Appendix 14.V – Total Number of Denied Claims (Section 20)

Denied Claims by CAR Code for Emergency Services State Fiscal Year 2014

CARC	Emergent Services Denial Reason	AMG	ACLA	LHCC	CHS	UHC	Total
2	Coinsurance Amount; Start: 01/01/1995;	30	0	0	0	0	30
4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.; Start: 01/01/1995 | Last Modified: 09/2	0	0	0	82	221	303
5	The procedure code/bill type is inconsistent with the place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.; Start: 01/01/1995 | Last Modified: 09/20/2009;	0	2	0	2	1	5
6	The procedure/revenue code is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.; Start: 01/01/1995 | Last Modified: 09/20/2009;	0	0	0	0	0	0
7	The procedure/revenue code is inconsistent with the patient's gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.; Start: 01/01/1995 | Last Modified: 09/20/2009;	0	0	1	0	0	1
8	The procedure code is inconsistent with the provider type/specialty (taxonomy). Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.; Start: 01/01/1995 | Last Modified: 09/20/2009;	0	1	0	0	2	3
9	The diagnosis is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.; Start: 01/01/1995 | Last Modified: 09/20/2009;	0	0	37	116	147	300
10	The diagnosis is inconsistent with the patient's gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.; Start: 01/01/1995 | Last Modified: 09/20/2009;	0	0	33	40	48	121
11	The diagnosis is inconsistent with the procedure. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.; Start: 01/01/1995 | Last Modified: 09/20/2009;	0	0	0	0	1	1
12	The diagnosis is inconsistent with the provider type. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.; Start: 01/01/1995 | Last Modified: 09/20/2009;	1,949	0	0	0	0	1,949
15	The authorization number is missing, invalid, or does not apply to the billed services or provider.; Start: 01/01/1995 | Last Modified: 09/30/2007;	0	0	0	0	23	23
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	0	3,366	198	13,612	24,541	41,717

CARC	Emergent Services Denial Reason	AMG	ACLA	LHCC	CHS	UHC	Total
18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO); Start: 01/01/1995 | Last Modified: 06/02/2013;	0	5,508	6,592	10,303	0	22,403
22	This care may be covered by another payer per coordination of benefits.; Start: 01/01/1995 | Last Modified: 09/30/2007;	0	36	29	20	4,583	4,668
23	The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA); Start: 01/01/1995 | Last Modified: 09/30/2012;	211	2,228	2	374	0	2,815
24	Charges are covered under a capitation agreement/managed care plan.; Start: 01/01/1995 | Last Modified: 09/30/2007;	0	0	0	2,210	13,798	16,008
26	Expenses incurred prior to coverage.; Start: 01/01/1995;	0	1,352	11	0	0	538
27	Expenses incurred after coverage terminated.; Start: 01/01/1995;	0	5,637	0	27	113	5,777
29	The time limit for filing has expired.; Start: 01/01/1995;	0	1,098	1,621	71	2,608	5,398
31	Patient cannot be identified as our insured.; Start: 01/01/1995 | Last Modified: 09/30/2007;	0	0	0	14	0	14
38	Now 242 and 243. Services not authorized / provided by network/primary care providers before 6/2/2013	0	0	0	12	0	12
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability) This change effective 11/1/2015: Charge exceeds fee schedule/maximum allowable or contracted/legislated f	0	200	464	127	0	791
50	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.; Start: 01/01/1995 | Last Modified: 09/	0	0	0	12	12	24
59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present	0	0	0	649	0	649
60	Charges for outpatient services are not covered when performed within a period of time prior to or after inpatient services.; Start: 01/01/1995 | Last Modified: 06/01/2008;	0	1	0	4	2	7
91	Dispensing fee adjustment.; Start: 01/01/1995;	2,131	0	0	0	0	2,131
94	Processed in Excess of charges.; Start: 01/01/1995;	0	4	0	0	0	4
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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 S	0	43	255	624	6,837	7,759
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.; S	0	2,487	0	5,299	415	8,201
106	Patient payment option/election not in effect.; Start: 01/01/1995;	176	0	0	0	0	176
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.; Start: 01/01/1995 | Last Modified: 01/29/2012;	0	1	2,711	2,955	0	5,667
112	Service not furnished directly to the patient and/or not documented.; Start: 01/01/1995 | Last Modified: 09/30/2007;	0	114	0	0	0	114
114	Procedure/product not approved by the Food and Drug Administration.; Start: 01/01/1995;	1	0	0	0	0	1

