

Appendix VIII – Total Number of Denied Claims (Section 20)

Denied Medical Claims by Claim Adjustment Reason Code (CARC) for Emergency Services July 1, 2015 – June 30, 2016

CARC CODE	CARC Description	AETNA	AMG	ACLA	LHCC	UHC	MCNA	Total
197	Precertification/authorization/notification absent.	60	30	0	249	552	0	891
18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	3,252	8,031	7,160	13,098	10,010	0	41,551
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 Service Payment Information REF), if present.	738	51	1,294	1,611	5,068	0	8,762
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.	3,047	165	3,977	16	1,832	0	9,037
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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	781	316	6,151	819	5,111	0	13,178
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).	0	5,720	0	0	9,984	0	15,704
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.)	0	0	414	2,506	0	0	2,920
150	Payer deems the information submitted does not support this level of service.	0	0	0	1,847	34	0	1,881
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.	80	111	58	0	34	0	283
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.	0	0	10	0	2	0	12
29	The time limit for filing has expired.	208	1,002	1,419	1,660	306	0	4,595
27	Expenses incurred after coverage terminated.	0	0	5,924	0	4,902	0	10,826
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	0	0	95	122	2,085	0	2,302
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.	4	0	666	0	0	0	670

169	Alternate benefit has been provided.	0	0	7	0	0	0	7
95	Plan procedures not followed.	0	0	60	0	0	0	60
22	This care may be covered by another payer per coordination of benefits.	88	0	165	6,462	100	0	6,815
119	Benefit maximum for this time period or occurrence has been reached.	307	299	2,077	5	29	0	2,717
256	Service not payable per managed care contract.	0	311	0	0	0	0	311
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 837).	1,619	0	5	0	162	0	1,786
204	This service/equipment/drug is not covered under the patient's current benefit plan	0	758	0	2,312	0	0	3,070
26	Expenses incurred prior to coverage.	1,958	0	251	1	864	0	3,074
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.)	0	2	76	186	0	0	264
177	Patient has not met the required eligibility requirements.	0	4,435	0	0	0	0	4,435
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	1,274	177	8	432	707	0	2,598
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.	22	68	40	111	369	0	610
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.	0	0	2	1	1	0	4
46	This (these) service(s) is (are) not covered.	472	0	2,148	0	0	0	2,620
31	Patient cannot be identified as our insured.	0	0	48	2	3,747	0	3,797
131	Claim specific negotiated discount.	0	0	4,772	0	0	0	4,772
199	Revenue code and Procedure code do not match.	283	473	0	0	0	0	756
128	Newborn's services are covered in the mother's Allowance.	0	1	0	0	8	0	9
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.	0	0	1,060	0	0	0	1,060
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.	0	5	0	3	0	0	8
39	Services denied at the time authorization/pre-certification was requested.	0	4	0	3	549	0	556
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)	3	8	2	0	0	0	13

15	The authorization number is missing, invalid, or does not apply to the billed services or provider.	0	0	0	3	0	0	3
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.	0	0	71	0	0	0	71
198	Precertification/authorization exceeded.	0	0	0	0	15	0	15
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.	0	82	0	0	119	0	201
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.	27	0	38	0	2	0	67
147	Provider contracted/negotiated rate expired or not on file.	49	0	0	0	0	0	49
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.	1	0	563	0	0	0	564
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).	0	13	0	0	0	0	13
146	Diagnosis was invalid for the date(s) of service reported.	5	0	160	0	37	0	202
151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.	4	0	13	0	0	0	17
23	The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)	0	46	1	152	0	0	199
181	Procedure code was invalid on the date of service.	1	0	63	0	1	0	65
193	Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.	2	0	0	88	0	0	90
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.	7	0	0	0	0	0	7
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 Information REF), if present.	2	3	1	0	3	0	9
182	Procedure modifier was invalid on the date of service.	2	0	47	0	9	0	58
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.	8	39	0	77	77	0	201

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.	0	0	0	0	351	0	351
B20	Procedure/service was partially or fully furnished by another provider.	0	0	46	0	190	0	236
206	National Provider Identifier - missing.	0	1	0	0	7	0	8
112	Service not furnished directly to the patient and/or not documented.	0	0	198	0	0	0	198
B14	Only one visit or consultation per physician per day is covered.	25	64	156	0	0	0	245
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.)	0	0	85	1	7	0	93
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.	53	0	0	0	0	0	53
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.)	0	0	137	0	0	0	137
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.	1	0	51	0	3	0	55
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	74	0	0	0	0	77
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.)	10	0	0	0	0	0	10
24	Charges are covered under a capitation agreement/managed care plan.	1	0	23	2	0	0	26
40	Charges do not meet qualifications for emergent/urgent care. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1	0	0	0	0	0	1
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.	0	128	1	0	0	0	129
120	Patient is covered by a managed care plan.	0	0	506	0	0	0	506
60	Charges for outpatient services are not covered when performed within a period of time prior to or after inpatient services.	0	0	1	0	14	0	15
110	Billing date predates service date.	0	0	1	0	1	0	2

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.	0	0	0	0	15	0	15
47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.	46	0	0	0	0	0	46
2	Coinsurance Amount	0	0	0	0	9	0	9
243	Services not authorized by network/primary care providers.	0	1	0	0	0	0	1
273	Coverage/program guidelines were exceeded.	0	0	0	0	0	0	0
19	This is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.	2	0	0	0	0	0	2
21	This injury/illness is the liability of the no-fault carrier.	0	0	0	0	1	0	1
No CARC provided		0	10	4	0	0	14	0
GRAND TOTAL		40,051	14,456	22,422	31,769	47,317	156,015	0

