APPENDIX VIII Denied Claims, July 1, 2016 - June 30, 2017[1]

By Claim Adjustment Reason Code (CARC) - Medical Emergency Services

CARC	CARC Description	ABH	ACLA	AMG	LHCC	UHC	MCNA[2]	Total
18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	4,040	6,714	8,492	14,308	11,129	-	44,683
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).	245	-	5,753	3	18,379		24,380
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.	625	8,874	336	1,091	2,624		13,550
27	Expenses incurred after coverage terminated.	-	5,435	2,220	312	5,465		13,432
22	This care may be covered by another payer per coordination of benefits.	869	69	-	11,451	757		13,146
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.	4,100	2,714	366	9	2,967		10,156
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.	807	2,352	102	1,098	5,117		9,476
29	The time limit for filing has expired.	1,137	1,450	1,284	2,261	2,306		8,438
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	1,655	-	3,311	126	2,666		7,758
26	Expenses incurred prior to coverage.	2,997	607	491	4	1,853		5,952
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	-	45	-	70	5,467		5,582
256	Service not payable per managed care contract.	-	-	1,605	-	2,868		4,473
204	This service/equipment/drug is not covered under the patient's current benefit plan	-	-	7	4,107	-		4,114
177	Patient has not met the required eligibility requirements.	-	-	2,917	-	-		2,917
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.)	-	453	-	2,258	3		2,714
31	Patient cannot be identified as our insured.	52	83	-	2	2,116		2,253
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).	1,928	1	-	-	187		2,116
199	Revenue code and Procedure code do not match.	91	-	1,599	-	-		1,690
197	Precertification/authorization/notification absent.	7	-	19	437	1,092		1,555
119	Benefit maximum for this time period or occurrence has been reached.	305	402	625	14	23		1,369
39	Services denied at the time authorization/pre-certification was requested.	1	-	-	-	1,273		1,274
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.	-	1,185	-	77	-		1,262
131	Claim specific negotiated discount.	-	1,061	-	-	-		1,061

CARC	CARC Description	ABH	ACLA	AMG	LHCC	UHC	MCNA[2]	Total
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)	-	922	4	-	-		926
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.	2	728	56	-	-		786
46	This (these) service(s) is (are) not covered.	426	330	-	-	-		756
146	Diagnosis was invalid for the date(s) of service reported.	33	584	-	21	96		734
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.)	-	135	3	364	26		528
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.	183	80	226	-	27		516
B14	Only one visit or consultation per physician per day is covered.	11	195	117	170	-		493
95	Plan procedures not followed.	-	459	-	-	-		459
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.	3	34	63	121	149		370
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.	6	-	223	-	137		366
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	337	-	-	-		339
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.	-	101	78	11	148		338
112	Service not furnished directly to the patient and/or not documented.	-	290	-	-	-		290
198	Precertification/authorization exceeded.	-	-	-	1	278		279
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.	-	255	-	-	-		255
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.)	-	-	248	-	-		248
B20	Procedure/service was partially or fully furnished by another provider.	-	49	-	-	180		229
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.	13	-	61	83	49		206
23	The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)	1	1	95	100	-		197
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.)	-	158	-	-	-		158
60	Charges for outpatient services are not covered when performed within a period of time prior to or after inpatient services.	-	-	-	-	151		151
242	Services not provided by network/primary care providers.	54	89	5	-	-		148
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.	69	60	1	-	6		136
150	Payer deems the information submitted does not support this level of service.	-	-	11	91	25		127

CARC	CARC Description	ABH	ACLA	AMG	LHCC	UHC	MCNA[2]	Total
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.	-	-	3	-	90		93
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).	23	-	64	1	-		88
147	Provider contracted/negotiated rate expired or not on file.	79	-	-	-	1		80
181	Procedure code was invalid on the date of service.	45	31	-	-	1		77
182	Procedure modifier was invalid on the date of service.	3	53	-	-	19		75
193	Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.	1	-	-	71	-		72
115	Procedure postponed, canceled, or delayed.	68	-	-	-	-		68
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).	2	-	57	-	-		59
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.)	-	55	-	-	2		57
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	47	-	-	2		50
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.	41	-	-	-	-		41
169	Alternate benefit has been provided.	-	37	-	-	-		37
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.	-	-	-	-	32		32
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.	25	-	3	-	-		28
2	Coinsurance Amount	-	-	-	-	26		26
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.	-	-	12	14	-		26
268	The Claim spans two calendar years. Please resubmit one claim per calendar year.	16	-	-	-	-		16
19	This is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.	14	-	-	-	-		14
24	Charges are covered under a capitation agreement/managed care plan.	-	11	-	-	-		11
128	Newborn's services are covered in the mother's Allowance.	-	-	-	-	10		10
20	This injury/illness is covered by the liability carrier.	9	-	-	-	-		9
151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.	4	4	-	-	-		8
228	Denied for failure of this provider, another provider or the subscriber to supply requested information to a previous payer for their adjudication	8	-	-	-	-		8
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	3	-	1	2		7

CARC	CARC Description	ABH	ACLA	AMG	LHCC	UHC	MCNA[2]	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.)	7	-	-	-	-		7
3	Co-payment Amount	-	-	-	-	6		6
15	The authorization number is missing, invalid, or does not apply to the billed services or provider.	3	-	-	3	-		6
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.	-	1	4	-	1		6
272	Coverage/program guidelines were not met.	-	-	-	5	-		5
136	Failure to follow prior payer's coverage rules. (Use only with Group Code OA)	-	-	-	3	-		3
273	Coverage/program guidelines were exceeded.	-	-	-	3	-		3
206	National Provider Identifier - missing.	-	-	2	-	-		2
13	The date of death precedes the date of service.	-	-	-	1	-		1
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	-	-	-	-		1
110	Billing date predates service date.	-	-	-	-	1		1
135	Interim bills cannot be processed.	1	-	-	-	-		1
200	Expenses incurred during lapse in coverage	-	1	-	-	-		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
D15	Claim lacks indication that service was supervised or evaluated by a physician.	1	-	-	-	-		1
	No CARC provided or invalid	279	-	1	-	-		280
TOTAL		**20,294**	**36,496**	**30,464**	**38,692**	**67,757**		**193,703**

Source: 173 Denied Claims Report

[1]As individual claims may have multiple denial codes, the total denial count by denial code will be greater than the count of claims denied.