CARC	Emergent Services Denial Reason	AMG	ACLA	LHCC	CHS	UHC	Total
117	Transportation is only covered to the closest facility that can provide the necessary care.; Start: 01/01/1995 | Last Modified: 09/30/2007;	6,408	0	0	0	0	6,408
119	Benefit maximum for this time period or occurrence has been reached.; Start: 01/01/1995 | Last Modified: 02/29/2004;	0	0	274	93	241	608
125	Submission/billing error(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.)	0	478	0	50	0	528
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.); Start: 02/28/1997 | Last Modified: 01/30/2011;	0	28	0	0	0	28
131	Claim specific negotiated discount.; Start: 02/28/1997;	0	383	0	0	0	383
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 (use only in Loop 2110 CAS segment of the 835 or Loop 2430 of the 8	0	1	0	0	4,946	4,947
140	Patient/Insured health identification number and name do not match.; Start: 06/30/1999;	13	0	0	1,732	4	1,749
146	Diagnosis was invalid for the date(s) of service reported.; Start: 06/30/2002 | Last Modified: 09/30/2007;	0	32	0	0	0	32
148	Information from another provider 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.); Start: 06/30/2	0	186	0	0	0	186
150	Payer deems the information submitted does not support this level of service.; Start: 10/31/2002 | Last Modified: 09/30/2007;	0	0	872	0	0	872
151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.; Start: 10/31/2002 | Last Modified: 01/27/2008;	3	8	0	0	0	11
153	Payer deems the information submitted does not support this dosage.; Start: 10/31/2002 | Last Modified: 09/30/2007;	9	0	0	0	0	9
167	This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.; Start: 06/30/2005 | Last Modified: 09/20/2009;	0	0	0	869	0	869
168	Service(s) have been considered under the patient's medical plan. Benefits are not available under this dental plan.; Start: 06/30/2005 | Last Modified: 09/30/2007;	8	0	0	0	0	8
169	Alternate benefit has been provided.; Start: 06/30/2005 | Last Modified: 09/30/2007;	0	3	0	0	0	3
170	Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.; Start: 06/30/2005 | Last Modified: 09/20/2009;	0	0	0	1,215	990	2,205
176	Prescription is not current.; Start: 06/30/2005 | Last Modified: 09/30/2007;	78	0	0	0	0	78
181	Procedure code was invalid on the date of service.; Start: 06/30/2005 | Last Modified: 09/30/2007;	52	25	0	0	0	77

CARC	Emergent Services Denial Reason	AMG	ACLA	LHCC	CHS	UHC	Total
182	Procedure modifier was invalid on the date of service.; Start: 06/30/2005 | Last Modified: 09/30/2007;	0	9	0	0	0	9
183	The referring provider is not eligible to refer the service billed. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.; Start: 06/30/2005 | Last Modified: 09/20/2009;	1	0	0	0	0	1
197	Precertification/authorization/notification absent.; Start: 10/31/2006 | Last Modified: 09/30/2007;	0	0	20	0	1	21
198	Precertification/authorization exceeded.; Start: 10/31/2006 | Last Modified: 09/30/2007;	0	0	0	0	0	0
199	Revenue code and Procedure code do not match.; Start: 10/31/2006;	0	0	0	2	28	30
200	Expenses incurred during lapse in coverage; Start: 10/31/2006;	102	3	0	0	0	105
201	Patient is responsible for amount of this claim/service through 'set aside arrangement' or other agreement. (Use only with Group Code PR) At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance	130	0	0	0	0	130
202	Non-covered personal comfort or convenience services.; Start: 02/28/2007 | Last Modified: 09/30/2007;	5,128	0	0	0	0	5,128
206	National Provider Identifier - missing.; Start: 07/09/2007 | Last Modified: 09/30/2007;	341	0	0	0	0	341
208	National Provider Identifier - Not matched.; Start: 07/09/2007 | Last Modified: 09/30/2007;	0	0	1	0	0	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	1,079	0	0	0	0	1,079
231	Mutually exclusive procedures cannot be done in the same day/setting. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.; Start: 07/01/2009 | Last Modified: 09/20/2009;	0	0	0	354	123	477
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.); Start: 01/24/2010;	0	0	40	0	0	40
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	23	833	0	0	0	856
239	Claim spans eligible and ineligible periods of coverage. Rebill separate claims.; Start: 03/01/2012 | Last Modified: 01/29/2012;	2,462	0	0	0	0	2,462
241	Low Income Subsidy (LIS) Co-payment Amount; Start: 06/03/2012;	344	0	0	0	0	344
243	Services not authorized by network/primary care providers.; Start: 06/03/2012 | Last Modified: 06/02/2013; Notes: This code replaces deactivated code 38	0	0	0	0	56	56
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	0	0	0	0	4	4
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).; Start: 09/30/2012	0	0	0	2	10	12