Denied Medical Claims by Claim Adjustment Reason Code for Non-Emergency Services July 1, 2015 – June 30, 2016

CARC CODE	CARC Description	AETNA	AMG	ACLA	LHCC	UHC	MCNA	Total
197	Precertification/authorization/notification absent.	130,951	227,564	162,532	362,413	574,389	0	1,457,849
18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	101,982	226,950	159,588	290,455	303,564	59,535	1,142,074
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 Service Payment Information REF), if present.	48,757	23,257	129,107	263,202	251,614	0	715,937
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.	111,121	173,851	87,413	34,558	155,990	2	562,935
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.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	35,887	61,640	130,695	141,737	136,555	19,588	526,102
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).	0	95,155	470	1,096	136,904	17,852	251,477
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.)	0	0	14,592	229,743	0	0	244,335
150	Payer deems the information submitted does not support this level of service.	3	843	75	67,152	120,282	0	188,355
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.	27,325	62,876	24,688	29,263	23,891	0	168,043
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.	9	1,039	129,978	19,321	782	0	151,129
29	The time limit for filing has expired.	6,405	26,550	41,210	61,320	6,043	2,110	143,638

27	Expenses incurred after coverage terminated.	3	1	65,072	14	68,996	1,210	135,296
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	0	4	4,224	12,588	110,874	10,465	138,155
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.	8,029	3,686	22,027	96	101,708	0	135,546
169	Alternate benefit has been provided.	0	0	98	0	0	130,733	130,831
95	Plan procedures not followed.	0	0	109,036	0	0	151	109,187
22	This care may be covered by another payer per coordination of benefits.	1,617	0	973	88,802	4,652	0	96,044
119	Benefit maximum for this time period or occurrence has been reached.	182	30,232	1,006	59,583	332	0	91,335
256	Service not payable per managed care contract.	0	84,693	0	0	0	0	84,693
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 837).	74,083	0	38	0	6,861	0	80,982
204	This service/equipment/drug is not covered under the patient's current benefit plan	395	26,454	3,935	46,711	1,236	0	78,731
26	Expenses incurred prior to coverage.	40,071	8	6,388	255	21,637	79	68,438
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.)	0	417	2,080	53,336	10,817	0	66,650
177	Patient has not met the required eligibility requirements.	10	58,783	0	0	0	227	59,020
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	14,038	10,616	3,534	17,177	15,002	0	60,367
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.	1,667	8,742	1,829	14,583	34,788	0	61,609
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.	1,168	1,791	1,775	30,311	2,342	22,916	60,303
46	This (these) service(s) is (are) not covered.	0	0	0	0	0	42,512	42,512
31	Patient cannot be identified as our insured.	0	0	827	39	40,172	18	41,056
131	Claim specific negotiated discount.	0	0	39,611	0	0	0	39,611
199	Revenue code and Procedure code do not match.	30,031	11,467	0	0	0	0	41,498
128	Newborn's services are covered in the mother's Allowance.	1	3,682	3,155	0	33,611	0	40,449
N640	Exceeds number/frequency approved/allowed within time period.	0	0	0	0	0	39,800	39,800
236	This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided	0	0	38,096	0	0	0	38,096

	on the same day according to the National Correct Coding Initiative or workers compensation state regulations/ fee schedule requirements.							
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.	0	11,848	417	25,057	117	0	37,439
39	Services denied at the time authorization/pre-certification was requested.	2,561	2,298	2,426	4,595	18,492	219	30,591
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)	23	1,134	27,718	0	0	0	28,875
15	The authorization number is missing, invalid, or does not apply to the billed services or provider.	10	90	112	26,287	0	1,454	27,953
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.	0	1	20,013	0	21	0	20,035
198	Precertification/authorization exceeded.	1,761	6,319	1,975	9,263	200	0	19,518
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.	1	4,454	5,951	3,186	2,959	665	17,216
242	Services not provided by network/primary care providers.	0	3,030	0	0	0	14,271	17,301
B23	Procedure billed is not authorized per your Clinical Laboratory Improvement Amendment (CLIA) proficiency test.	0	0	16,408	632	1	0	17,041
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.	1,930	164	5,728	7,959	829	0	16,610
147	Provider contracted/negotiated rate expired or not on file.	16,048	45	0	0	0	0	16,093
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.	2,196	0	10,779	0	0	0	12,975
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 Information REF), if present.	0	0	0	23	0	12,241	12,264

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).	0	2,043	0	3,612	5,865	101	11,621
62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.	0	0	0	0	0	10,870	10,870
146	Diagnosis was invalid for the date(s) of service reported.	354	11	4,718	2,495	2,978	0	10,556
151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.	1,218	0	6,913	0	2,150	0	10,281
23	The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)	5	1,153	23	8,682	0	0	9,863
181	Procedure code was invalid on the date of service.	1,341	0	7,876	0	23	267	9,507
193	Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.	343	0	0	6,952	0	1,311	8,606
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.	2,799	3,023	2,455	0	246	0	8,523
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 Information REF), if present.	104	625	1,629	489	4,493	0	7,340
182	Procedure modifier was invalid on the date of service.	98	0	6,703	57	144	0	7,002
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.	385	1,214	3	1,832	2,645	0	6,079
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.	1,284	40	1,166	35	1,483	433	4,441
B20	Procedure/service was partially or fully furnished by another provider.	0	0	466	21	1,577	2,353	4,417
206	National Provider Identifier - missing.	0	130	0	3,923	420	0	4,473
112	Service not furnished directly to the patient and/or not documented.	0	0	3,912	0	77	0	3,989
55	Procedure/treatment/drug is deemed experimental/investigational by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0	4,160	0	0	0	0	4,160
B14	Only one visit or consultation per physician per day is covered.	68	2,370	749	0	0	718	3,905