[2]MCNA reported no claim denials for emergency services.

APPENDIX VIII Denied Claims, July 1, 2016 - June 30, 2017[1]

By Claim Adjustment Reason Code (CARC) - Medical Non-Emergency Services

CARC	CARC Description	ABH	ACLA	AMG	LHCC	MCNA	UHC	Total
197	Precertification/authorization/notification absent.	89,143	307,803	205,691	432,126	7,689	762,049	1,804,501
18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	171,955	224,401	302,349	362,422	52,599	351,452	1,465,178
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.	67,708	297,629	39,597	319,754	130	282,597	1,007,415
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.	195,046	132,004	259,453	35,938	6,090	197,463	825,994
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.	42,743	162,115	97,460	229,101	5,593	119,310	656,322
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).	4,193	3,408	110,439	2,115	16,829	283,684	420,668
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.)	-	44,158	-	309,311	-	44	353,513
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	53	1,757	2,249	6,451	8,782	265,684	284,976
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.	16,708	25,551	5,028	22,987	-	186,527	256,801
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.	50,865	33,830	77,434	40,223	-	35,635	237,987
29	The time limit for filing has expired.	31,688	43,320	31,306	76,723	5,727	46,600	235,364
256	Service not payable per managed care contract.	-	82	128,956	-	-	105,515	234,553
95	Plan procedures not followed.	-	209,318	10	-	140	-	209,468
22	This care may be covered by another payer per coordination of benefits.	14,422	982	-	156,803	10,839	16,501	199,547
15	The authorization number is missing, invalid, or does not apply to the billed services or provider.	10,796	69	749	185,132	1,722	-	198,468
204	This service/equipment/drug is not covered under the patient's current benefit plan	275	-	29,376	101,399	39,750	1,692	172,492
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	27,849	293	51,268	27,411	-	52,642	159,463
27	Expenses incurred after coverage terminated.	45	57,978	26,003	4,721	2,788	67,209	158,744
150	Payer deems the information submitted does not support this level of service.	10	-	5,318	23,592	4	114,887	143,811
169	Alternate benefit has been provided.	4	645	20	-	117,465	-	118,134
26	Expenses incurred prior to coverage.	48,080	12,477	10,057	430	165	32,551	103,760
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)	6	96,683	1,430	-	1	-	98,120
198	Precertification/authorization exceeded.	3,041	12,044	20,410	52,109	-	8,861	96,465

CARC	CARC Description	ABH	ACLA	AMG	LHCC	MCNA	UHC	Total
119	Benefit maximum for this time period or occurrence has been reached.	2,072	5,808	38,516	43,950	-	1,249	91,595
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.	16	75,761	3,927	9,255	1,111	919	90,989
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.	-	1,287	20,285	21,251	42,637	227	85,687
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.	1,821	12,194	2,060	34,801	26,138	1,678	78,692
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).	513	-	2,367	4,122	525	63,344	70,871
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).	60,617	7	-	-	16	8,459	69,099
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.	116	49,703	-	11,916	16	-	61,751
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.)	281	4,134	1,313	49,046	-	1,906	56,680
39	Services denied at the time authorization/pre-certification was requested.	5,954	3,954	3,401	8,271	77	33,114	54,771
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.	536	1,247	11,849	13,768	-	17,437	44,837
128	Newborn's services are covered in the mother's Allowance.	-	2,637	3,469	-	-	34,881	40,987
177	Patient has not met the required eligibility requirements.	26	-	32,455	-	14	8	32,503
31	Patient cannot be identified as our insured.	352	1,328	1	72	239	30,324	32,316
147	Provider contracted/negotiated rate expired or not on file.	29,314	-	-	-	-	10	29,324
199	Revenue code and Procedure code do not match.	17,372	-	9,045	-	-	12	26,429
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.	70	-	23,614	-	-	244	23,928
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.	-	-	20	-	-	22,392	22,412
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.	3,261	17,384	-	-	-	-	20,645
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.	2	5,620	1,241	3,168	434	6,318	16,783
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.	1,566	6,036	197	7,421	3	473	15,696
146	Diagnosis was invalid for the date(s) of service reported.	1,053	8,407	64	1,198	23	4,090	14,835
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.	8,069	617	5,019	-	-	974	14,679
272	Coverage/program guidelines were not met.	-	6,262	29	381	7,541	-	14,213
B23	Procedure billed is not authorized per your Clinical Laboratory Improvement Amendment (CLIA) proficiency test.	-	12,675	-	1	-	1	12,677

CARC	CARC Description	ABH	ACLA	AMG	LHCC	MCNA	UHC	Total
193	Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.	1,147	-	-	10,411	849	-	12,407
23	The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)	72	47	2,249	8,597	74	-	11,039
181	Procedure code was invalid on the date of service.	1,536	8,003	3	-	1,026	31	10,599
B14	Only one visit or consultation per physician per day is covered.	104	787	3,128	101	5,027	-	9,147
131	Claim specific negotiated discount.	3	9,003	-	-	-	-	9,006
182	Procedure modifier was invalid on the date of service.	121	8,287	-	34	2	381	8,825
206	National Provider Identifier - missing.	-	-	1,718	3,392	1,212	2,356	8,678
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.	2,257	2,252	55	152	502	3,082	8,300
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.	-	-	7,781	-	7	1	7,789
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.	-	-	18	4,799	2,673	-	7,490
242	Services not provided by network/primary care providers.	385	821	1,262	-	4,639	-	7,107
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	1,922	1,814	329	-	2,640	6,707
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.	79	-	2,824	-	103	3,614	6,620
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.	-	6,265	1	-	125	9	6,400
46	This (these) service(s) is (are) not covered.	2,094	4,211	11	-	-	-	6,316
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.	401	-	2,057	1,367	-	1,661	5,486
112	Service not furnished directly to the patient and/or not documented.	-	5,124	-	-	-	226	5,350
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.)	387	-	1,154	3	3,778	-	5,322
B16	'New Patient' qualifications were not met.	-	-	-	1,336	-	3,955	5,291
151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.	2,603	1,268	-	-	-	964	4,835
B20	Procedure/service was partially or fully furnished by another provider.	1	642	2	20	1,447	2,109	4,221
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.)	-	3,479	-	11	-	184	3,674
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.	189	1,307	233	1,588	-	252	3,569
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.	-	-	-	-	3,051	-	3,051
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.)	-	2,907	-	-	-	-	2,907

