code		Emergency						Non-Emergency						MCO Total	MCNA (non-ER)
		ABH	ACLA	HB	LHC	UHC	Total	ABH	ACLA	HB	LHC	UHC	Total		
197	Precertification/authorization/notification absent.	1	8	18	218	522	767	46,912	192,326	228,162	627,282	492,592	1,587,274	1,588,041	-
18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	3,384	401	12,495	12,128	9,345	37,753	194,577	17,707	405,178	385,129	219,092	1,221,683	1,315,639	56,203
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.)	1,260	2,300	800	561	10,302	15,223	128,494	275,846	41,215	401,034	345,753	1,192,342	1,247,036	39,471
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	3,875	2,023	310	893	5,024	12,125	262,617	124,548	200,348	190,111	308,311	1,085,935	1,122,534	24,474
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. 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.)	1,101	3,704	409	1,590	4,479	11,283	127,740	116,840	114,221	345,096	143,201	847,098	867,001	8,620
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).	687	6,300	3,482	5	13,732	24,206	18,307	155,828	82,807	2,883	223,394	483,219	519,170	11,745
29	The time limit for filing has expired.	843	1,489	1,364	2,701	2,486	8,883	46,405	68,545	52,610	120,581	62,050	350,191	362,074	3,000
256	Service not payable per managed care contract.	-	-	2,190	-	1,124	3,314	1	365	158,213	38	145,563	304,180	307,494	-
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	-	79	-	166	4,370	4,615	334	611	2,848	12,553	233,304	249,650	261,601	7,336
27	Expenses incurred after coverage terminated.	1	4,925	4,969	680	6,167	16,742	34	63,335	63,362	13,835	84,668	225,234	247,052	5,076
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	-	-	274	1	35	310	369	12,467	11,347	189,572	11,456	225,211	225,564	43
22	This care may be covered by another payer per coordination of benefits.	1,044	1	-	10,898	80	12,023	22,068	352	-	166,902	5,944	195,266	221,114	13,825

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		ABH	ACLA	HB	LHC	UHC	Total	ABH	ACLA	HB	LHC	UHC	Total		
4	The procedure code is inconsistent with the modifier used or a required modifier is missing.	267	144	250	-	33	694	37,145	31,757	64,064	26,607	28,136	187,709	188,403	-
119	Benefit maximum for this time period or occurrence has been reached.	1	-	897	41	-	939	6,887	6,111	35,019	95,688	1,590	145,295	146,235	1
204	This service/equipment/drug is not covered under the patient's current benefit plan	-	-	7	4,058	-	4,065	483	-	17,785	115,691	5,379	139,338	143,417	14
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	1,097	-	3,016	288	1,296	5,697	22,935	127	53,458	27,205	21,152	124,877	130,799	225
95	Plan procedures not followed.	-	1,234	-	-	-	1,234	-	111,740	11	-	-	111,751	113,004	19
6	The procedure/revenue code is inconsistent with the patient's age.	22	2	29	20	1	74	1,692	5,438	12,918	63,474	1,806	85,328	112,822	27,420
234	This procedure is not paid separately. 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.)	55	181	4	459	26	725	44,349	3,903	6,552	36,501	2,511	93,816	94,542	1
222	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific.	-	-	9	42	-	51	-	1,498	27,652	41,809	292	71,251	93,442	22,140
198	Precertification/authorization exceeded.	-	-	1	-	193	194	2,612	12,533	19,593	47,578	8,757	91,073	91,267	-
169	Alternate benefit has been provided.	-	36	-	-	-	36	3	611	11	-	-	625	88,156	87,495
11	The diagnosis is inconsistent with the procedure.	1	-	92	-	-	93	6,609	23,431	4,989	2,711	49,497	87,237	87,330	-
26	Expenses incurred prior to coverage.	2,724	390	648	95	1,101	4,958	43,007	5,556	10,043	2,215	17,422	78,243	83,326	125
A1	Claim/Service denied. 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.)	-	-	2	758	-	760	-	3	31	78,820	12	78,866	79,626	-
39	Services denied at the time authorization/pre-certification was requested.	-	-	-	-	1,382	1,382	3,513	4,019	6,525	6,386	45,373	65,816	67,269	71
163	Attachment/other documentation referenced on the claim was not received.	-	-	-	-	-	-	-	49,956	-	7,454	-	57,410	57,410	-
133	The disposition of this service line is pending further review. (Use only with Group Code OA). Note: Use of this code requires a reversal and correction when the service line is finalized.	880	-	-	69	107	1,056	32,283	174	13	11,240	6,020	49,730	50,797	11
B8	Alternative services were available, and should have been utilized.	-	-	-	-	-	-	-	-	-	-	50,154	50,154	50,154	-
273	Coverage/program guidelines were exceeded.	-	21	-	-	-	21	38,330	556	3,460	50	-	42,396	42,417	-

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		ABH	ACLA	HB	LHC	UHC	Total	ABH	ACLA	HB	LHC	UHC	Total		
147	Provider contracted/negotiated rate expired or not on file.	183	-	-	-	-	183	42,182	-	-	-	-	42,182	42,365	-
128	Newborn's services are covered in the mother's Allowance.	-	-	-	-	16	16	-	2,709	3,615	-	35,045	41,369	41,385	-
B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated.	-	-	37	-	382	419	982	-	11,118	378	23,475	35,953	36,372	-
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.	-	643	-	8	-	651	427	31,576	-	746	-	32,749	33,400	-
150	Payer deems the information submitted does not support this level of service.	-	-	80	18	-	98	-	2,759	9,555	14,969	4,260	31,543	31,652	11
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).	5	256	9	-	-	270	204	5,140	568	5,465	15,276	26,653	27,431	508
107	The related or qualifying claim/service was not identified on this claim.	-	206	4	-	-	210	2,108	18,575	6,504	-	-	27,187	27,397	-
8	The procedure code is inconsistent with the provider type/specialty (taxonomy).	-	-	-	1	-	1	603	5,391	6,409	8,426	2,613	23,442	23,444	1
5	The procedure code/bill type is inconsistent with the place of service.	37	75	295	82	155	644	1,754	8,581	4,062	3,656	3,940	21,993	23,293	656
9	The diagnosis is inconsistent with the patient's age.	3	22	14	78	41	158	229	1,063	1,467	12,607	5,915	21,281	21,469	30
242	Services not provided by network/primary care providers.	-	-	-	4	-	4	2,464	6,546	3,498	3,064	-	15,572	19,796	4,220
272	Coverage/program guidelines were not met.	-	-	-	64	-	64	3	7,983	14	2,714	-	10,714	18,158	7,380
15	The authorization number is missing, invalid, or does not apply to the billed services or provider.	4	-	35	1	-	40	4,779	-	168	10,653	-	15,600	17,219	1,579
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.	-	-	-	-	-	-	-	1	-	5,687	-	5,688	16,960	11,272