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.)	0	0	3,351	141	309	0	3,801
272	Coverage/program guidelines were not met.	0	1	0	0	0	3,581	3,582
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.	3,411	58	0	0	0	0	3,469
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.)	0	0	3,261	0	0	0	3,261
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.	51	136	890	1,586	475	0	3,138
B5	Coverage/program guidelines were not met or were exceeded.	0	3,032	0	0	0	0	3,032
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.	0	0	0	0	0	2,979	2,979
N20	Service not payable with other service rendered on the same date.	0	0	0	0	0	2,824	2,824
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).	32	1,658	0	0	0	0	1,690
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.)	848	0	0	0	0	835	1,683
17	Requested information was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)	0	0	0	0	0	1,625	1,625
B8	Alternative services were available, and should have been utilized. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1	58	0	0	1,541	0	1,600
24	Charges are covered under a capitation agreement/managed care plan.	0	0	1,241	179	0	0	1,420
164	Attachment/other documentation referenced on the claim was not received in a timely fashion.	0	0	0	0	0	1,378	1,378

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.	105	262	274	0	487	0	1,128
40	Charges do not meet qualifications for emergent/urgent care. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	1	0	0	0	0	1,121	1,122
208	National Provider Identifier - Not matched.	0	25	0	4	0	1,025	1,054
B16	'New Patient' qualifications were not met.	0	0	0	546	468	0	1,014
171	Payment is denied when performed/billed by this type of provider in this type of facility. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	545	0	312	0	0	0	857
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.	32	280	72	0	182	87	653
56	Procedure/treatment has not been deemed 'proven to be effective' by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0	0	0	0	0	713	713
M51	Missing/incomplete/invalid procedure code(s).	0	23	0	0	0	647	670
163	Attachment/other documentation referenced on the claim was not received.	0	0	0	0	627	0	627
N290	Missing/incomplete/invalid rendering provider primary identifier.	0	0	0	0	0	569	569
120	Patient is covered by a managed care plan.	0	0	0	0	0	0	0
M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	0	0	0	0	0	450	450
60	Charges for outpatient services are not covered when performed within a period of time prior to or after inpatient services.	0	0	17	0	390	0	407
N786	Benefit limitation for the orthodontic active and/or retention phase of treatment.	0	0	0	0	0	385	385
86	Statutory Adjustment.	0	0	0	0	0	367	367
N384	Records indicate that the referenced body part/tooth has been removed in a previous procedure.	0	0	0	0	0	353	353
110	Billing date predates service date.	0	0	0	0	310	0	310
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.	0	0	308	2	0	0	310
N292	Missing/incomplete/invalid service facility name.	0	0	0	0	0	289	289

N36	Claim must meet primary payer's processing requirements before we can consider payment.	0	0	0	0	0	276	276
M56	Missing/incomplete/invalid payer identifier.	0	262	0	0	0	0	262
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.	0	0	0	0	211	0	211
84	Capital Adjustment. (Handled in MIA)	22	171	0	0	0	0	193
MA70	Missing/incomplete/invalid provider representative signature.	0	0	0	0	0	152	152
47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.	80	1	0	0	0	0	81
2	Coinsurance Amount	0	0	0	0	99	0	99
104	Managed care withholding.	0	0	0	0	87	0	87
140	Patient/Insured health identification number and name do not match.	0	0	0	0	0	82	82
N340	Missing/incomplete/invalid subscriber birth date.	0	0	0	0	0	78	78
63	Correction to a prior claim.	0	0	0	0	0	71	71
MA75	Missing/incomplete/invalid patient or authorized representative signature.	0	0	0	0	0	67	67
B12	Services not documented in patients' medical records.	0	51	0	0	0	0	51
99	Medicare Secondary Payer Adjustment Amount.	0	0	0	0	0	43	43
149	Lifetime benefit maximum has been reached for this service/benefit category.	41	0	0	0	0	0	41
243	Services not authorized by network/primary care providers.	0	40	0	0	0	0	40
273	Coverage/program guidelines were exceeded.	0	0	0	40	0	0	40
260	Processed under Medicaid ACA Enhanced Fee Schedule	0	38	0	0	0	0	38
108	Rent/purchase guidelines were not met. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0	0	0	0	34	0	34
239	Claim spans eligible and ineligible periods of coverage. Rebill separate claims.	29	0	0	0	0	0	29
35	Lifetime benefit maximum has been reached.	0	1	27	0	0	0	28
249	This claim has been identified as a readmission. (Use only with Group Code CO)	0	0	0	27	0	0	27
138	Appeal procedures not followed or time limits not met.	0	9	0	0	0	16	25
152	Payer deems the information submitted does not support this length of service. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	0	0	0	0	22	0	22
70	Cost outlier - Adjustment to compensate for additional costs.	0	0	20	0	0	0	20
42	Charges exceed our fee schedule or maximum allowable amount. (Use CARC 45)	0	0	0	0	0	19	19
123	Payer refund due to overpayment.	0	0	0	0	0	17	17