CARC	Emergent Services Denial Reason	AMG	ACLA	LHCC	CHS	UHC	Total
264	Adjustment for postage cost. Note: To be used for pharmaceuticals only.; Start: 11/01/2014;	41	0	0	0	0	41
269	Anesthesia not covered for this service/procedure. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.; Start: 03/01/2015;	27	0	0	0	0	27
270	Claim received by the medical plan, but benefits not available under this plan. Submit these services to the patient's dental plan for further consideration.; Start: 07/01/2015;	1,145	0	0	0	0	1,145
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.); Start: 01/01/1995 | Last Modified: 09/20/2009;	0	36	3,889	478	0	4,403
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.; Start: 01/01/1995 | Last Mod	0	0	0	276	374	650
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.; Start: 01/01/1995;	0	1,341	0	0	0	1,341
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.; Start: 01/01/1995;	0	53	34	0	0	87
B14	Only one visit or consultation per physician per day is covered.; Start: 01/01/1995 | Last Modified: 09/30/2007;	1	0	0	0	0	1
B20	Procedure/service was partially or fully furnished by another provider.; Start: 01/01/1995 | Last Modified: 09/30/2007;	0	23	0	0	0	23
	No CARC reported	1,904	0	0	0	0	1,904
	Health Plan Total	**23,797**	**25,520**	**17,084**	**41,624**	**60,129**	**168,154**

Denied Claims by CAR Code for Non-Emergency Services State Fiscal Year 2014

CARC	Non-Emergent Services Denial Reason	AMG	ACLA	LHCC	CHS	UHC	Total
4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.; Start: 01/01/1995	7,376	192	11,039	16,406	21,213	56,226
5	The procedure code/bill type is inconsistent with the place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.; Start: 01/01/1995 | Last Modified: 09/20/2009;	1,034	3,205	0	8,314	15,453	28,006
6	The procedure/revenue code is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.; Start: 01/01/1995 | Last Modified: 09/20/2009;	439	1,356	19,984	12,886	10,752	45,417
7	The procedure/revenue code is inconsistent with the patient's gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.; Start: 01/01/1995 | Last Modified: 09/20/2009;	52	278	487	93	244	1,154
8	The procedure code is inconsistent with the provider type/specialty (taxonomy). Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.; Start: 01/01/1995 | Last Modified: 09/20/2009;	952	86,264	638	110,211	216,947	415,012
9	The diagnosis is inconsistent with the patient's age. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.; Start: 01/01/1995 | Last Modified: 09/20/2009;	4,550	14	7,119	7,045	8,638	27,366
10	The diagnosis is inconsistent with the patient's gender. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.; Start: 01/01/1995 | Last Modified: 09/20/2009;	847	0	810	1,363	845	3,865
11	The diagnosis is inconsistent with the procedure. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.; Start: 01/01/1995 | Last Modified: 09/20/2009;	2,747	0	26	168	7	2,948
13	The date of death precedes the date of service.; Start: 01/01/1995;	0	0	0	9	16	25
15	The authorization number is missing, invalid, or does not apply to the billed services or provider.; Start: 01/01/1995 | Last Modified: 09/30/2007;	8	20	112	228	2,786	3,154
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)	77,096	55,148	35,907	312,876	534,466	1,014,863
18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO); Start: 01/01/1995 | Last Modified: 06/02/2013;	107,026	125,320	148,257	400,507	40	781,150
20	This injury/illness is covered by the liability carrier.; Start: 01/01/1995 | Last Modified: 09/30/2007;	0	7	0	0	0	7