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		ABH	ACLA	HB	LHC	UHC	Total	ABH	ACLA	HB	LHC	UHC	Total		
58	Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.	14	79	-	1	6	100	1,278	5,026	169	8,567	654	15,694	16,338	544
23	The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)	-	2	159	217	-	378	-	21	3,186	11,828	-	15,035	15,418	5
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.)	-	-	209	-	-	209	192	-	12,098	1	-	12,291	14,826	2,326
231	Mutually exclusive procedures cannot be done in the same day/setting.	71	-	4	-	-	75	4,465	676	8,215	-	-	13,356	13,431	-
59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.)	5	-	11	-	-	16	8,231	-	4,574	-	90	12,895	12,911	-
146	Diagnosis was invalid for the date(s) of service reported.	152	43	1	3	94	293	5,572	3,015	5	1,035	2,863	12,490	12,790	7
181	Procedure code was invalid on the date of service.	3	1	-	-	1	5	814	10,609	14	3	6	11,446	12,585	1,134
50	These are non-covered services because this is not deemed a 'medical necessity' by the payer.	-	-	-	-	-	-	229	426	1,500	542	8,329	11,026	11,566	540
55	Procedure/treatment/drug is deemed experimental/investigational by the payer.	-	-	-	-	-	-	56	-	10,220	-	-	10,276	10,323	47
46	This (these) service(s) is (are) not covered.	-	-	-	-	-	-	3,722	5,681	-	-	-	9,403	9,403	-
193	Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.	28	-	-	5	-	33	7,852	-	-	769	-	8,621	9,201	547
182	Procedure modifier was invalid on the date of service.	-	54	-	1	11	66	75	8,308	-	233	290	8,906	8,972	-
199	Revenue code and Procedure code do not match.	32	-	3	-	-	35	1,189	-	7,465	-	1	8,655	8,718	28
B16	'New Patient' qualifications were not met.	-	-	-	-	-	-	-	-	1,999	1,560	4,285	7,844	7,844	-
206	National Provider Identifier - missing.	-	2	2	3	-	7	-	567	554	3,223	539	4,883	6,637	1,747
115	Procedure postponed, canceled, or delayed.	140	-	-	-	-	140	5,083	-	-	-	-	5,083	5,223	-
185	The rendering provider is not eligible to perform the service billed.	-	49	-	6	-	55	-	4,833	-	165	11	5,009	5,178	114
171	Payment is denied when performed/billed by this type of provider in this type of facility.	16	-	-	-	-	16	4,215	-	-	-	-	4,215	4,231	-

CARC Code		Emergency						Non-Emergency						MCO Total	MCNA (non-ER)
		ABH	ACLA	HB	LHC	UHC	Total	ABH	ACLA	HB	LHC	UHC	Total		
B20	Procedure/service was partially or fully furnished by another provider.	-	76	-	-	279	355	-	574	-	4	1,777	2,355	4,177	1,467
269	Anesthesia not covered for this service/procedure.	-	-	-	-	-	-	-	-	-	-	-	-	3,427	3,427
129	Prior processing information appears incorrect. 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.)	-	68	-	-	5	73	-	2,975	-	-	102	3,077	3,150	-
31	Patient cannot be identified as our insured.	-	-	-	6	9	15	537	1,194	1	315	394	2,441	2,760	304
10	The diagnosis is inconsistent with the patient's gender.	19	42	38	-	1	100	528	546	1,051	8	137	2,270	2,370	-
B14	Only one visit or consultation per physician per day is covered.	28	141	11	153	-	333	319	496	389	58	-	1,262	2,124	529
250	The attachment/other documentation that was received was the incorrect attachment/document. The expected attachment/document is still missing. 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).	3	-	27	-	-	30	67	53	1,920	-	-	2,040	2,073	3
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Note: 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)	-	-	18	-	-	18	3	-	1,957	-	-	1,960	2,009	31
7	The procedure/revenue code is inconsistent with the patient's gender.	1	-	-	-	-	1	95	1,511	363	34	2	2,005	2,006	-
35	Lifetime benefit maximum has been reached.	-	-	-	-	-	-	1	1,755	-	-	-	1,756	1,756	-
P14	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day. To be used for Property and Casualty only.	-	-	-	-	-	-	458	-	1,100	-	-	1,558	1,558	-
B5	Coverage/program guidelines were not met or were exceeded.	-	-	-	-	-	-	-	-	-	1,481	-	1,481	1,481	-
151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.	-	-	-	-	7	7	1,008	4	4	-	380	1,396	1,403	-

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		ABH	ACLA	HB	LHC	UHC	Total	ABH	ACLA	HB	LHC	UHC	Total		
54	**Multiple physicians/assistants are not covered in this case.**	-	-	-	-	-	-	185	388	485	-	344	1,402	**1,402**	-
166	**These services were submitted after this payers responsibility for processing claims under this plan ended.**	-	-	-	-	-	-	-	1,180	4	-	-	1,184	**1,184**	-
249	**This claim has been identified as a readmission. (Use only with Group Code CO)**	-	-	-	-	-	-	-	-	-	1,167	-	1,167	**1,167**	-
268	**The Claim spans two calendar years. Please resubmit one claim per calendar year.**	14	-	-	-	-	14	1,024	-	-	-	-	1,024	**1,038**	-
233	**Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.**	-	-	-	-	-	-	-	-	-	-	3	3	**959**	956
12	**The diagnosis is inconsistent with the provider type.**	150	-	-	-	-	150	775	-	-	-	-	775	**925**	-
40	**Charges do not meet qualifications for emergent/urgent care.**	-	-	-	-	-	-	-	-	-	-	21	21	**907**	886
24	**Charges are covered under a capitation agreement/managed care plan.**	-	8	-	59	-	67	1	603	-	188	-	792	**859**	-
170	**Payment is denied when performed/billed by this type of provider.**	-	-	-	-	33	33	134	547	9	-	50	740	**773**	-
138	**Appeal procedures not followed or time limits not met.**	-	-	-	-	-	-	-	-	-	-	-	-	**536**	536
56	**Procedure/treatment has not been deemed 'proven to be effective' by the payer.**	-	-	-	-	-	-	-	-	1	-	-	1	**522**	521
110	**Billing date predates service date.**	-	-	-	-	1	1	1	2	-	-	498	501	**502**	-
60	**Charges for outpatient services are not covered when performed within a period of time prior to or after inpatient services.**	-	-	-	-	12	12	-	-	-	-	435	435	**447**	-
200	**Expenses incurred during lapse in coverage**	-	-	-	-	-	-	6	-	-	-	-	6	**412**	406
136	**Failure to follow prior payer's coverage rules. (Use only with Group Code OA)**	-	-	-	1	14	15	-	-	-	70	297	367	**382**	-
134	**Technical fees removed from charges.**	-	-	-	-	-	-	380	-	-	-	-	380	**380**	-
152	**Payer deems the information submitted does not support this length of service.**	-	-	-	-	-	-	-	-	-	-	-	-	**355**	355
112	**Service not furnished directly to the patient and/or not documented.**	-	-	-	-	94	94	-	-	-	-	250	250	**344**	-
189	**'Not otherwise classified' or 'unlisted' procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service**	-	-	-	-	-	-	2	285	-	4	-	291	**291**	-
216	**Based on the findings of a review organization**	-	-	-	-	-	-	-	-	1	-	-	1	**223**	222
167	**This (these) diagnosis(es) is (are) not covered.**	-	-	-	-	-	-	1	119	-	-	-	120	**204**	84