216	Based on the findings of a review organization	0	2	15	0	0	0	17
M144	Pre-/post-operative care payment is included in the allowance for the surgery/procedure.	0	0	0	0	0	15	15
32	Our records indicate that this dependent is not an eligible dependent as defined.	0	0	14	0	0	0	14
M86	Service denied because payment already made for same/similar procedure within set time frame.	0	0	0	0	0	13	13
258	Claim/service not covered when patient is in custody/incarcerated. Applicable federal, state or local authority may cover the claim/service.	0	12	0	0	0	0	12
233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.	0	0	0	9	2	0	11
N351	Service date outside of the approved treatment plan service dates.	0	11	0	0	0	0	11
189	'Not otherwise classified' or 'unlisted' procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service	0	0	0	10	0	0	10
M23	Missing invoice.	0	10	0	0	0	0	10
214	Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only	0	0	0	0	0	9	9
MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	0	9	0	0	0	0	9
M77	Missing/incomplete/invalid/inappropriate place of service.	0	8	0	0	0	0	8
N39	Procedure code is not compatible with tooth number/letter.	0	0	0	0	0	8	8
186	Level of care change adjustment.	0	0	7	0	0	0	7
28	Coverage not in effect at the time the service was provided.	0	0	0	0	0	7	7
19	This is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.	4	0	0	0	0	0	4
MA36	Missing/incomplete/invalid patient name.	0	6	0	0	0	0	6
65	Procedure code was incorrect. This payment reflects the correct code.	0	0	0	0	0	4	4
B1	Non-covered visits.	0	1	0	0	3	0	4
20	This injury/illness is covered by the liability carrier.	1	0	0	2	0	0	3
21	This injury/illness is the liability of the no-fault carrier.	0	0	0	2	0	0	2

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.)	0	0	3	0	0	0	3
30	Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.	0	3	0	0	0	0	3
B9	Patient is enrolled in a Hospice.	3	0	0	0	0	0	3
116	The advance indemnification notice signed by the patient did not comply with requirements.	2	0	0	0	0	0	2
34	Insured has no coverage for newborns.	1	1	0	0	0	0	2
M76	Missing/incomplete/invalid diagnosis or condition.	0	2	0	0	0	0	2
1	Deductible Amount	0	0	0	0	1	0	1
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.	0	0	1	0	0	0	1
3	Co-payment Amount	0	0	0	0	1	0	1
94	Processed in Excess of charges.	0	0	1	0	0	0	1
D15	Claim lacks indication that service was supervised or evaluated by a physician.	1	0	0	0	0	0	1
M130	Missing invoice or statement certifying the actual cost of the lens, less discounts, and/or the type of intraocular lens used.	0	1	0	0	0	0	1
N26	Missing itemized bill/statement.	0	1	0	0	0	0	1
N54	Claim information is inconsistent with pre-certified/authorized services.	0	1	0	0	0	0	1
P4	Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only	0	0	1	0	0	0	1
No CARC provided		0	286	551	237	0	11,686	10,612
GRAND TOTAL		1,322,007	671,760	1,191,178	1,931,640	2,213,011	7,752,414	422,818

Denied Claims by NCPDP Reject Codes for Emergency Services July 1, 2015 – June 30, 2016

NCPDP Reject Code	NCPDP Reject Description	AETNA	AMG	ACLA	LHCC	UHC	Total
79	Refill Too Soon	0	14	258	0	225	497
76	Plan Limitations Exceeded	2	20	58	0	1,183	1,263
70	Product/Service Not Covered – Plan/Benefit Exclusion	2	13	153	0	3,435	3,603
75	Prior Authorization Required	0	229	284	0	455	968
88	DUR Reject Error	0	22	86	0	1,034	1,142
MR	Product Not On Formulary	0	612	0	0	0	612
41	Submit Bill To Other Processor Or Primary Payer	0	2	3	0	1,176	1,181
85	Claim Not Processed	0	2	0	0	1	3
65	Patient Is Not Covered	0	0	6	0	967	973
69	Filled After Coverage Terminated	2	1	0	0	1,355	1,358
39	M/I Diagnosis Code	0	0	3	0	0	3
7X	Days Supply Exceeds Plan Limitation	0	2	0	0	0	2
AC	Product Not Covered Non-Participating Manufacturer	0	5	0	0	0	5
83	Duplicate Paid/Captured Claim	0	0	9	0	319	328
19	M/I Days Supply	0	0	0	0	10	10
77	Discontinued Product/Service ID Number	0	0	0	0	72	72
54	Non-Matched Product/Service ID Number	0	2	1	0	0	3
DV	M/I Other Payer Amount Paid	0	15	0	0	0	15
78	Cost Exceeds Maximum	0	0	2	0	20	22
M2	Recipient Locked In	0	7	0	0	68	75
50	Non-Matched Pharmacy Number	0	0	1	0	184	185
13	M/I Other Coverage Code	0	0	0	0	1	1
6C	M/I Other Payer ID Qualifier	0	1	0	0	12	13
7C	M/I Other Payer ID	0	3	0	0	0	3
EV	M/I Prior Authorization Number Submitted	0	97	0	0	5	102
40	Pharmacy Not Contracted With Plan On Date Of Service	0	1	0	0	0	1
22	M/I Dispense As Written (DAW)/Product Selection Code	0	0	7	0	0	7
BB	Diagnosis Code Qualifier Submitted Not Covered	0	9	0	0	0	9
E5	M/I Professional Service Code	0	3	0	0	0	3
67	Filled Before Coverage Effective	0	0	0	0	14	14