CARC	Non-Emergent Services Denial Reason	AMG	ACLA	LHCC	CHS	UHC	Total
22	This care may be covered by another payer per coordination of benefits.; Start: 01/01/1995 | Last Modified: 09/30/2007;	0	724	559	509	111,921	113,713
23	The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA); Start: 01/01/1995 | Last Modified: 09/30/2012;	1,300	28,921	657	6,810	0	37,688
24	Charges are covered under a capitation agreement/managed care plan.; Start: 01/01/1995 | Last Modified: 09/30/2007;	0	24	73	7,771	246,638	254,506
26	Expenses incurred prior to coverage.; Start: 01/01/1995;	3	14,743	705	0	0	14,863
27	Expenses incurred after coverage terminated.; Start: 01/01/1995;	22	73,342	7	251	1,207	74,829
28	Coverage not in effect at the time the service was provided.	0	84,899	0	0	0	84,899
29	The time limit for filing has expired.; Start: 01/01/1995;	22,179	38,632	16,812	751	33,394	111,768
31	Patient cannot be identified as our insured.; Start: 01/01/1995 | Last Modified: 09/30/2007;	0	23	34	467	59	583
32	Our records indicate that this dependent is not an eligible dependent as defined.; Start: 01/01/1995;	0	2	0	0	0	2
34	Insured has no coverage for newborns.; Start: 01/01/1995 | Last Modified: 09/30/2007;	0	0	16	0	0	16
35	Lifetime benefit maximum has been reached.; Start: 01/01/1995 | Last Modified: 10/31/2002;	1	0	0	181	4	186
38	Now 242 and 243. Services not authorized / provided by network/primary care providers before 6/2/2013	0	0	0	3,031	0	3,031
39	Services denied at the time authorization/pre-certification was requested.; Start: 01/01/1995;	462	369	1	0	0	832
42	Charges exceed our fee schedule or maximum allowable amount. (Use CARC 45)	0	4,158	0	0	0	4,158
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use only with Group Codes PR or CO depending upon liability) This change effective 11/1/2015: Charge exceeds fee schedule/maximum allowable or contracted/legislated	30,202	146,022	8,219	14,105	0	198,548
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. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Inform	0	0	2,908	0	0	2,908
50	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.; Start: 01/01/1995	79	285	43	387	171	965
52	The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.	0	92	0	0	0	92

CARC	Non-Emergent Services Denial Reason	AMG	ACLA	LHCC	CHS	UHC	Total
54	Multiple physicians/assistants are not covered in this case. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.; Start: 01/01/1995 | Last Modified: 09/20/2009;	180	84	0	2	1	267
55	Procedure/treatment is deemed experimental/investigational by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. This change effective 9/1/2015	849	0	0	25	33	907
58	Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.; Start: 01/01/1995	0	0	0	8	0	8
59	Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present	152	1,827	0	224,055	45,453	271,487
60	Charges for outpatient services are not covered when performed within a period of time prior to or after inpatient services.; Start: 01/01/1995 | Last Modified: 06/01/2008;	0	77	0	99	33	209
78	Non-Covered days/Room charge adjustment.; Start: 01/01/1995;	0	0	0	27	0	27
94	Processed in Excess of charges.; Start: 01/01/1995;	0	19	0	2	0	21
95	Plan procedures not followed.; Start: 01/01/1995 | Last Modified: 09/30/2007;	0	163	0	0	0	163
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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 S)	4,025	60,833	66,830	62,771	306,442	500,901
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	21,477	34,135	71	251,191	8,792	315,666
107	The related or qualifying claim/service was not identified on this claim. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.; Start: 01/01/1995 | Last Modified: 09/20/2009;	0	0	0	33,376	970	34,346
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.; Start: 01/01/1995 | Last Modified: 01/29/2012;	4,271	408	14,263	10,694	0	29,636
112	Service not furnished directly to the patient and/or not documented.; Start: 01/01/1995 | Last Modified: 09/30/2007;	0	2,966	0	0	0	2,966
119	Benefit maximum for this time period or occurrence has been reached.; Start: 01/01/1995 | Last Modified: 02/29/2004;	10,068	697	29,079	14,270	205,725	259,839