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19	This is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.	29	-	-	-	-	29	161	-	-	-	-	161	193	3
28	Coverage not in effect at the time the service was provided.	-	-	-	-	-	-	-	-	161	-	-	161	161	-
D20	Claim/Service missing service/product information.	-	-	-	-	-	-	80	76	-	-	-	156	156	-
149	Lifetime benefit maximum has been reached for this service/benefit category.	-	-	-	-	-	-	-	15	-	107	-	122	131	9
261	The procedure or service is inconsistent with the patient's history.	-	-	-	-	-	-	64	66	-	-	-	130	131	1
227	Information requested from the patient/insured/responsible party was not provided 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.)	1	-	-	-	-	1	-	-	126	-	-	126	127	-
14	The date of birth follows the date of service.	-	-	-	-	-	-	46	-	2	-	-	48	126	78
177	Patient has not met the required eligibility requirements.	-	-	4	-	-	4	1	-	88	-	2	91	116	21
B12	Services not documented in patients' medical records.	-	-	-	-	-	-	11	-	87	1	-	99	99	-
52	The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.	-	-	-	-	-	-	2	-	88	-	-	90	90	-
228	Denied for failure of this provider, another provider or the subscriber to supply requested information to a previous payer for their adjudication	4	-	-	-	-	4	69	-	-	-	-	69	73	-
246	This non-payable code is for required reporting only.	-	-	-	-	-	-	29	-	-	26	-	55	55	-
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.	-	-	-	-	-	-	-	-	-	-	-	-	45	45
13	The date of death precedes the date of service.	-	-	-	-	-	-	-	-	-	41	-	41	41	-
20	This injury/illness is covered by the liability carrier.	2	-	-	-	-	2	6	33	-	-	-	39	41	-
32	Our records indicate that this dependent is not an eligible dependent as defined.	-	-	-	-	-	-	-	4	-	-	30	34	34	-

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B11	The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.	-	-	-	-	-	-	-	-	-	-	30	30	30	-
243	Services not authorized by network/primary care providers.	-	-	-	-	-	-	-	-	28	-	-	28	28	-
108	Rent/purchase guidelines were not met.	-	-	-	-	-	-	14	-	-	-	10	24	24	-
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. (Use only with Group code OA)	1	-	-	-	-	1	21	-	-	-	-	21	22	-
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	-	-	-	19	-	19	20	-
239	Claim spans eligible and ineligible periods of coverage. Rebill separate claims.	-	-	-	-	-	-	18	-	1	-	-	19	19	-
101	Predetermination: anticipated payment upon completion of services or claim adjudication.	-	-	-	-	-	-	-	-	-	-	-	-	16	16
267	Claim/service spans multiple months. 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.)	-	-	-	-	-	-	-	-	-	-	16	16	16	-
1	Deductible Amount	-	-	-	-	-	-	1	-	-	-	14	15	15	-
140	Patient/Insured health identification number and name do not match.	-	-	-	-	-	-	-	-	-	-	1	1	13	12
208	National Provider Identifier - Not matched.	-	-	-	-	-	-	-	-	9	1	3	13	13	-
144	Incentive adjustment, e.g. preferred product/service.	-	-	-	-	-	-	-	-	-	-	-	-	10	10
258	Claim/service not covered when patient is in custody/incarcerated. Applicable federal, state or local authority may cover the claim/service.	-	-	-	-	-	-	-	-	10	-	-	10	10	-
103	Provider promotional discount (e.g., Senior citizen discount).	-	-	-	-	-	-	6	-	-	-	-	6	6	-
202	Non-covered personal comfort or convenience services.	-	-	-	-	-	-	6	-	-	-	-	6	6	-
238	Claim spans eligible and ineligible periods of coverage, this is the reduction for the ineligible period. (Use only with Group Code PR)	-	-	-	-	-	-	6	-	-	-	-	6	6	-
253	Sequestration - reduction in federal payment	-	-	-	-	-	-	2	-	-	-	-	2	5	3

CARC Code		Emergency						Non-Emergency						MCO Total	MCNA (non-ER)
		ABH	ACLA	HB	LHC	UHC	Total	ABH	ACLA	HB	LHC	UHC	Total		
271	Prior contractual reductions related to a current periodic payment as part of a contractual payment schedule when deferred amounts have been previously reported. (Use only with group code OA)	-	-	-	-	-	-	5	-	-	-	-	5	5	-
D18	Claim/Service has missing diagnosis information.	-	-	-	-	-	-	-	-	4	-	-	4	4	-
N657		-	-	-	-	-	-	-	-	4	-	-	4	4	-
131	Claim specific negotiated discount.	-	-	-	-	-	-	-	-	3	-	-	3	3	-
21	This injury/illness is the liability of the no-fault carrier.	-	-	-	-	-	-	3	-	-	-	-	3	3	-
280		-	-	-	-	-	-	-	-	3	-	-	3	3	-
B9	Patient is enrolled in a Hospice.	-	-	-	-	-	-	-	-	-	-	3	3	3	-
		-	-	-	-	-	-	-	-	2	-	-	2	2	-
183	The referring provider is not eligible to refer the service billed.	-	-	-	-	-	-	2	-	-	-	-	2	2	-
260	Processed under Medicaid ACA Enhanced Fee Schedule	-	-	-	-	-	-	-	-	2	-	-	2	2	-
276	Services denied by the prior payer(s) are not covered by this payer.	-	-	-	-	-	-	-	-	-	-	-	-	2	2
62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.	-	-	-	-	-	-	1	-	1	-	-	2	2	-
B23	Procedure billed is not authorized per your Clinical Laboratory Improvement Amendment (CLIA) proficiency test.	-	-	-	-	-	-	2	-	-	-	-	2	2	-
116	The advance indemnification notice signed by the patient did not comply with requirements.	-	-	-	-	-	-	1	-	-	-	-	1	1	-
141	Claim spans eligible and ineligible periods of coverage.	-	-	-	-	-	-	-	-	1	-	-	1	1	-
173	Service/equipment was not prescribed by a physician.	-	-	-	-	-	-	-	-	-	-	-	-	1	1
186	Level of care change adjustment.	-	-	-	-	-	-	-	-	1	-	-	1	1	-
187	Consumer Spending Account payments (includes but is not limited to Flexible Spending Account, Health Savings Account, Health Reimbursement Account, etc.)	-	-	-	-	-	-	1	-	-	-	-	1	1	-
192	Non standard adjustment code from paper remittance. Note: This code is to be used by providers/payers providing Coordination of Benefits information to another payer in the 837 transaction only. This code is only used when the non-standard code cannot be reasonably mapped to an existing Claims Adjustment Reason Code, specifically Deductible, Coinsurance and Co-payment.	-	-	-	-	-	-	1	-	-	-	-	1	1	-