E6	M/I Result Of Service Code	0	3	0	0	0	3
09	M/I Date Of Birth	0	0	0	0	115	115
443	Other Payer-Patient Responsibility Amount Grouping Incorrect	0	10	0	0	0	10
R9	Value In Gross Amount Due Does Not Follow Pricing Formulae	0	7	0	0	0	7
NR	M/I Other Payer- Patient Responsibility Amount Count	0	2	0	0	0	2
56	Non-Matched Prescriber ID	0	0	0	0	15	15
21	M/I Product/Service ID	0	2	0	0	54	56
CB	M/I Patient Last Name	0	0	0	0	108	108
25	M/I Prescriber ID	2	1	0	0	2	5
9	M/I Date Of Birth	0	0	3	0	0	3
5E	M/I Other Payer Reject Count	0	2	0	0	0	2
8W	Discrepancy Between Other Coverage Code and Other Payer Amount Paid	0	2	0	0	0	2
8K	DAW Code Value Not Supported	0	3	0	0	0	3
80	Drug-Diagnosis Mismatch	0	0	0	0	8	8
7V	Duplicate Refills,	0	1	0	0	0	1
81	Claim Too Old	0	0	0	0	3	3
42	Plan's Prescriber data base indicates the Prescriber ID Submitted is inactive or expired	0	8	0	0	0	8
33	M/I Prescription Origin Code	0	0	0	0	13	13
EU	M/I Prior Authorization Type Code	0	35	0	0	3	38
8E	M/I DUR/PPS Level Of Effort	0	7	0	0	0	7
HA	M/I Flat Sales Tax Amount Submitted	0	0	0	0	20	20
6Z	Provider Not Eligible To Perform Service/Dispense Product	0	1	0	0	0	1
DQ	M/I Usual And Customary Charge	0	0	0	0	5	5
10	M/I Patient Gender Code	0	0	0	0	55	55
EZ	M/I Prescriber ID Qualifier	0	1	0	0	4	5
E7	M/I Quantity Dispensed	0	0	0	0	8	8
A1	ID Submitted is associated with a Sanctioned Prescriber	0	0	0	0	36	36
R2	Other Payer Reject Count Does Not Match Number Of Repetitors	0	0	0	0	14	14
28	M/I Date Prescription Written	0	0	0	0	2	2
AB	Date Written Is After Date Filled	0	1	0	0	0	1
E1	M/I Product/Service ID Qualifier	0	4	0	0	0	4
EW	M/I Intermediary Authorization Type Id	0	3	0	0	0	3

05	M/I Service Provider Number	0	0	0	0	2	2
E2	M/I Route of Administration	0	1	0	0	0	1
8R	Submission Clarification Code Value Not Supported	0	6	0	0	0	6
17	M/I Fill Number	0	0	0	0	5	5
EF	M/I Compound Dosage Form Description Code	0	0	0	0	4	4
DN	M/I Basis Of Cost Determination	0	0	0	0	1	1
9M	Minimum Of Two Ingredients Required	0	0	0	0	1	1
No NCPDP Provided		1	0	0	0	0	1
GRAND TOTAL		875	8	1,160	0	11,014	13,057

Denied Claims by NCPDP Reject Codes for Non-Emergency Services July 1, 2015 – June 30, 2016

NCPDP Reject Code	NCPDP Reject Description	AETNA	AMG	ACLA	LHCC	UHC	Total
79	Refill Too Soon	12,049	152,897	148,640	281,737	80,396	675,719
76	Plan Limitations Exceeded	17,474	128,423	61,436	381,240	62,155	650,728
70	Product/Service Not Covered – Plan/Benefit Exclusion	32,577	41,683	155,681	54,099	178,345	462,385
75	Prior Authorization Required	3,714	104,014	9,743	294,208	51,909	463,588
88	DUR Reject Error	22,591	47,146	65,759	0	160,348	295,844
MR	Product Not On Formulary	0	188,095	0	0	0	188,095
41	Submit Bill To Other Processor Or Primary Payer	5,442	39,388	11,888	28,254	45,522	130,494
85	Claim Not Processed	6	13,001	0	110,654	344	124,005
65	Patient Is Not Covered	0	2,858	80,055	6	30,935	113,854
69	Filled After Coverage Terminated	22,899	19,537	2	0	48,599	91,037
68	Filled After Coverage Expired	0	0	0	92,103	0	92,103
06	M/I Group ID	409	7	0	59,472	0	59,888
39	M/I Diagnosis Code	0	7	53,882	0	9	53,898
7X	Days Supply Exceeds Plan Limitation	9	47,386	0	0	0	47,395
AC	Product Not Covered Non-Participating Manufacturer	0	31,998	0	0	0	31,998
83	Duplicate Paid/Captured Claim	160	204	14,150	32	12,904	27,450
60	Product/Service Not Covered For Patient Age	0	0	23	22,599	0	22,622
19	M/I Days Supply	5,810	127	0	270	15,069	21,276
96	Scheduled Downtime	0	20,862	0	0	0	20,862
77	Discontinued Product/Service ID Number	2,272	7,430	2,265	4,439	2,087	18,493
54	Non-Matched Product/Service ID Number	0	5,317	7,292	5,813	0	18,422
AJ	Generic Drug Required	0	0	0	14,962	0	14,962
DV	M/I Other Payer Amount Paid	606	11,447	5	2,718	0	14,776
78	Cost Exceeds Maximum	0	446	7,114	1,644	4,227	13,431
52	Non-Matched Cardholder ID	0	302	88	12,669	0	13,059
M2	Recipient Locked In	0	8,967	0	2,636	862	12,465
50	Non-Matched Pharmacy Number	0	1,088	1,671	19	9,174	11,952
13	M/I Other Coverage Code	11,452	200	0	9	70	11,731
6C	M/I Other Payer ID Qualifier	2	10,596	0	0	260	10,858
7C	M/I Other Payer ID	0	10,626	0	0	73	10,699