CARC	CARC Description	ABH	ACLA	AMG	LHCC	MCNA	UHC	Total
35	Lifetime benefit maximum has been reached.	1	2,753	-	-	3	-	2,757
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.	1,367	1,085	-	-	-	-	2,452
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).	128	-	2,180	-	40	-	2,348
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.	2,183	-	17	-	-	-	2,200
115	Procedure postponed, canceled, or delayed.	1,819	-	-	-	-	-	1,819
273	Coverage/program guidelines were exceeded.	33	920	738	96	-	-	1,787
60	Charges for outpatient services are not covered when performed within a period of time prior to or after inpatient services.	-	-	-	-	-	1,766	1,766
B5	Coverage/program guidelines were not met or were exceeded.	5	-	1,714	-	-	-	1,719
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.	194	338	464	-	-	78	1,074
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.	7	-	-	-	1,046	-	1,053
24	Charges are covered under a capitation agreement/managed care plan.	-	772	-	182	-	-	954
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.	-	708	5	-	209	-	922
233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.	-	-	-	6	811	31	848
249	This claim has been identified as a readmission. (Use only with Group Code CO)	-	-	-	785	-	-	785
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.	782	-	-	-	-	-	782
P14	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. To be used for Property and Casualty only.	-	22	233	-	472	-	727
200	Expenses incurred during lapse in coverage	2	1	367	-	343	-	713
208	National Provider Identifier - Not matched.	-	-	675	2	-	-	677
2	Coinsurance Amount	-	-	-	-	-	591	591
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.	3	-	-	-	558	-	561
268	The Claim spans two calendar years. Please resubmit one claim per calendar year.	442	-	-	-	-	-	442
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.	-	-	8	-	348	-	356
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.)	333	-	-	-	-	-	333
110	Billing date predates service date.	-	4	-	-	-	226	230
D18	Claim/Service has missing diagnosis information.	10	-	192	-	-	-	202
B12	Services not documented in patients' medical records.	4	-	127	1	-	-	132
19	This is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.	100	-	-	-	19	-	119
261	The procedure or service is inconsistent with the patient's history.	86	22	-	-	-	-	108
203	Discontinued or reduced service.	10	-	85	-	-	-	95
163	Attachment/other documentation referenced on the claim was not received.	-	-	-	-	44	48	92

CARC	CARC Description	ABH	ACLA	AMG	LHCC	MCNA	UHC	Total
216	Based on the findings of a review organization	-	39	1	-	-	40	80
3	Co-payment Amount	51	-	-	-	-	23	74
14	The date of birth follows the date of service.	27	2	-	-	41	-	70
228	Denied for failure of this provider, another provider or the subscriber to supply requested information to a previous payer for their adjudication	61	-	-	-	-	-	61
28	Coverage not in effect at the time the service was provided.	-	-	56	-	-	-	56
136	Failure to follow prior payer's coverage rules. (Use only with Group Code OA)	-	-	-	51	-	2	53
190	Payment is included in the allowance for a Skilled Nursing Facility (SNF) qualified stay.	-	-	-	-	46	-	46
13	The date of death precedes the date of service.	-	-	-	44	-	-	44
20	This injury/illness is covered by the liability carrier.	42	-	-	-	-	-	42
114	Procedure/product not approved by the Food and Drug Administration.	-	-	-	-	-	29	29
108	Rent/purchase guidelines were not met. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	-	-	-	-	-	27	27
101	Predetermination: anticipated payment upon completion of services or claim adjudication.	-	-	-	-	21	-	21
160	Injury/illness was the result of an activity that is a benefit exclusion.	18	-	-	-	-	-	18
246	This non-payable code is for required reporting only.	-	-	17	-	-	1	18
D21	This (these) diagnosis(es) is (are) missing or are invalid	-	-	18	-	-	-	18
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.)	-	16	-	-	-	-	16
116	The advance indemnification notice signed by the patient did not comply with requirements.	-	-	15	-	-	-	15
135	Interim bills cannot be processed.	15	-	-	-	-	-	15
51	These are non-covered services because this is a pre-existing condition. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	14	-	-	-	-	-	14
D20	Claim/Service missing service/product information.	-	14	-	-	-	-	14
P07	The applicable fee schedule/fee database does not contain the billed code. Please resubmit a bill with the appropriate fee schedule/fee database code(s) that best describe the service(s) provided and supporting documentation if required. To be used for Property and Casualty only. The applicable fee schedule/fee database does not contain the billed code. Please resubmit a bill with the appropriate fee schedule/fee database code(s) that best describe the service(s) provided and supporting documentation if required. To be used for Property and Casualty only.	14	-	-	-	-	-	14
140	Patient/Insured health identification number and name do not match.	-	-	-	-	13	-	13
149	Lifetime benefit maximum has been reached for this service/benefit category.	2	9	-	-	2	-	13
164	Attachment/other documentation referenced on the claim was not received in a timely fashion.	-	-	12	1	-	-	13
239	Claim spans eligible and ineligible periods of coverage. Rebill separate claims.	13	-	-	-	-	-	13
47	This (these) diagnosis(es) is (are) not covered, missing, or are invalid.	5	-	6	-	-	-	11
52	The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.	-	-	11	-	-	-	11
138	Appeal procedures not followed or time limits not met.	11	-	-	-	-	-	11
62	Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.	-	-	8	-	-	-	8
189	'Not otherwise classified' or 'unlisted' procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service	-	-	7	1	-	-	8
B11	The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.	-	-	-	-	-	8	8
210	Payment adjusted because pre-certification/authorization not received in a timely fashion	-	-	-	-	5	-	5
70	Cost outlier - Adjustment to compensate for additional costs.	-	-	-	-	-	4	4
48	This (these) procedure(s) is (are) not covered.	-	-	3	-	-	-	3