CARC Code		Emergency						Non-Emergency						MCO Total	MCNA (non-ER)
		ABH	ACLA	HB	LHC	UHC	Total	ABH	ACLA	HB	LHC	UHC	Total		
195	**Refund issued to an erroneous priority payer for this claim/service.**	-	-	-	-	-	-	1	-	-	-	-	1	1	-
232	**Institutional Transfer Amount. Note - Applies to institutional claims only and explains the DRG amount difference when the patient care crosses multiple institutions.**	-	-	-	-	-	-	1	-	-	-	-	1	1	-
257	**The disposition of the claim/service is undetermined during the premium payment grace period, per Health Insurance Exchange requirements. This claim/service will be reversed and corrected when the grace period ends (due to premium payment or lack of premium payment). (Use only with Group Code OA)**	-	-	-	-	-	-	1	-	-	-	-	1	1	-
282	**The procedure/revenue code is inconsistent with the type of bill. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.**	-	-	-	-	-	-	-	-	1	-	-	1	1	-
34	**Insured has no coverage for newborns.**	-	-	-	-	-	-	1	-	-	-	-	1	1	-
75	**Direct Medical Education Adjustment.**	1	-	-	-	-	1	-	-	-	-	-	-	1	-
P9	**No available or correlating CPT/HCPCS code to describe this service. To be used for Property and Casualty only.**	-	-	-	-	-	-	-	-	-	1	-	1	1	-
Total		**18,189**	**25,005**	**32,227**	**36,383**	**62,966**	**174,770**	**1,192,502**	**1,428,095**	**1,727,319**	**3,118,261**	**2,625,820**	**10,091,997**	**10,616,706**	**349,939**

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 and are 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 9928

APPENDIX VIII - Total Number of Denied Pharmacy Claims, July 1, 2017 - June 30, 2018 [1]

by 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	
76	Plan Limitations Exceeded	-	4		287	9,313	9,604	134,624	206,691	127,965	623,776	374,541	1,467,597	1,477,201
79	Refill Too Soon	-	1		39	426	466	199,431	245,067	285,925	369,558	195,405	1,295,386	1,295,852
70	Product/Service Not Covered	-	8		70	10,407	10,485	126,246	224,622	48,970	412,932	424,926	1,237,696	1,248,181
88	DUR Reject Error	-	5		14	7,072	7,091	12,965	78,676	194,656	153,830	541,724	981,851	988,942
41	Submit Bill To Other Processor Or Primary Payer	-	2		38	3,141	3,181	9,926	27,616	21,877	471,194	116,016	646,629	649,810
75	Prior Authorization Required	-	1		60	1,246	1,307	48,340	4,726	187,433	183,282	142,282	566,063	567,370
19	M/I Days Supply	-	-		122	14	136	68,901	-	124	161,471	131,587	362,083	362,219
69	Filled After Coverage Terminated	-	-		2	2,273	2,275	55,870	-	52,420	103,392	91,292	302,974	305,249
39	M/I Diagnosis Code	-	3		22	-	25	4,559	168,668	7	61,073	50	234,357	234,382
MR	Product Not On Formulary	-	-		-	-	-	-	-	194,667	-	-	194,667	194,667
65	Patient Is Not Covered	-	-		-	2,430	2,430	-	81,685	2,844	7	90,677	175,213	177,643
80	Drug-Diagnosis Mismatch	-	-		-	207	207	543	-	176	-	115,950	116,669	116,876
7X	Days Supply Exceeds Plan Limitation	-	-		-	-	-	23	-	93,015	42	-	93,080	93,080
85	Claim Not Processed	-	-		13	27	40	7	-	11,433	47,305	684	59,429	59,469
50	Non-Matched Pharmacy Number	-	-		1	887	888	258	9,448	893	4,195	36,362	51,156	52,044
68	Filled After Coverage Expired	-	-		1	-	1	-	-	-	48,308	-	48,308	48,309
44	Plan's Prescriber data base indicates the associated DEA to submitted Prescriber ID Is not found	-	-		14	2,491	2,505	6,541	1,639	-	12,805	22,216	43,201	45,706
77	Discontinued Product/Service ID Number	-	-		3	413	416	5,045	4,752	11,563	9,237	14,265	44,862	45,278
AC	Product Not Covered Non-Participating Manufacturer	-	-		-	-	-	-	-	44,885	-	-	44,885	44,885
83	Duplicate Paid/Captured Claim	-	-		3	152	155	2,193	2,333	7,338	12,209	12,139	36,212	36,367
06	M/I Group Number	-	-		1	-	1	-	-	6	33,968	62	34,036	34,037
7W	Refills Exceed allowable Refills	-	-		31	-	31	-	-	1,757	31,315	-	33,072	33,103
E7	M/I Quantity Dispensed	-	-		4	93	97	463	1,283	63	3,656	26,141	31,606	31,703
54	Non-Matched Product/Service ID Number	-	-		-	-	-	-	13,834	13,525	2,215	-	29,574	29,574
40	Pharmacy Not Contracted With Plan On Date Of Service	-	-		3	-	3	1,480	-	11,894	10,670	-	24,044	24,047
13	M/I Other Coverage Cod	-	-		1	9	10	22,072	-	196	668	269	23,205	23,215
09	M/I Birth Date	-	-		-	114	114	3,578	5,880	3	9,126	3,224	21,811	21,925
21	M/I Product/Service ID	-	-		-	108	108	3,332	33	359	3,545	7,603	14,872	14,980
96	HBL:System Downtime	-	-		-	-	-	-	-	13,505	-	-	13,505	13,505
78	Cost Exceeds Maximum	-	1		1	15	17	-	9,184	653	461	2,848	13,146	13,163
22	M/I Dispense As Written (DAW)/Product Selection Code	-	-		-	1	1	-	12,733	81	32	14	12,860	12,861
DV	M/I Other Payer Amount Paid	-	-		2	-	2	1,637	-	5,486	4,882	-	12,005	12,007
M2	Recipient Locked In	-	-		-	158	158	-	-	8,205	740	2,437	11,382	11,540
46	Plan's Prescriber data base indicates associated DEA to submitted Prescriber ID does not allow this drug DEA Schedule	-	-		-	328	328	112	3,360	-	312	6,049	9,833	10,161
33	M/I Prescription Origin Code	-	-		-	126	126	1,747	-	191	4,394	3,428	9,760	9,886
JE	M/I Percentage Sales Tax Basis Submitted	-	-		-	5	5	-	-	8,342	-	152	8,494	8,499
9E	Quantity Does Not Match Dispensing Unit	-	-		-	-	-	-	-	8,399	-	-	8,399	8,399
6C	M/I Other Payer ID Qualifier	-	-		-	13	13	-	-	7,931	2	384	8,317	8,330
7C	M/I Other Payer ID	-	-		-	8	8	1	-	7,982	-	300	8,283	8,291
EV	M/I Prior Authorization Number Submitted	-	-		-	23	23	-	-	6,772	-	1,440	8,212	8,235