EV	M/I Prior Authorization Number Submitted	0	9,011	0	0	312	9,323
40	Pharmacy Not Contracted With Plan On Date Of Service	656	6,468	0	2,234	0	9,358
22	M/I Dispense As Written (DAW)/Product Selection Code	0	69	8,184	257	0	8,510
BB	Diagnosis Code Qualifier Submitted Not Covered	0	6,466	0	0	0	6,466
PE	M/I Request Coordination Of Benefits/Other Payments Segment	0	6,339	0	0	0	6,339
E5	M/I Professional Service Code	471	5,761	0	0	5	6,237
HE	M/I Percentage Sales Tax Rate Submitted	0	6,000	66	0	3	6,069
67	Filled Before Coverage Effective	1,096	219	0	1,740	2,763	5,818
E6	M/I Result Of Service Code	0	5,726	0	0	0	5,726
JE	M/I Percentage Sales Tax Basis Submitted	0	5,508	0	0	8	5,516
09	M/I Date Of Birth	983	1	0	2,317	2,014	5,315
04	M/I Processor Control Number	20	2,340	0	2,677	0	5,037
443	Other Payer-Patient Responsibility Amount Grouping Incorrect	0	4,821	0	0	0	4,821
51	Non-Matched Group ID	0	0	0	4,140	0	4,140
R9	Value In Gross Amount Due Does Not Follow Pricing Formulae	0	3,770	0	0	0	3,770
NR	M/I Other Payer- Patient Responsibility Amount Count	0	3,752	0	5	2	3,759
56	Non-Matched Prescriber ID	287	0	1	2,979	426	3,693
21	M/I Product/Service ID	592	420	3	394	2,098	3,507
CB	M/I Patient Last Name	0	5	0	0	3,426	3,431
25	M/I Prescriber ID	210	1,304	784	1,103	55	3,456
9	M/I Date Of Birth	0	0	3,036	0	99	3,135
5E	M/I Other Payer Reject Count	1	2,842	0	0	0	2,843
8W	Discrepancy Between Other Coverage Code and Other Payer Amount Paid	393	2,239	0	0	0	2,632
8K	DAW Code Value Not Supported	0	2,568	0	0	0	2,568
80	Drug-Diagnosis Mismatch	0	108	0	0	2,350	2,458
7J	Patient Relationship Code Value Not Supported	0	2,190	0	0	0	2,190
9V	Prescriber ID Qualifier Submitted Not Covered	0	2,061	0	0	0	2,061
446	COB/Other Payments Segment Incorrectly Formatted	0	0	1,753	0	0	1,753
HB	M/I Other Payer Amount Paid Count	0	1,724	0	0	3	1,727
GE	M/I Percentage Sales Tax Amount Submitted	0	1,695	0	0	1	1,696
7V	Duplicate Refills,	0	1,682	0	0	0	1,682
81	Claim Too Old	318	432	371	187	368	1,676

42	Plan's Prescriber data base indicates the Prescriber ID Submitted is inactive or expired	7	1,643	0	0	0	1,650
7M	Discrepancy Between Other Coverage Code And Other Coverage Information On File	1,596	0	0	0	0	1,596
33	M/I Prescription Origin Code	573	209	0	158	633	1,573
NQ	M/I Other Payer- Patient Responsibility Amount	594	80	0	835	0	1,509
EU	M/I Prior Authorization Type Code	0	1,286	0	1	84	1,371
8E	M/I DUR/PPS Level Of Effort	0	1,302	0	0	0	1,302
609	COB Claim Not Required, Patient Liability Amount Submitted Was Zero	0	1,276	0	0	0	1,276
HC	M/I Other Payer Amount Paid Qualifier	11	127	0	1,094	0	1,232
HA	M/I Flat Sales Tax Amount Submitted	0	0	0	0	1,055	1,055
6Z	Provider Not Eligible To Perform Service/Dispense Product	0	984	0	0	0	984
11	M/I Patient Relationship Code	0	521	0	412	0	933
DQ	M/I Usual And Customary Charge	45	464	0	0	409	918
10	M/I Patient Gender Code	2	20	0	0	734	756
EZ	M/I Prescriber ID Qualifier	0	703	0	15	40	758
9E	Quantity Does Not Match Dispensing Unit	0	698	0	0	0	698
E7	M/I Quantity Dispensed	68	28	0	111	474	681
A1	ID Submitted is associated with a Sanctioned Prescriber	0	340	0	0	297	637
R2	Other Payer Reject Count Does Not Match Number Of Repetitors	0	16	0	37	578	631
82	Claim Is Post-Dated	130	0	3	343	83	559
28	M/I Date Prescription Written	0	362	0	0	162	524
44	Plan's Prescriber data base indicates the associated DEA to submitted Prescriber ID Is not found	525	0	0	0	0	525
AB	Date Written Is After Date Filled	0	149	0	362	0	511
E3	M/I Incentive Amount Submitted	467	21	0	0	9	497
E1	M/I Product/Service ID Qualifier	0	430	0	0	13	443
7Q	Other Payer ID Qualifier Value Not Supported	0	431	0	0	0	431
30	Reversal Request Outside Processor Reversal Window	0	397	0	27	0	424
6G	Coordination Of Benefits/Other Payments Segment Required For Adjudication	0	0	0	394	0	394
EW	M/I Intermediary Authorization Type Id	0	359	0	0	0	359
15	M/I Date of Service	0	344	0	0	0	344
E8	M/I Other Payer Date	0	333	0	6	0	339
23	M/I Ingredient Cost Submitted	2	263	58	0	0	323
AG	Days Supply Limitation For Product/Service	323	0	0	0	0	323