CARC	CARC Description	ABH	ACLA	AMG	LHCC	MCNA	UHC	Total
100	Payment made to patient/insured/responsible party/employer.	3	-	-	-	-	-	3
229	Partial charge amount not considered by Medicare due to the initial claim Type of Bill being 12X. Note: This code can only be used in the 837 transaction to convey Coordination of Benefits information when the secondary payer's cost avoidance policy allows providers to bypass claim submission to a prior payer. (Use only with Group Code PR)	3	-	-	-	-	-	3
B9	Patient is enrolled in a Hospice.	-	-	-	-	-	3	3
173	Service/equipment was not prescribed by a physician.	-	-	-	-	2	-	2
243	Services not authorized by network/primary care providers.	2	-	-	-	-	-	2
P21	Payment denied based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional regulations or payment policies, use only if no other code is applicable. 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') if the jurisdictional regulation applies. 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) if the regulations apply. To be used for Property and Casualty Auto only.	-	-	-	-	2	-	2
154	Payer deems the information submitted does not support this day's supply.	-	-	1	-	-	-	1
165	Referral absent or exceeded.	1	-	-	-	-	-	1
166	These services were submitted after this payers responsibility for processing claims under this plan ended.	-	-	-	-	1	-	1
202	Non-covered personal comfort or convenience services.	-	-	-	-	1	-	1
D15	Claim lacks indication that service was supervised or evaluated by a physician.	1	-	-	-	-	-	1
M76	Missing/incomplete/invalid diagnosis or condition	-	-	1	-	-	-	1
P7	The applicable fee schedule/fee database does not contain the billed code. Please resubmit a bill with the appropriate fee schedule/fee database code(s) that best describe the service(s) provided and supporting documentation if required. To be used for Property and Casualty only.	-	-	-	-	1	-	1
	No CARC provided	25,095	-	1,798	641	-	-	27,534
TOTAL		951,909	1,944,638	1,596,544	2,631,319	383,630	3,183,305	10,691,345

Source: 173 Denied Claims Report

[1]As individual claims may have multiple denial codes, the total denial count by denial code will be greater than the count of claims denied.

APPENDIX VIII Denied Claims, July 1, 2016 - June 30, 2017[1]

Denied Claims for Emergency Pharmacy Services by National Council for Prescription Drug Program (NCPDP) rejection code

NCPDP CODE	NCPDP Rejection Reason Code Description	ABH	ACLA	AMG	LHCC[2]	UHC	Total
76	Plan Limitations Exceeded	.	5	33		6,613	6,651
70	Product/Service Not Covered	.	9	4		5,993	6,006
88	DUR Reject Error	.	3	9		3,469	3,481
41	Submit Bill To Other Processor Or Primary Payer	.	1	1		2,397	2,399
69	Filled After Coverage Terminated	1	.	1		1,715	1,717
75	Prior Authorization Required	.	1	302		1,129	1,432
65	Patient Is Not Covered	.	1	.		1,204	1,205
CB	M/I Patient Last Name	.	.	.		698	698
50	Non-Matched Pharmacy Number	.	.	.		548	548
10	M/I Patient Gender Code	.	.	.		537	537
79	Refill Too Soon	1	5	29		462	497
44	Plan's Prescriber data base indicates the associated DEA to submitted Prescriber ID Is not found	.	.	.		478	478
19	M/I Days Supply	.	.	.		443	443
9	M/I Birth Date	.	.	.		343	343
77	Discontinued Product/Service ID Number	.	.	1		302	303
MR	Product Not On Formulary	.	.	298		.	298
08	M/I Group Number	.	.	.		245	245
569	Provide Appeals Grievance Notice	.	.	.		190	190
56	Non-Matched Prescriber ID	.	.	.		159	159
85	Claim Not Processed	.	.	1		155	156
33	M/I Prescription Origin Code	.	.	.		129	129
83	Duplicate Paid/Captured Claim	.	.	.		123	123
E7	M/I Quantity Dispensed	.	.	.		116	116
M2	Recipient Locked In	.	.	7		92	99
21	M/I Product/Service ID	.	.	.		94	94
EV	M/I Prior Authorization Number Submitted	.	.	66		19	85
80	Drug-Diagnosis Mismatch	.	.	.		64	64
17	M/I Fill Number	.	.	.		63	63
46	Plan's Prescriber data base indicates associated DEA to submitted Prescriber ID does not allow this drug DEA Schedule	.	.	.		58	58
78	Cost Exceeds Maximum	.	6	.		38	44
R2	Other Payer Reject Count Does Not Match Number Of Repetitions	.	.	.		44	44
HA	M/I Flat Sales Tax Amount Submitted	.	.	.		38	38

NCPDP CODE	NCPDP Rejection Reason Code Description	ABH	ACLA	AMG	LHCC[2]	UHC	Total
13	M/I Other Coverage Cod	.	.	.		37	37
6C	M/I Other Payer ID Qualifier	.	.	1		29	30
67	Filled Before Coverage Effective	.	.	.		28	28
EZ	M/I Prescriber ID Qualifier	.	.	.		28	28
25	M/I Prescriber ID	.	.	.		22	22
EU	M/I Prior Authorization Type Code	.	.	8		10	18
DQ	M/I Usual And Customary Charge	.	.	.		16	16
35	M/I Primary Care Provider ID	.	.	.		14	14
7X	Days Supply Exceeds Plan Limitation	.	.	.		13	13
A1	ID Submitted is associated with a Sanctioned Prescriber	.	.	.		12	12
E1	M/I Product/Service ID Qualifier	.	.	9		3	12
EX	M/I Intermediary Authorization ID	.	.	12		.	12
GE	M/I Percentage Sales Tax Amount Submitted	.	.	.		12	12
39	M/I Diagnosis Code	.	3	.		7	10
613	The Packagaing Methodology OR Dispensing Frequency is Missing OR Inappropriate for LTC Short Cycle	.	.	.		10	10
8E	M/I DUR/PPS Level Of Effort	.	.	10		.	10
52	Non-Matched Cardholder ID	.	.	.		9	9
28	M/I Date Prescription Written	.	.	.		8	8
64	Claim Submitted Does Not Match Prior Authorization	.	8	.		.	8
HE	M/I Percentage Sales Tax Rate Submitted	.	6	1		1	8
EF	M/I Compound Dosage Form Descriptin Code	.	.	.		7	7
EW	M/I Intermediary Authorization Type ID	.	.	7		.	7
23	M/I Ingredient Cost Submitted	.	5	.		1	6
81	Claim Too Old	.	.	.		6	6
9T	Prior Authorization Type Code Submitted Not Covered	.	.	6		.	6
11	M/I Patient Relationship Code	.	.	.		5	5
40	Pharmacy Not Contracted With Plan On Date Of Service	.	.	4		.	4
7C	M/I Other Payer ID	.	.	1		3	4
07	M/I Service Provider Number	.	.	.		3	3
71	Prescriber Is Not Covered	.	.	.		3	3
84	Claim Has Not Been Paid/Captured	.	.	.		3	3
96	Scheduled Downtime	.	.	3		.	3
4X	M/I Patient Residence	.	.	.		3	3
5C	M/I Other Payer Coverage Type	.	.	.		3	3
A3	This Product May Be Covered Under Hospice – Medicare A	.	.	.		3	3
E6	M/I Result Of Service Code	.	.	2		1	3
R9	Value In Gross Amount Due Does Not Follow Pricing Formulae	.	.	3		.	3