CARC	Non-Emergent Services Denial Reason	AMG	ACLA	LHCC	CHS	UHC	Total
125	Submission/billing error(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.)	0	90,665	0	5,844	0	96,509
128	Newborn's services are covered in the mother's Allowance.; Start: 02/28/1997;	3,230	2,874	0	0	255	6,359
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.); Start: 02/28/1997 | Last Modified: 01/30/2011;	0	1,291	0	0	0	1,291
131	Claim specific negotiated discount.; Start: 02/28/1997;	0	9,575	0	0	0	9,575
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 (use only in Loop 2110 CAS segment of the 835 or Loop 2430)	0	3	0	415	90,127	90,545
140	Patient/Insured health identification number and name do not match.; Start: 06/30/1999;	0	0	0	21,593	100	21,693
146	Diagnosis was invalid for the date(s) of service reported.; Start: 06/30/2002 | Last Modified: 09/30/2007;	0	2,260	599	0	0	2,859
148	Information from another provider 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.); Start: 06/30/2	0	3,920	0	38	0	3,958
150	Payer deems the information submitted does not support this level of service.; Start: 10/31/2002 | Last Modified: 09/30/2007;	84	0	32,728	1	0	32,813
151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.; Start: 10/31/2002 | Last Modified: 01/27/2008;	1	346	0	40	0	387
153	Payer deems the information submitted does not support this dosage.; Start: 10/31/2002 | Last Modified: 09/30/2007;	0	34,546	0	0	0	34,546
154	Payer deems the information submitted does not support this day's supply.; Start: 10/31/2002 | Last Modified: 09/30/2007;	0	14,173	0	0	0	14,173
166	These services were submitted after this payers responsibility for processing claims under this plan ended.; Start: 02/28/2005;	0	0	0	102	343	445
167	This (these) diagnosis(es) is (are) not covered. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.; Start: 06/30/2005 | Last Modified: 09/20/2009;	0	711	0	4,442	0	5,153
169	Alternate benefit has been provided.; Start: 06/30/2005 | Last Modified: 09/30/2007;	0	48	0	0	0	48
170	Payment is denied when performed/billed by this type of provider. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.; Start: 06/30/2005 | Last Modified: 09/20/2009;	1,307	0	0	12,970	11,192	25,469

CARC	Non-Emergent Services Denial Reason	AMG	ACLA	LHCC	CHS	UHC	Total
173	Service/equipment was not prescribed by a physician.; Start: 06/30/2005 | Last Modified: 07/01/2013;	1	0	0	0	0	1
177	Patient has not met the required eligibility requirements.; Start: 06/30/2005 | Last Modified: 09/30/2007;	71	0	0	0	0	71
179	Patient has not met the required waiting requirements. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.; Start: 06/30/2005 | Last Modified: 09/20/2009;	0	111,876	0	0	0	111,876
180	Patient has not met the required residency requirements.; Start: 06/30/2005 | Last Modified: 09/30/2007;	0	0	0	0	0	0
181	Procedure code was invalid on the date of service.; Start: 06/30/2005 | Last Modified: 09/30/2007;	0	6,278	0	0	0	6,278
182	Procedure modifier was invalid on the date of service.; Start: 06/30/2005 | Last Modified: 09/30/2007;	0	5,651	32	0	0	5,683
184	The prescribing/ordering provider is not eligible to prescribe/order the service billed. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.; Start: 06/30/2005 | Last Modified: 09/20/20	0	0	0	0	21	21
185	The rendering provider is not eligible to perform the service billed. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.; Start: 06/30/2005 | Last Modified: 09/20/2009;	0	2	0	0	0	2
188	This product/procedure is only covered when used according to FDA recommendations.; Start: 06/30/2005;	0	6	0	0	0	6
189	'Not otherwise classified' or 'unlisted' procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service; Start: 06/30/2005;	0	0	7	0	0	7
193	Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.; Start: 02/28/2006 | Last Modified: 01/27/2008;	0	0	177	0	0	177
197	Precertification/authorization/notification absent.; Start: 10/31/2006 | Last Modified: 09/30/2007;	92,136	11,115	104,106	1,480	2,673	211,510
198	Precertification/authorization exceeded.; Start: 10/31/2006 | Last Modified: 09/30/2007;	820	524	819	0	0	2,163
199	Revenue code and Procedure code do not match.; Start: 10/31/2006;	3	0	0	159	680	842
200	Expenses incurred during lapse in coverage; Start: 10/31/2006;	0	135	0	0	0	135
203	Discontinued or reduced service.; Start: 02/28/2007 | Last Modified: 09/30/2007;	0	1,059	0	0	0	1,059
204	This service/equipment/drug is not covered under the patient's current benefit plan; Start: 02/28/2007;	474	133,871	0	0	0	134,345
206	National Provider Identifier - missing.; Start: 07/09/2007 | Last Modified: 09/30/2007;	553	0	3,948	0	0	4,501