NCPDP Code		Emergency						Non-Emergency						Total
		ABH	ACLA	HB	LHC	UHC	Total	ABH	ACLA	HB	LHC	UHC	Total	
CB	M/I Patient Last Name	-	-		-	304	304	-	-	3	-	6,607	6,610	6,914
7M	Discrepancy Between Other Coverage Code And Other Coverage Information On File	-	-		-	-	-	2,070	-	-	4,813	-	6,883	6,883
HE	M/I Percentage Sales Tax Rate Submitted	-	-		-	2	2	-	-	6,727	-	141	6,868	6,870
AG	Days Supply Limitation For Product/Service	-	-		-	-	-	702	-	2	5,689	-	6,393	6,393
25	M/I Prescriber ID	-	-		2	19	21	1,009	1,357	926	2,275	588	6,155	6,176
56	Non-Matched Prescriber ID	-	-		1	168	169	831	5	-	1,739	3,130	5,705	5,874
446	ACLA: BOTH OTH PAYR PD AND OTH PAYR PAT RESP	-	-		-	-	-	-	5,540	-	-	-	5,540	5,540
R2	HBL: Other Payer Reject Count Does Not Match Number Of Repetitions	-	-		-	80	80	-	-	8	18	5,368	5,394	5,474
E5	M/I Professional Service Code	-	-		-	5	5	23	-	4,811	99	313	5,246	5,251
E6	M/I Result Of Service Code	-	-		-	3	3	-	-	5,078	-	65	5,143	5,146
PE	HBL: M/I COB/Other Payments Segment	-	-		-	-	-	-	-	5,105	-	-	5,105	5,105
NQ	M/I Other Payer- Patient Responsibility Amount	-	-		-	-	-	783	-	14	3,586	-	4,383	4,383
04	M/I Processor Control Number	-	-		1	-	1	39	-	2,397	1,945	-	4,381	4,382
DQ	M/I Usual And Customary Charge	-	-		-	20	20	223	426	1,135	1,327	1,082	4,193	4,213
AJ	Generic Drug Required	-	-		-	-	-	-	-	-	3,937	-	3,937	3,937
8W	Discrepancy Between Other Coverage Code and Other Payer Amount Paid	-	-		-	-	-	644	-	1,814	1,398	-	3,856	3,856
7J	Patient Relationship Code Value Not Supported	-	-		-	-	-	-	-	3,807	-	-	3,807	3,807
10	M/I Patient Gender Code	-	-		-	185	185	47	-	19	-	3,472	3,538	3,723
52	Non-Matched Cardholder ID	-	-		-	-	-	-	-	1,153	2,355	18	3,526	3,526
67	Filled Before Coverage Effective	-	-		-	10	10	204	-	292	2,492	443	3,431	3,441
NR	M/I Other Payer- Patient Responsibility Amount Count	-	-		-	-	-	-	-	3,061	2	15	3,078	3,078
816	HBL: Pharmacy Benefit Exclusion, May Be Covered Under Patient's Medical Benefit	-	-		-	-	-	-	-	2,827	-	-	2,827	2,827
GE	M/I Percentage Sales Tax Amount Submitted	-	-		-	22	22	-	-	1,988	-	774	2,762	2,784
5E	M/I Other Payer Reject Count	-	-		-	-	-	-	-	2,604	2	-	2,606	2,606
818	HBL: Medication Administration Not Covered, Plan Benefit Exclusion; HBL:	-	-		-	-	-	2,529	-	19	-	-	2,548	2,548
443	HBL: Other Payer-Patient Responsibility Amount Grouping Incorrect	-	-		-	-	-	-	-	2,296	-	-	2,296	2,296
R9	HBL:Value In Gross Amount Due Does Not Follow Pricing Formulae; Procedure Modifier Code Count Does Not Match Number Of Repetitions	-	-		-	-	-	-	-	2,286	-	-	2,286	2,286
60	Product/Service Not Covered For Patient Age	-	-		1	-	1	-	41	2	2,194	-	2,237	2,238
777	HBL: Plan's Prescriber data base not able to verify active state license with prescriptive authority for Prescriber ID Submitted	-	-		-	-	-	-	-	1,981	-	-	1,981	1,981
81	Claim Too Old	-	-		-	7	7	49	74	493	865	474	1,955	1,962
8K	DAW Code Value Not Supported	-	-		-	-	-	-	-	1,944	-	-	1,944	1,944
51	Non-Matched Group ID	-	-		-	-	-	-	-	17	1,871	-	1,888	1,888
11	M/I Patient Relationship Code	-	-		-	-	-	-	-	1,319	470	-	1,789	1,789
7V	Duplicate Refills,	-	-		-	-	-	-	-	1,708	-	-	1,708	1,708
HB	M/I Other Payer Amount Paid Count	-	-		-	-	-	2	-	1,539	-	37	1,578	1,578
82	Claim Is Post-Dated	-	-		-	1	1	364	24	-	721	418	1,527	1,528
17	M/I Fill Number	-	-		1	109	110	279	-	-	2	1,117	1,398	1,508
EU	M/I Prior Authorization Type Code	-	-		-	17	17	-	-	831	-	649	1,480	1,497