NCPDP CODE	NCPDP Rejection Reason Code Description	ABH	ACLA	AMG	LHCC[2]	UHC	Total
51	Non-Matched Group ID	.	.	.		2	2
DV	M/I Other Payer Amount Paid	.	.	.		2	2
E5	M/I Professional Service Code	.	.	2		.	2
EK	M/I Scheduled Prescription ID Number	.	.	.		2	2
JE	M/I Percentage Sales Tax Basis Submitted	.	.	1		1	2
NX	M/I Submission Clarification Code Count	.	.	.		2	2
09	M/I Cardholder ID Number	.	.	.		1	1
34	M/I Submission Clarification Code	.	.	.		1	1
54	Non-Matched Product/Service ID Number	.	.	1		.	1
82	Claim Is Post-Dated	.	.	.		1	1
92	System Unavailable/Host Unavailable	.	.	.		1	1
444	Benefit Stage Amount Grouping Incorrect	.	.	1		.	1
485		.	.	1		.	1
619	Prescriber Type 1 NPI Required	.	.	.		1	1
645		.	.	.		1	1
4Y	Patient Residence Value Not Supported	.	.	.		1	1
9M	Minimum Of Two Ingredients Required	.	.	.		1	1
BB	Diagnosis Code Qualifier Submitted Not Covered	.	.	1		.	1
CP	M/I Patient Zip/Postal Zone	.	.	1		.	1
CX	M/I Patient ID Qualifier	.	.	.		1	1
E4	M/I Reason For Service Code	.	.	.		1	1
H6	M/I DUR Co-Agent ID	.	.	.		1	1
HC	M/I Other Payer Amount Paid Qualifier	.	.	.		1	1
J9	M/I DUR Co-Agent ID Qualifier	.	.	.		1	1
MV	M/I Benefit State Outlier	.	.	1		.	1
NR	M/I Other Payer- Patient Responsibility Amount Count	.	.	.		1	1
RK	Partial Fill Transaction Not Supported	.	.	.		1	1
TOTAL		2	53	828	0	28,282	29,165

Source: 173 Denied Claims Report

[1]As individual claims may have multiple denial codes, the total denial count by denial code will be greater than the count of claims denied.

[2]LHCC reported no claim denials for emergency pharmacy services.

APPENDIX VIII Denied Claims, July 1, 2016 - June 30, 2017[1]

By Claim Adjustment Reason Code (CARC) - Non-Emergency Pharmacy Services

NCPCP Code	NCPCP Description	ABH	ACLA	AMG	LHC	UHC	Total
79	Refill Too Soon	124,735	233,078	257,036	372,723	119,422	1,106,994
76	Plan Limitations Exceeded	45,965	95,680	186,678	639,568	104,291	1,072,182
75	Prior Authorization Required	15,228	12,070	261,942	516,122	82,342	887,704
70	Product/Service Not Covered	86,757	201,674	70,388	101,597	273,289	733,705
88	DUR Reject Error	7,997	144,867	52,015	.	238,884	443,763
MR	Product Not On Formulary	.	.	276,711	.	.	276,711
41	Submit Bill To Other Processor Or Primary Payer	12,429	22,559	49,396	78,419	87,076	249,879
85	Claim Not Processed	9	.	15,992	205,022	2,535	223,558
23	M/I Ingredient Cost Submitted	5	213,818	316	4	32	214,175
69	Filled After Coverage Terminated	35,533	.	35,045	.	64,839	135,417
19	M/I Days Supply	17,747	.	194	575	111,209	129,725
65	Patient Is Not Covered	.	68,545	4,413	17	44,546	117,521
68	Filled After Coverage Expired	.	.	.	101,284	.	101,284
64	Claim Submitted Does Not Match Prior Authorization	.	90,745	.	.	.	90,745
7X	Days Supply Exceeds Plan Limitation	8	.	88,201	.	.	88,209
08	M/I Group Number	427	.	30	69,028	9,163	78,648
39	M/I Diagnosis Code	.	70,874	27	.	107	71,008
AC	Product Not Covered Non-Participating Manufacturer	.	.	54,023	.	.	54,023
HE	M/I Percentage Sales Tax Rate Submitted	.	32,454	8,838	.	13	41,305
60	Product/Service Not Covered For Patient Age	.	50	.	40,434	.	40,484
50	Non-Matched Pharmacy Number	249	7,850	1,708	185	21,806	31,798
54	Non-Matched Product/Service ID Number	.	5,985	11,810	11,752	.	29,547
96	Scheduled Downtime	.	.	29,354	.	.	29,354
77	Discontinued Product/Service ID Number	1,794	1,530	12,136	5,675	7,771	28,906
80	Drug-Diagnosis Mismatch	.	.	198	.	26,879	27,077
AJ	Generic Drug Required	.	.	.	22,962	.	22,962
13	M/I Other Coverage Cod	20,379	.	388	17	1,805	22,589
DV	M/I Other Payer Amount Paid	1,953	154	11,922	5,034	16	19,079
M2	Recipient Locked In	.	.	9,926	5,195	1,540	16,661
40	Pharmacy Not Contracted With Plan On Date Of Service	1,223	.	10,560	4,763	.	16,546
78	Cost Exceeds Maximum	.	10,673	540	3,777	1,398	16,388
'09	M/I Birth Date	1,823	4,140	.	3,036	7,007	16,006
7W	Refills Exceed allowable Refills	.	.	541	13,658	.	14,199
52	Non-Matched Cardholder ID	.	71	251	13,684	23	14,029