CARC	Non-Emergent Services Denial Reason	AMG	ACLA	LHCC	CHS	UHC	Total
207	National Provider identifier - Invalid format; Start: 07/09/2007 | Last Modified: 06/01/2008;	0	678	0	0	0	678
208	National Provider Identifier - Not matched.; Start: 07/09/2007 | Last Modified: 09/30/2007;	0	0	6	0	0	6
216	Based on the findings of a review organization; Start: 01/27/2008;	5	1	0	0	0	6
222	Exceeds the contracted maximum number of hours/days/units by this provider for this period. This is not patient specific. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	3,588	845	11,135	0	0	15,568
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	0	1	0	0	0	1
231	Mutually exclusive procedures cannot be done in the same day/setting. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.; Start: 07/01/2009 | Last Modified: 09/20/2009;	0	0	0	7,739	2,398	10,137
233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.; Start: 01/24/2010;	7	0	0	37	5	49
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.); Start: 01/24/2010;	784	0	50,031	0	0	50,815
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	96	25,521	0	0	0	25,617
243	Services not authorized by network/primary care providers.; Start: 06/03/2012 | Last Modified: 06/02/2013; Notes: This code replaces deactivated code 38	0	0	0	328	2,750	3,078
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	1,390	0	0	0	0	1,390
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	1,608	0	0	16	84	1,708
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).; Start: 09/30/2012	51,577	673	0	249	1,311	53,810
256	Service not payable per managed care contract.; Start: 06/02/2013;	19,558	0	0	0	0	19,558
273	Coverage/program guidelines were exceeded.	0	23,410	0	0	0	23,410

CARC	Non-Emergent Services Denial Reason	AMG	ACLA	LHCC	CHS	UHC	Total
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.); Start: 01/01/1995 | Last Modified: 09/20/2009;	0	1,757	156,615	8,981	0	167,353
A8	Ungroupable DRG.; Start: 01/01/1995 | Last Modified: 09/30/2007;	1	0	0	0	0	1
B5	Coverage/program guidelines were not met or were exceeded.; Start: 01/01/1995 | Last Modified: 09/30/2007;	1,307	0	891	0	0	2,198
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.; Start: 01/01/1995	88	0	0	17,241	9,582	26,911
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.; Start: 01/01/1995;	12	66,601	0	0	974	67,587
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.; Start: 01/01/1995;	5	12,875	3,948	0	0	16,828
B14	Only one visit or consultation per physician per day is covered.; Start: 01/01/1995 | Last Modified: 09/30/2007;	333	0	0	22	2	357
B15	This service/procedure requires that a qualifying service/procedure be received and covered. The qualifying other service/procedure has not been received/adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment)	36	0	0	0	0	36
B16	'New Patient' qualifications were not met.; Start: 01/01/1995 | Last Modified: 09/30/2007;	0	0	0	10,096	7,119	17,215
B20	Procedure/service was partially or fully furnished by another provider.; Start: 01/01/1995 | Last Modified: 09/30/2007;	0	299	9	0	165	473
B23	Procedure billed is not authorized per your Clinical Laboratory Improvement Amendment (CLIA) proficiency test.; Start: 01/01/1995 | Last Modified: 09/30/2007;	0	15,966	0	14,754	29,625	60,345
D18	Claim/Service has missing diagnosis information.	0	14,719	0	0	0	14,719
204,15,119,18 Combined	204-This service/equipment/drug is not covered under the patient's current benefit plan 15-The authorization number is missing, invalid, or does not apply to the billed services or provider. 119-Benefit maximum for this time period or occurrence has been reached. 18-Exact duplicate claim/service	428,859	0	0	0	0	428,859
	No CARC reported	37,073	0	382	0	416	37,871
	Health Plan Total	**942,404**	**1,359,524**	**730,089**	**1,607,436**	**1,932,072**	**6,571,525**