NCPDP Code		Emergency						Non-Emergency						Total
		ABH	ACLA	HB	LHC	UHC	Total	ABH	ACLA	HB	LHC	UHC	Total	
8E	M/I DUR/PPS Level Of Effort	-	-		-	-	-	-	-	1,250	-	8	1,258	1,258
43	Plan's Prescriber data base indicates the associated DEA to submitted Prescriber ID is inactive	-	-		-	-	-	353	68	-	789	-	1,210	1,210
A1	ID Submitted is associated with a Sanctioned Prescriber	-	-		-	9	9	15	807	232	-	92	1,146	1,155
609	HBL: COB Claim Not Required, Patient Liability Amount Submitted Was Zero	-	-		-	-	-	-	-	1,154	-	-	1,154	1,154
9V	Prescriber ID Qualifier Submitted Not Covered	-	-		-	-	-	-	-	1,134	-	-	1,134	1,134
EZ	M/I Prescriber ID Qualifier	-	-		-	7	7	4	-	542	19	384	949	956
28	M/I Date Prescription Written	-	-		-	7	7	2	-	422	287	234	945	952
BB	Diagnosis Code Qualifier Submitted Not Covered	-	-		-	-	-	-	-	897	-	-	897	897
645	HBL: Repackaged product is not covered by the contract.	-	-		-	-	-	-	-	858	-	-	858	858
DU	M/I Gross Amount Due	-	-		-	-	-	-	755	89	-	-	844	844
42	Plan's Prescriber data base indicates the Prescriber ID Submitted is inactive or expired	-	-		-	-	-	53	5	608	173	-	839	839
3Y	Prior Authorization Denied	-	-		1	-	1	-	-	-	799	-	799	800
HA	M/I Flat Sales Tax Amount Submitted	-	-		-	18	18	-	-	-	-	773	773	791
15	M/I Date of Service	-	-		-	-	-	-	5	691	-	-	696	696
E1	M/I Product/Service ID Qualifier	-	-		-	2	2	-	-	626	-	41	667	669
30	HBL: Reversal request outside processor reversal window.	-	-		7	-	7	-	-	311	321	-	632	639
8R	Submission Clarification Code Value Not Supported	-	-		-	-	-	-	-	584	-	-	584	584
E4	M/I Reason For Service Code	-	-		-	2	2	-	-	482	-	83	565	567
35	M/I Primary Care Provider ID	-	-		-	18	18	-	-	214	-	322	536	554
O5	HBL: PRESCRIBER NOT ALLOWED	-	-		-	-	-	-	-	554	-	-	554	554
01	M/I Bin Number	-	-		-	-	-	-	-	54	353	-	407	407
EW	HBL: M/I Intermediary Authorization Type ID	-	-		-	-	-	-	-	384	-	-	384	384
29	M/I Number Refills Authorized	-	-		-	-	-	-	-	-	364	-	364	364
73	Refills Are Not Covered	-	-		-	-	-	-	287	3	64	-	354	354
6T	Compound Segment Required For Adjudication	-	-		-	-	-	79	-	46	225	-	350	350
23	M/I Ingredient Cost Submitted	-	-		-	-	-	16	35	209	86	-	346	346
6Z	Provider Not Eligible To Perform Service/Dispense Product	-	-		-	-	-	-	-	338	-	-	338	338
E3	M/I Incentive Amount Submitted	-	-		-	-	-	17	103	32	84	90	326	326
619	ACLA&LHC: Prescriber Type 1 NPI Required	-	-		-	-	-	-	222	-	103	-	325	325
DN	M/I Basis Of Cost Determination	-	-		-	5	5	-	-	198	-	113	311	316
34	M/I Submission Clarification Code	-	-		-	2	2	-	-	292	2	11	305	307
RE	M/I Compound Product ID Qualifier	-	-		-	-	-	90	-	-	215	-	305	305
05	M/I Service Provider Number	-	-		-	2	2	7	-	6	18	222	253	255
R0	Professional Service Code of “MA” required for Vaccine Incentive Fee Submitted	-	-		-	-	-	-	97	154	-	-	251	251
AB	Date Written Is After Date Filled	-	-		1	-	1	-	-	200	46	-	246	247
E9	M/I Provider ID	-	-		-	-	-	-	-	240	-	3	243	243
71	Prescriber Is Not Covered	-	-		-	-	-	15	-	104	75	45	239	239
2N	M/I Prescriber State/Province Address	-	-		-	-	-	66	-	37	134	-	237	237
47	HBL: PHARMACY SIGNATURE REQUIRED	-	-		-	-	-	-	-	234	-	-	234	234
E2	M/I Route of Administration	-	-		-	-	-	-	-	217	-	-	217	217
HC	M/I Other Payer Amount Paid Qualifier	-	-		-	-	-	19	-	114	50	12	195	195
92	System Unavailable/Host Unavailable	-	-		-	3	3	-	-	-	-	186	186	189

NCPDP Code		Emergency						Non-Emergency						Total
		ABH	ACLA	HB	LHC	UHC	Total	ABH	ACLA	HB	LHC	UHC	Total	
8A	Compound Requires At Least One Covered Ingredient	-	-		-	-	-	-	-	-	180	-	180	180
E8	M/I Other Payer Date	-	-		-	-	-	-	-	164	1	-	165	165
9G	Quantity Dispensed Exceeds Maximum Allowed	-	-		-	-	-	-	-	164	-	-	164	164
5C	M/I Other Payer Coverage Type	-	-		-	-	-	7	-	84	14	56	161	161
C2	HBL: Claim is secondary and requires documentation for processing	-	-		-	-	-	-	-	160	-	-	160	160
99	HBL:Host Processing Error	-	-		-	-	-	33	-	6	119	-	158	158
08	M/I Person Code	-	-		-	-	-	-	-	146	1	-	147	147
6G	Coordination Of Benefits/Other Payments Segment Required For Adjudication	-	-		-	-	-	-	-	-	129	-	129	129
7Q	Other Payer ID Qualifier Value Not Supported	-	-		-	-	-	-	-	125	-	-	125	125
8N	Future Date Prescription Written Not Allowed,	-	-		-	-	-	-	-	121	-	-	121	121
EF	M/I Compound Dosage Form Descriptin Code	-	-		-	5	5	-	-	42	-	72	114	119
NX	M/I Submission Clarification Code Count	-	-		-	2	2	-	-	-	-	100	100	102
4Y	Patient Residence Value Not Supported	-	-		-	-	-	-	-	99	-	-	99	99
55	Non-Matched Product Package Size	-	-		-	-	-	-	99	-	-	-	99	99
827	HBL: Pharmacy Service Provider Is Temporarily Suspended From Processing Claims By Payer/Processor	-	-		-	-	-	-	-	89	-	-	89	89
20	M/I Compound Code	-	-		-	-	-	-	-	83	-	1	84	84
CY	M/I Patient ID	-	-		-	1	1	-	-	42	-	41	83	84
CA	M/I Patient First Name	-	-		-	2	2	-	-	24	2	47	73	75
9M	Minimum Of Two Ingredients Required	-	-		-	1	1	-	-	-	-	71	71	72
8Z	Product/Service ID Qualifier Value Not Supported	-	-		-	-	-	-	-	70	-	-	70	70
DY	M/I Date Of Injury	-	-		-	-	-	-	-	63	-	-	63	63
PT	HBL: M/I Workers Compensation Segment; Value In Gross Amount Due Does Not Follow Pricing Formulae	-	-		-	-	-	-	-	63	-	-	63	63
2E	M/I Primary Care Provider ID Qualifier	-	-		-	-	-	-	-	60	2	-	62	62
R6	Product/Service Not Appropriate For This Location	-	-		-	-	-	-	-	-	53	-	53	53
EG	M/I Compound Dispensing Unit Form Indicator	-	-		-	-	-	-	-	48	-	-	48	48
NP	M/I Other Payer- Patient Responsibility Amount Qualifier	-	-		-	-	-	5	-	22	20	-	47	47
H8	M/I Other Amount Claimed Submitted Qualifier	-	-		-	-	-	-	-	41	-	1	42	42
EK	M/I Scheduled Prescription ID Number	-	-		-	-	-	-	-	39	-	-	39	39
EX	HBL: M/I Intermediary Authorization ID; INVALID RX NUMBER	-	-		-	-	-	-	-	36	-	-	36	36
1T	PCN Must Contain Processor/Payer Assigned Value	-	-		-	-	-	-	-	-	34	-	34	34
WE	M/I Diagnosis Code Qualifier	-	-		-	-	-	-	-	28	-	6	34	34
CO	M/I Patient State/Province Address	-	-		-	-	-	-	-	33	-	-	33	33
XJ	HBL: INVALID ING COST	-	-		-	-	-	-	-	32	-	-	32	32
7B	Service Provider ID Qualifier Value Not Supported For Processor/Payer	-	-		-	-	-	-	-	31	-	-	31	31
831	HBL: Product Service ID Carve-Out, Bill Medicaid Fee For Service, DUPLICATE CLAIM, Medication Administration Not Covered, Plan Benefit Exclusion	-	-		-	-	-	-	-	30	-	-	30	30
CX	M/I Patient ID Qualifier	-	-		-	-	-	-	-	23	-	6	29	29
442	HBL: Other Payer Amount Paid Grouping Incorrect	-	-		-	-	-	-	-	28	-	-	28	28
72	Primary Prescriber Is Not Covered	-	-		-	-	-	-	-	-	28	-	28	28