NCPCP Code	NCPCP Description	ABH	ACLA	AMG	LHC	UHC	Total
6C	M/I Other Payer ID Qualifier	2	.	12,341	.	685	13,028
7C	M/I Other Payer ID	.	.	12,396	.	143	12,539
EV	M/I Prior Authorization Number Submitted	.	.	12,041	.	472	12,513
CB	M/I Patient Last Name	.	.	1	.	10,955	10,956
E7	M/I Quantity Dispensed	161	455	83	244	8,800	9,743
09	M/I Cardholder ID Number	.	8,991	.	.	34	9,025
JE	M/I Percentage Sales Tax Basis Submitted	.	.	8,184	.	51	8,235
22	M/I Dispense As Written (DAW)/Product Selection Code	.	7,649	152	342	14	8,157
83	Duplicate Paid/Captured Claim	330	1,234	254	28	5,934	7,780
E5	M/I Professional Service Code	990	.	6,346	.	38	7,374
PE	M/I COB/Other Payments Segment	.	.	7,104	.	.	7,104
21	M/I Product/Service ID	1,242	.	463	449	4,446	6,600
E6	M/I Result Of Service Code	.	.	6,428	.	6	6,434
10	M/I Patient Gender Code	.	.	8	.	5,993	6,001
443	Other Payer-Patient Responsibility Amount Grouping Incorrect	.	.	5,741	.	.	5,741
R9	Value In Gross Amount Due Does Not Follow Pricing Formulae	.	95	4,936	.	.	5,031
NR	M/I Other Payer- Patient Responsibility Amount Count	.	.	4,981	.	6	4,987
56	Non-Matched Prescriber ID	456	.	.	2,558	1,842	4,856
67	Filled Before Coverage Effective	794	.	324	2,933	765	4,816
5E	M/I Other Payer Reject Count	.	.	4,241	.	.	4,241
33	M/I Prescription Origin Code	888	.	291	252	2,713	4,144
44	Plan's Prescriber data base indicates the associated DEA to submitted Prescriber ID Is not found	1,309	.	.	.	2,631	3,940
8W	Discrepancy Between Other Coverage Code and Other Payer Amount Paid	1,045	.	2,809	.	.	3,854
51	Non-Matched Group ID	.	.	.	3,739	49	3,788
06	M/I Processor Control Number	24	.	2,672	1,065	.	3,761
25	M/I Prescriber ID	456	775	1,370	795	343	3,739
8K	DAW Code Value Not Supported	.	.	3,105	.	.	3,105
7J	Patient Relationship Code Value Not Supported	.	.	2,936	.	.	2,936
7M	Discrepancy Between Other Coverage Code And Other Coverage Information On File	2,855	.	.	.	.	2,855
NQ	M/I Other Payer- Patient Responsibility Amount	1,101	.	63	1,611	.	2,775
7V	Duplicate Refills,	.	.	2,625	.	.	2,625
6G	Coordination Of Benefits/Other Payments Segment Required For Adjudication	.	.	1,735	726	.	2,461
9V	Prescriber ID Qualifier Submitted Not Covered	.	.	2,353	.	.	2,353
HB	M/I Other Payer Amount Paid Count	.	.	2,257	.	9	2,266
GE	M/I Percentage Sales Tax Amount Submitted	.	.	1,530	.	380	1,910
DQ	M/I Usual And Customary Charge	159	.	699	191	796	1,845

NCPCP Code	NCPCP Description	ABH	ACLA	AMG	LHC	UHC	Total
446	COB/Other Payments Segment Incorrectly Formatted	.	1,765	.	.	.	1,765
8E	M/I DUR/PPS Level Of Effort	.	.	1,705	.	1	1,706
R2	Other Payer Reject Count Does Not Match Number Of Repetitions	.	.	.	79	1,574	1,653
609	COB Claim Not Required, Patient Liability Amount Submitted Was Zero	.	.	1,589	.	.	1,589
EU	M/I Prior Authorization Type Code	.	.	1,413	6	155	1,574
BB	Diagnosis Code Qualifier Submitted Not Covered	.	.	1,523	.	.	1,523
81	Claim Too Old	35	71	526	487	259	1,378
11	M/I Patient Relationship Code	.	.	814	342	119	1,275
9E	Quantity Does Not Match Dispensing Unit	.	.	1,165	.	.	1,165
EZ	M/I Prescriber ID Qualifier	4	.	832	12	256	1,104
82	Claim Is Post-Dated	199	1	.	604	267	1,071
E3	M/I Incentive Amount Submitted	986	.	29	.	27	1,042
6Z	Provider Not Eligible To Perform Service/Dispense Product	.	.	951	.	.	951
28	M/I Date Prescription Written	.	.	644	2	258	904
46	Plan's Prescriber data base indicates associated DEA to submitted Prescriber ID does not allow this drug DEA Schedule	45	.	.	.	773	818
818		706	.	26	.	.	732
29	M/I Number Refills Authorized	.	.	.	721	.	721
17	M/I Fill Number	.	.	.	.	711	711
73	Refills Are Not Covered	.	178	5	520	.	703
E1	M/I Product/Service ID Qualifier	.	.	615	.	29	644
42	Plan's Prescriber data base indicates the Prescriber ID Submitted is inactive or expired	104	.	507	.	.	611
AB	Date Written Is After Date Filled	.	.	202	379	.	581
8A	Compound Requires At Least One Covered Ingredient	.	.	.	553	.	553
AG	Days Supply Limitation For Product/Service	551	.	1	.	1	553
15	M/I Date of Service	.	.	536	.	.	536
A1	ID Submitted is associated with a Sanctioned Prescriber	.	38	290	.	194	522
30	Reversal Request Outside Processor Reversal Window	.	.	438	54	.	492
9T	Prior Authorization Type Code Submitted Not Covered	.	.	481	.	.	481
EW	M/I Intermediary Authorization Type ID	.	.	463	.	.	463
O5		.	.	456	.	.	456
7Q	Other Payer ID Qualifier Value Not Supported	.	.	430	.	.	430
84	Claim Has Not Been Paid/Captured	.	396	.	.	8	404
E9	M/I Provider ID	.	.	392	.	1	393
71	Prescriber Is Not Covered	92	64	177	.	50	383
07	M/I Service Provider Number	3	101	118	.	152	374
97	Payer Unavailable	.	.	.	372	.	372