DU	M/I Gross Amount Due	0	102	0	216	0	318
7W	Refills Exceed allowable Refills	0	301	0	0	0	301
71	Prescriber ID Is Not Covered	34	171	94	0	0	299
5C	M/I Other Payer Coverage Type	1	188	0	61	17	267
05	M/I Service Provider Number	6	430	0	0	245	681
E4	M/I Reason For Service Code	0	248	0	0	3	251
E2	M/I Route of Administration	0	249	0	0	0	249
61	Product/Service Not Covered For Patient Gender	0	0	0	215	0	215
E9	M/I Provider ID	0	211	0	0	0	211
H8	M/I Other Amount Claimed Submitted Qualifier	0	201	0	0	0	201
8R	Submission Clarification Code Value Not Supported	0	187	0	0	0	187
72	Primary Prescriber Is Not Covered	0	0	0	173	0	173
08	M/I Person Code	0	142	0	0	0	142
35	M/I Primary Care Provider ID	0	128	0	0	11	139
C1	MEM/DEP covered by another carrier	0	133	0	0	0	133
47	Pharmacy signature required	0	118	0	0	0	118
17	M/I Fill Number	0	0	0	0	111	111
34	M/I Submission Clarification Code	0	102	0	0	4	106
C2	COB w/exp of benefits not attached	0	102	0	0	0	102
8B	Compound Segment Missing On A Compound Claim	0	0	0	91	0	91
8N	Future Date Prescription Written Not Allowed,	0	89	0	0	0	89
8Z	Product/Service ID Qualifier Value Not Supported	0	89	0	0	0	89
442	Other Payer Amount Paid Grouping Incorrect	0	85	0	0	0	85
EF	M/I Compound Dosage Form Description Code	0	55	0	0	26	81
NP	M/I Other Payer- Patient Responsibility Amount Qualifier	12	59	0	4	0	75
84	Claim Has Not Been Paid/Captured	1	0	0	0	69	70
SH	Other Payer-Patient Responsibility Amount Count Does Not Match Number of Repetitions	0	15	0	48	4	67
614	Uppercase Character(S) Required	0	65	0	0	0	65
2N	M/I Prescriber State/Province Address	1	62	0	0	0	63
CX	M/I Patient ID Qualifier	0	63	0	0	0	63
8A	Compound Requires At Least One Covered Ingredient	0	0	0	62	0	62
DN	M/I Basis Of Cost Determination	0	56	0	0	4	60

6T	Compound Segment Required For Adjudication	42	13	0	0	0	55
8M	Sum Of Compound Ingredient Costs Does Not Equal Ingredient Cost Submitted	0	0	0	55	0	55
FC	Not in closed formulary	0	55	0	0	0	55
P4	Coordination Of Benefits/Other Payments Count Does Not Match Number Of Repetitions	0	13	0	41	0	54
7P	Coordination Of Benefits/Other Payments Count Exceeds Number of Supported Payers	0	14	0	39	0	53
EX	M/I Intermediary Authorization ID	0	53	0	0	0	53
465	Patient ID Qualifier Does Not Precede Patient ID	0	52	0	0	0	52
DR	M/I Prescriber Last Name	0	31	0	20	0	51
01	M/I Bin Number	0	25	0	25	0	50
478	Other Payer ID Qualifier Does Not Precede Other Payer ID	0	42	0	0	0	42
EK	M/I Scheduled Prescription ID Number	0	42	0	0	0	42
3Y	Prior Authorization Denied	0	0	0	39	0	39
XJ	Invalid Ingredient Cost	0	38	0	0	0	38
64	Claim Submitted Does Not Match Prior Authorization	0	0	37	0	0	37
441	Other Amount Claimed Submitted Grouping Incorrect	0	36	0	0	0	36
WE	M/I Diagnosis Code Qualifier	0	35	0	0	1	36
B2	M/I Service Provider ID Qualifier	0	12	0	6	17	35
472	Other Amount Claimed Submitted Qualifier Does Not Precede Other Amount Claimed Submitted	0	34	0	0	0	34
EG	M/I Compound Dispensing Unit Form Indicator	0	34	0	0	0	34
37	Drug not covered by Plan	0	32	0	0	0	32
481	Other Payer Reject Count Does Not Precede Other Payer Reject Code	0	30	0	0	0	30
9M	Minimum Of Two Ingredients Required	0	0	0	0	27	27
CA	M/I Patient First Name	0	27	0	0	0	27
55	Non-Matched Product Package Size	0	0	26	0	0	26
2E	M/I Primary Care Provider ID Qualifier	0	25	0	0	0	25
4Y	Patient Residence Value Not Supported	0	24	0	0	0	24
RK	Partial Fill Transaction Not Supported	0	0	0	22	1	23
PD	M/I Request Clinical Segment	0	22	0	0	0	22
YD	Other Payer-Patient Responsibility Amount Count Exceeds Number Of Occurrences Supported	0	0	0	22	0	22
46	Plan's Prescriber data base indicates associated DEA to submitted Prescriber ID does not allow this drug DEA Schedule	21	0	0	0	0	21