NCPDP Code		Emergency						Non-Emergency						Total
		ABH	ACLA	HB	LHC	UHC	Total	ABH	ACLA	HB	LHC	UHC	Total	
478	HBL: Other Payer ID Qualifier Does Not Precede Other Payer ID	-	-		-	-	-	-	-	26	-	-	26	26
9T	Prior Authorization Type Code Submitted Not Covered	-	-		-	-	-	-	-	23	-	-	23	23
FC	HBL: NON-FORMULARY	-	-		-	-	-	-	-	22	-	-	22	22
7P	Coordination Of Benefits/Other Payments Count Exceeds Number of Supported Payers	-	-		-	-	-	-	-	3	18	-	21	21
G1	M/I Compound Type	-	-		-	-	-	-	-	21	-	-	21	21
P4	Coordination Of Benefits/Other Payments Count Does Not Match Number Of Repetitions	-	-		-	-	-	-	-	3	18	-	21	21
YD	Other Payer-Patient Responsibility Amount Count Exceeds Number Of Occurrences Supported	-	-		-	-	-	-	-	-	20	-	20	20
32	M/I Level Of Service	-	-		-	-	-	-	-	6	-	13	19	19
RK	Partial Fill Transaction Not Supported	-	-		-	-	-	-	-	-	3	16	19	19
614	HBL: Uppercase Character(s) Required & COB Claim Not Required, Patient Liability Amount Submitted Was Zero	-	-		-	-	-	-	-	18	-	-	18	18
C1	HBL: MEM/DEP COVERED BY ANOTHER CARRIER; EM/DEP COVERED BY ANOTHER CARRIER	-	-		-	-	-	-	-	17	-	-	17	17
SH	Other Payer-Patient Responsibility Amount Count Does Not Match Number of Repetitions	-	-		-	-	-	-	-	12	5	-	17	17
SF	Other Payer Amount Paid Count Does Not Match Number Of Repetitions	-	-		-	-	-	3	-	10	3	-	16	16
465	HBL: Patient ID Qualifier Does Not Precede Patient ID	-	-		-	-	-	-	-	15	-	-	15	15
EE	M/I Compound Ingredient Drug Cost	-	-		-	-	-	-	-	11	4	-	15	15
SG	Submission Clarification Code Count Does Not Match Number of Repetitions	-	-		-	-	-	-	-	12	-	3	15	15
AD	Billing Provider Not Eligible To Bill This Claim Type	-	-		-	-	-	-	-	13	-	-	13	13
DR	M/I Prescriber Last Name	-	-		-	-	-	-	-	8	5	-	13	13
PF	HBL: M/I Compound Segment	-	-		-	-	-	-	-	13	-	-	13	13
VE	M/I Diagnosis Code Count	-	-		-	-	-	-	-	3	-	10	13	13
YC	Other Payer Reject Count Exceeds Number Of Occurrences Supported	-	-		-	-	-	-	-	5	8	-	13	13
3M	HBL: M/I Prescriber Phone Number	-	-		-	-	-	-	-	12	-	-	12	12
CP	M/I Patient Zip/Postal Zone	-	-		-	-	-	-	-	11	-	-	11	11
J9	HBL: M/I DUR Co-Agent ID Qualifier; UHC: FutureDtNotAllowedFor DOB	-	-		-	-	-	-	-	3	-	8	11	11
P3	Compound Ingredient Component Count Does Not Match Number Of Repetitions	-	-		-	-	-	1	-	10	-	-	11	11
H6	M/I DUR Co-Agent ID	-	-		-	-	-	-	-	3	-	7	10	10
02	M/I Version/Release Number	-	-		-	-	-	3	-	-	6	-	9	9
12	M/I Patient Location	-	-		-	-	-	-	-	4	4	1	9	9
26	M/I Unit Of Measure	-	-		-	-	-	-	-	9	-	-	9	9
2K	M/I Prescriber Street Address	-	-		-	-	-	-	-	9	-	-	9	9
2M	M/I Prescriber City Address	-	-		-	-	-	-	-	9	-	-	9	9
37	HBL: ESI Reject Description Unknown	-	-		-	-	-	-	-	9	-	-	9	9
R1	HBL:Other Amount Claimed Submitted Count Does Not Match Number Of Repetitions	-	-		-	-	-	-	-	9	-	-	9	9
CM	M/I Patient Street Address	-	-		-	-	-	-	-	8	-	-	8	8
H7	M/I Other Amount Claimed Submitted Count	-	-		-	-	-	-	-	1	-	7	8	8