NCPCP Code	NCPCP Description	ABH	ACLA	AMG	LHC	UHC	Total
DU	M/I Gross Amount Due	.	155	112	96	.	363
HA	M/I Flat Sales Tax Amount Submitted	.	.	.	.	347	347
E4	M/I Reason For Service Code	2	.	325	.	11	338
5C	M/I Other Payer Coverage Type	9	.	173	96	25	303
47	Pharmacy Signature Requried	.	.	302	.	.	302
72	Primary Prescriber Is Not Covered	.	.	.	298	.	298
E8	M/I Other Payer Date	.	.	267	6	.	273
35	M/I Primary Care Provider ID	.	.	121	.	151	272
HC	M/I Other Payer Amount Paid Qualifier	17	.	147	99	1	264
H8	M/I Other Amount Claimed Submitted Qualifier	.	.	257	.	.	257
C1	MEM/DEP Covered by Another Carrier	.	.	244	.	.	244
E2	M/I Route of Administration	.	.	227	.	.	227
816		.	.	222	.	.	222
R0	Professional Service Code of “MA” required for Vaccine Incentive Fee Submitted	.	.	220	.	.	220
61	Product/Service Not Covered For Patient Gender	.	6	.	207	.	213
NP	M/I Other Payer- Patient Responsibility Amount Qualifier	5	.	200	3	.	208
8R	Submission Clarification Code Value Not Supported	.	.	183	.	.	183
CX	M/I Patient ID Qualifier	.	.	154	.	1	155
465	Patient ID Qualifier Does Not Preced Patient ID	.	.	151	.	.	151
EK	M/I Scheduled Prescription ID Number	.	.	141	.	4	145
92	System Unavailable/Host Unavailable	.	.	.	.	140	140
DN	M/I Basis Of Cost Determination	.	.	123	.	13	136
EF	M/I Compound Dosage Form Descriptin Code	.	.	74	.	61	135
08	M/I Person Code	.	.	130	.	3	133
442	Other Payer Amount Paid Grouping Incorrect	.	.	120	.	.	120
C2	COB W/Exp of Benefits Not Attached	.	.	115	.	.	115
34	M/I Submission Clarification Code	.	.	97	.	13	110
8N	Future Date Prescription Written Not Allowed,	.	.	104	.	.	104
EX	M/I Intermediary Authorization ID	.	.	101	.	.	101
8B	Compound Segment Missing On A Compound Claim	.	.	4	92	.	96
YD	Other Payer-Patient Responsibility Amount Count Exceeds Number Of Occurrences Supported	.	.	.	96	.	96
7B	Service Provider ID Qualifier Value Not Supported For Processor/Payer	.	.	93	.	.	93
P4	Coordination Of Benefits/Other Payments Count Does Not Match Number Of Repetitions	.	.	10	83	.	93
7P	Coordination Of Benefits/Other Payments Count Exceeds Number of Supported Payers	.	.	10	81	.	91
04	M/I Bin Number	.	.	19	70	.	89

NCPCP Code	NCPCP Description	ABH	ACLA	AMG	LHC	UHC	Total
8Z	Product/Service ID Qualifier Value Not Supported	.	.	89	.	.	89
43	Plan's Prescriber data base indicates the associated DEA to submitted Prescriber ID is inactive	87	.	.	.	.	87
6T	Compound Segment Required For Adjudication	56	.	23	.	.	79
CA	M/I Patient First Name	.	.	13	.	55	68
FC	Not In Closed Formulary	.	.	67	.	.	67
3Y	Prior Authorization Denied	.	.	.	66	.	66
2N	M/I Prescriber State/Province Address	2	.	60	.	.	62
8M	Sum Of Compound Ingredient Costs Does Not Equal Ingredient Cost Submitted	.	.	.	60	.	60
645		.	.	58	.	.	58
38	M/I Basis Of Cost	.	.	.	54	2	56
XJ	Invalid Ingredient Cost	.	.	54	.	.	54
CY	M/I Patient ID	.	.	40	.	13	53
478	Other Payer ID Qualifier Does Not Precede Other Payer ID	.	.	51	.	.	51
441	Other Amount Claimed Submitted Grouping Incorrect	.	.	48	.	.	48
2E	M/I Primary Care Provider ID Qualifier	.	.	45	.	.	45
SG	Submission Clarification Code Count Does Not Match Number of Repetitions	.	.	44	.	.	44
SH	Other Payer-Patient Responsibility Amount Count Does Not Match Number of Repetitions	.	.	18	26	.	44
9M	Minimum Of Two Ingredients Required	.	.	.	.	41	41
472	Other Amount Claimed Submitted Qualifier Does Not Procede Other Amount Claimed Submitted	.	.	39	.	.	39
CO	M/I Patient State/Province Address	.	.	39	.	.	39
AD	Billing Provider Not Eligible To Bill This Claim Type	.	.	36	.	.	36
B2	M/I Service Provider ID Qualifier	.	.	14	6	16	36
55	Non-Matched Product Package Size	.	35	.	.	.	35
RE	M/I Compound Product ID Qualifier	33	.	.	.	.	33
EG	M/I Compound Dispensing Unit Form Indicator	.	.	32	.	.	32
445	Diagnosis Code Groupint Incorrect	.	.	30	.	.	30
SF	Other Payer Amount Paid Count Does Not Match Number Of Repetitions	.	.	15	15	.	30
WE	M/I Diagnosis Code Qualifier	.	.	27	.	3	30
1Y	Claim Segment Required For Adjudication	.	.	29	.	.	29
827		.	.	28	.	.	28
37	Drug Not Covered by Plan	.	.	27	.	.	27
DR	M/I Prescriber Last Name	.	.	2	25	.	27
4Y	Patient Residence Value Not Supported	.	.	25	.	1	26
6P	Pricing Segment Required For Adjudication	.	.	26	.	.	26
MV	M/I Benefit Stage Qualifier	.	.	23	.	.	23