2K	M/I Prescriber Street Address	0	20	0	0	0	20
5	M/I Service Provider Number	0	0	0	0	19	19
CP	M/I Patient Zip/Postal Zone	0	19	0	0	0	19
26	M/I Unit Of Measure	0	17	0	0	0	17
9G	Quantity Dispensed Exceeds Maximum Allowed	0	17	0	0	0	17
A2	ID Submitted is associated to a Deceased Prescriber	0	17	0	0	0	17
SF	Other Payer Amount Paid Count Does Not Match Number Of Repetitions	0	15	0	2	0	17
YC	Other Payer Reject Count Exceeds Number Of Occurrences Supported	0	7	0	9	0	16
1W	Multi-Ingredient Compound Must Be A Single Transaction	0	1	0	14	0	15
20	M/I Compound Code	0	15	0	0	0	15
43	Plan's Prescriber data base indicates the associated DEA to submitted Prescriber ID is inactive	15	0	0	0	0	15
8D	Compound Segment Present On A Non- Compound Claim	0	9	0	6	0	15
EE	M/I Compound Ingredient Drug Cost	0	3	0	11	0	14
2D	M/I Provider Accept Assignment Indicator	0	13	0	0	0	13
RE	M/I Compound Product ID Qualifier	12	0	0	0	0	12
SG	Submission Clarification Code Count Does Not Match Number of Repetitions	0	9	0	0	2	11
G1	M/I Compound Type	0	10	0	0	0	10
9T	Prior Authorization Type Code Submitted Not Covered	0	8	0	0	0	8
XH	Missing or invalid quantity	0	8	0	0	0	8
1T	PCN Must Contain Processor/Payer Assigned Value	0	0	0	7	0	7
3M	M/I Prescriber Phone Number	0	7	0	0	0	7
NX	M/I Submission Clarification Code Count	0	0	0	0	7	7
PF	M/I Request Compound Segment	0	7	0	0	0	7
PH	M/I Request DUR/PPS Segment	0	7	0	0	0	7
12	M/I Place of Service	6	0	0	0	0	6
445	Diagnosis Code Grouping Incorrect	0	6	0	0	0	6
6P	Pricing Segment Required For Adjudication	0	6	0	0	0	6
PC	M/I Request Claim Segment	0	6	0	0	0	6
16	M/I Prescription/Service Reference Number	0	5	0	0	0	5
474	Prescriber ID Qualifier Does Not Precede Prescriber ID	0	5	0	0	0	5
73	Refills Are Not Covered	0	1	4	0	0	5
7B	Service Provider ID Qualifier Value Not Supported For Processor/Payer	0	5	0	0	0	5

AK	M/I Software Vendor/Certification ID	4	1	0	0	0	5
CO	M/I Patient State/Province Address	0	5	0	0	0	5
1Y	Claim Segment Required For Adjudication	0	4	0	0	0	4
2M	M/I Prescriber City Address	0	4	0	0	0	4
32	M/I Level Of Service	0	2	0	0	2	4
H9	M/I Other Amount Claimed Submitted	0	3	0	1	0	4
RV	Multiple Reversals Per Transmission Not Supported	0	0	0	4	0	4
02	M/I Version/Release Number	3	0	0	0	0	3
38	M/I Basis Of Cost Determination	0	0	0	0	3	3
475	Primary Care Provider ID Qualifier Does Not Precede Primary Care Provider ID	0	3	0	0	0	3
489	DUR Co-Agent ID Qualifier Does Not Precede DUR Co-Agent ID	0	3	0	0	0	3
4X	M/I Patient Residence	0	0	0	3	0	3
7Y	Compounds Not Covered,	3	0	0	0	0	3
92	System Unavailable/Host Unavailable	0	0	0	0	3	3
95	Time Out	0	3	0	0	0	3
EM	M/I Prescription/Service Reference Number Qualifier	0	2	0	0	1	3
J9	M/I Dur Co-Agent Id Qualifier	0	3	0	0	0	3
MP	Other Payer Cardholder ID Not Covered	0	3	0	0	0	3
P7	Diagnosis Code Count Does Not Match Number Of Repetitions	0	3	0	0	0	3
YE	Submission Clarification Code Count Exceeds Number of Occurrences Supported	0	3	0	0	0	3
14	M/I Eligibility Clarification Code	0	2	0	0	0	2
483	Other Payer-Patient Responsibility Amount Qualifier Does Not Precede Other Payer-Patient Responsibility Amount	0	2	0	0	0	2
619	Prescriber Type 1 NPI Required	2	0	0	0	0	2
7R	Other Payer Amount Paid Count Exceeds Number of Supported Groupings	0	0	0	2	0	2
9Z	Duplicate Product ID In Compound	0	2	0	0	0	2
CY	M/I Patient ID	0	2	0	0	0	2
EY	M/I Provider ID Qualifier	0	1	0	0	1	2
M5	Requires Manual Claim	0	2	0	0	0	2
MV	M/I Benefit Stage Qualifier	0	2	0	0	0	2
MW	M/I Benefit Stage Amount	0	2	0	0	0	2
NV	M/I Delay Reason Code	0	2	0	0	0	2
P3	Compound Ingredient Component Count Does Not Match Number Of Repetitions	0	2	0	0	0	2

U7	M/I Pharmacy Service Type	0	2	0	0	0	2
2B	M/I Medicaid Indicator	0	1	0	0	0	1
444	Benefit Stage Amount Grouping Incorrect	0	1	0	0	0	1
469	Submission Clarifications Code Count Does Not Precede Submission Clarification Code	0	1	0	0	0	1
480	Other Payer Amount Paid Count Does Not Precede Other Payer Amount Paid And/Or Qualifier	0	1	0	0	0	1
6E	M/I Other Payer Reject Code	1	0	0	0	0	1
87	Reversal Not Processed	0	1	0	0	0	1
EC	M/I Compound Ingredient Component Count	0	1	0	0	0	1
R1	Other Amount Claimed Submitted Count Does Not Match Number Of Repetitions	0	1	0	0	0	1
RN	Plan Limits Exceeded On Intended Partial Fill Field Limitations	0	1	0	0	0	1
No NCPDP Provided		834	0	0	0	0	834
GRAND TOTAL		634,948	147,006	997,013	1,392,609	722,370	3,893,946