NCPDP Code		Emergency						Non-Emergency						Total
		ABH	ACLA	HB	LHC	UHC	Total	ABH	ACLA	HB	LHC	UHC	Total	
38	M/I Basis Of Cost	-	-		-	1	1	-	-	-	-	6	6	7
441	HBL: Other Amount Claimed Submitted Grouping Incorrect	-	-		-	-	-	-	-	7	-	-	7	7
472	HBL: Diagnosis Code Grouping Incorrect & Other Amount Claimed Submitted Qualifier Does Not Precede Other Amount Claimed Submitted	-	-		-	-	-	-	-	7	-	-	7	7
H9	M/I Other Amount Claimed Submitted	-	-		-	-	-	-	-	-	7	-	7	7
506	HBL: Prescription/ Service Reference Number Qualifier Value Not Supported	-	-		-	-	-	-	-	6	-	-	6	6
8B	Compound Segment Missing On A Compound Claim	-	-		-	-	-	-	-	-	6	-	6	6
8M	Sum Of Compound Ingredient Costs Does Not Equal Ingredient Cost Submitted	-	-		-	-	-	-	-	-	6	-	6	6
B2	M/I Service Provider ID Qualifier	-	-		-	-	-	-	-	5	1	-	6	6
O1	HBL: PHARMACY RESTRICTION	-	-		-	-	-	-	-	6	-	-	6	6
XH	HBL: MISSING OR INVALID QUANTITY	-	-		-	-	-	-	-	6	-	-	6	6
CN	M/I Patient City Address	-	-		-	-	-	-	-	5	-	-	5	5
07	M/I Cardholder ID Number	-	-		-	-	-	-	-	4	-	-	4	4
4C	M/I Coordination Of Benefits/Other Payments Count	-	-		-	-	-	-	-	-	-	4	4	4
EUE	UHC: NA	-	-		-	-	-	-	-	-	-	4	4	4
PH	HBL: M/I DUR/PPS Segment	-	-		-	-	-	-	-	4	-	-	4	4
PJ	HBL: M/I Insurance Segment	-	-		-	-	-	-	-	4	-	-	4	4
RN	HBL: Plan Limits Exceeded On Intended Partial Fill Values	-	-		-	-	-	-	-	4	-	-	4	4
445	HBL: Diagnosis Code Grouping Incorrect	-	-		-	-	-	-	-	3	-	-	3	3
480	HBL: Other Payer Amount Paid Qualifier Does Not Precede Other Payer Amount Paid	-	-		-	-	-	-	-	3	-	-	3	3
483	HBL:Other Payer-Patient Responsibility Amount Qualifier Does Not Precede Other Payer-Patient Responsibility Amount	-	-		-	-	-	-	-	3	-	-	3	3
7Y	Compounds Not Covered,	-	-		-	-	-	-	-	-	3	-	3	3
8F	HBL: CMPD HAS NON COVERED INGREDIENT(S)	-	-		-	-	-	-	-	3	-	-	3	3
EC	M/I Compound Ingredient Component Count	-	-		-	-	-	-	-	3	-	-	3	3
MV	HBL: M/I Benefit Stage Qualifier	-	-		-	-	-	-	-	2	-	1	3	3
YB	UHC: M/I BenefitStageQualifier	-	-		-	-	-	-	-	2	-	1	3	3
YB	Other Amount Claimed Submitted Count Exceeds Number Of Occurrences Supported	-	-		-	-	-	-	-	3	-	-	3	3
YE	Submission Clarification Code Count Exceeds Number of Occurrences Supported	-	-		-	-	-	-	-	3	-	-	3	3
16	M/I Prescription/Service Reference Number	-	-		-	-	-	-	-	2	-	-	2	2
1W	Multi-Ingredient Compound Must Be A Single Transaction	-	-		-	-	-	-	-	-	2	-	2	2
2J	M/I Prescriber First Name	-	-		-	-	-	-	-	2	-	-	2	2
444	HBL:Benefit Stage Amount Grouping Incorrect	-	-		-	-	-	-	-	2	-	-	2	2
485	HBL: Benefit Stage Qualifier Does Not Precede Benefit Stage Amount	-	-		-	-	-	-	-	2	-	-	2	2
489	HBL: DUR Co-Agent ID Qualifier Does Not Precede DUR Co-Agent ID	-	-		-	-	-	-	-	2	-	-	2	2
6E	M/I Other Payer Reject Code	-	-		-	-	-	-	-	-	2	-	2	2
6P	Pricing Segment Required For Adjudication	-	-		-	-	-	-	-	2	-	-	2	2

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	-	-		-	-	-	-	-	-	-	2	2	2
7R	Other Payer Amount Paid Count Exceeds Number of Supported Groupings	-	-		-	-	-	-	-	-	2	-	2	2
8D	Compound Segment Present On A Non- Compound Claim	-	-		-	-	-	-	-	2	-	-	2	2
9Y	Compound Product ID Qualifier Submitted Not Covered	-	-		-	-	-	-	-	2	-	-	2	2
HG	HBL: M/I Days Supply Intended To Be Dispensed	-	-		-	-	-	-	-	2	-	-	2	2
MX	HBL: Benefit Stage Count Does Not Match Number Of Repetitions	-	-		-	-	-	-	-	2	-	-	2	2
PC	HBL: M/I Claim Segment	-	-		-	-	-	-	-	2	-	-	2	2
RJ	HBL: Associated Partial Fill Transaction Not On File	-	-		-	-	-	-	1	1	-	-	2	2
14	M/I Eligibility Clarification Code	-	-		-	-	-	-	-	-	-	1	1	1
471	HBL: Other Amount Claimed Submitted Count Does Not Precede Other Amount Claimed Amount And/Or Qualifier	-	-		-	-	-	-	-	1	-	-	1	1
488	HBL: DUR/PPS Code Counter Does Not Precede DUR Data Fields	-	-		-	-	-	-	-	1	-	-	1	1
616	HBL: Submission Clarification Code 8 Required When Compound Ingredient Quantity Is 0	-	-		-	-	-	-	-	1	-	-	1	1
620	HBL: This Product/Service May Be Covered Under Medicare Part D	-	-		-	-	-	-	-	1	-	-	1	1
621	This Medicaid Patient Is Medicare Eligible	-	-		-	-	-	-	-	1	-	-	1	1
66	Patient Age Exceeds Maximum Age	-	-		-	-	-	-	-	1	-	-	1	1
7E	HBL: M/I DUR/PPS Code Counter	-	-		-	-	-	-	-	1	-	-	1	1
9Z	Duplicate Product ID In Compound	-	-		-	-	-	-	-	1	-	-	1	1
AK	M/I Software Vendor/Certification ID	-	-		-	-	-	-	-	-	1	-	1	1
CC	M/I Cardholder First Name	-	-		-	-	-	-	-	1	-	-	1	1
ED	M/I Compound Ingredient Quantity	-	-		-	-	-	-	-	1	-	-	1	1
EJ	M/I Originally Prescribed Product/Service ID Qualifier	-	-		-	-	-	-	-	-	-	1	1	1
EM	M/I Prescription/Service Reference Number Qualifier	-	-		-	-	-	-	-	-	-	1	1	1
HF	HBL: M/I Quantity Intended To Be Dispensed	-	-		-	-	-	-	-	1	-	-	1	1
M6	HBL: Host Eligibility Error	-	-		-	-	-	-	-	1	-	-	1	1
MP	Other Payer Cardholder ID Not Covered	-	-		-	-	-	-	-	1	-	-	1	1
MU	UHC: M/I Benefit Stage Count	-	-		-	-	-	-	-	-	-	1	1	1
P7	HBL: Diagnosis Code Count Does Not Match Number Of Repetitions	-	-		-	-	-	-	-	1	-	-	1	1
P8	HBL: DUR/PPS Code Counter Out Of Sequence	-	-		-	-	-	-	-	1	-	-	1	1
R3	HBL: Procedure Modifier Code Count Does Not Match Number Of Repetitions	-	-		-	-	-	-	-	1	-	-	1	1
RM	Completion Transaction Not Permitted With Same 'Date Of Service As Partial Transaction	-	-		-	-	-	-	-	1	-	-	1	1
X8	Procedure Modifier Code Count Exceeds Number Of Occurrences Supported	-	-		-	-	-	-	-	1	-	-	1	1
XF		-	-		-	-	-	-	-	1	-	-	1	1
Total			25		747	42,539	43,311	720,480	1,112,181	1,455,716	2,823,316	2,392,285	8,503,978	8,547,289

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.