NCPCP Code	NCPCP Description	ABH	ACLA	AMG	LHC	UHC	Total
YC	Other Payer Reject Count Exceeds Number Of Occurrences Supported	.	.	1	22	.	23
469	Submission Clarifications Code Count Does Not Precede Submission Clarification Code	.	.	21	.	.	21
MW	M/I Benefit State Amount	.	.	21	.	.	21
12	M/I Patient Location	15	.	4	.	1	20
20	M/I Compound Code	.	.	20	.	.	20
EE	M/I Compound Ingredient Drug Cost	.	.	4	16	.	20
G1	M/I Compound Type	.	.	19	.	.	19
87	Reversal Not Processed	.	.	18	.	.	18
2K	M/I Prescriber Street Address	.	.	18	.	.	18
2M	M/I Prescriber City Address	.	.	18	.	.	18
CP	M/I Patient Zip/Postal Zone	.	.	17	.	.	17
66	Patient Age Exceeds Maximum Age	.	.	.	.	16	16
26	M/I Unit Of Measure	.	.	15	.	.	15
VE	M/I Diagnosis Code Count	.	.	12	.	3	15
3M	M/I Prescriber Phone Number	.	.	14	.	.	14
O1		.	.	14	.	.	14
RK	Partial Fill Transaction Not Supported	.	.	.	10	4	14
H7	M/I Other Amount Claimed Submitted Count	.	.	12	.	.	12
NX	M/I Submission Clarification Code Count	.	.	.	.	12	12
474	Prescriber ID Qualifier Does Not Precede Prescriber ID	.	.	11	.	.	11
HG	M/I Days Supply Intended To Be Dispensed	.	.	11	.	.	11
614	Uppercase Character(S) Required	.	.	10	.	.	10
P3	Compound Ingredient Component Count Does Not Match Number Of Repetitions	.	.	10	.	.	10
569	Provide Appeal Grievance Notice	.	.	.	.	9	9
EB	M/I Originally Prescribed Quantity	.	.	.	.	9	9
H9	M/I Other Amount Claimed Submitted	.	.	.	8	.	8
493		.	.	7	.	.	7
2B	M/I Medicaid Indicator	.	.	7	.	.	7
4X	M/I Patient Residence	.	.	.	3	4	7
YE	Submission Clarification Code Count Exceeds Number of Occurrences Supported	.	.	7	.	.	7
471		.	.	6	.	.	6
8D	Compound Segment Present On A Non- Compound Claim	.	.	.	6	.	6
P7	Diagnosis Code Count Does Not Match Number Of Repetitions	.	.	6	.	.	6
RV	Multiple Reversals Per Transmission Not Supported	.	.	.	6	.	6
489	DUR Co-Agent ID Qualifier Does Not Precede DUR Co-Agent ID	.	.	5	.	.	5
616		.	.	5	.	.	5
J9	M/I DUR Co-Agent ID Qualifier	.	.	5	.	.	5

NCPCP Code	NCPCP Description	ABH	ACLA	AMG	LHC	UHC	Total
XH	Missing or Invalid Quantity	.	.	5	.	.	5
1W	Multi-Ingredient Compound Must Be A Single Transaction	.	.	.	4	.	4
9G	Quantity Dispensed Exceeds Maximum Allowed	.	.	4	.	.	4
HF	M/I Quantity Intended To Be Dispensed	.	.	4	.	.	4
PF	M/I Compound Segment	.	.	4	.	.	4
05	M/I Version/Release Number	3	.	.	.	.	3
14	M/I Eligibility Clarification Code	.	.	2	.	1	3
32	M/I Level Of Service	.	.	1	.	2	3
MP	Other Payer Cardholder ID Not Covered	.	.	3	.	.	3
U7	M/I Pharmacy Service Type	.	.	.	2	1	3
99	Host Processing Error	2	.	.	.	.	2
480	Other Payer Amount Paid Count Does Not Precede Other Pfayer Amount Paid And/Or Qualifier	.	.	2	.	.	2
6W	DUR/PPS Segment Required For Adjudication	.	.	2	.	.	2
7G	Future Date Not Allowed For DOB	.	.	.	.	2	2
9Z	Duplicate Product ID In Compound	.	.	2	.	.	2
A2	ID Submitted is associated to a Deceased Prescriber	.	.	2	.	.	2
EC	M/I Compound Ingredient Component Count	.	.	2	.	.	2
EJ	M/I Originally Prescribed Product/Service ID Qualifier	.	.	.	.	2	2
EM	M/I Prescription/Service Reference Number Qualifier	.	.	2	.	.	2
NV	M/I Delay Reason Code	.	.	2	.	.	2
R3	Procedure Modifier Code Count Does Not Match Number Of Repetitions	.	.	2	.	.	2
RJ	Associated Partial Fill Transaction Not On File	.	.	2	.	.	2
TS	M/I Pay To Qualifier	.	.	.	.	2	2
X8	Procedure Modifier Code Count Exceeds Number Of Occurrences Supported	.	.	2	.	.	2
02		.	.	.	1	.	1
16	M/I Prescription/Service Reference Number	.	.	1	.	.	1
444	Benefit Stage Amount Grouping Incorrect	.	.	1	.	.	1
483	Other Payer-Patient Responsibility Amount Qualifier Does Not Precede Other Payer-Patient Responsibility Amount	.	.	1	.	.	1
485		.	.	1	.	.	1
619	Prescriber Type 1 NPI Required	1	.	.	.	.	1
858		.	.	.	1	.	1
2P	M/I Prescriber Zip/Postal Zone	.	.	1	.	.	1
4C	M/I Coordination Of Benefits/Other Payments Count	.	.	.	.	1	1
54	Multiple Physicians/Assistants Are Not Covered In This Case. Note: Refer to 835 Healthcare Policy Identifications Segment (loop 2110 Service Payment Information REF), If Present	.	.	.	1	.	1

NCPCP Code	NCPCP Description	ABH	ACLA	AMG	LHC	UHC	Total
8F		.	.	1	.	.	1
9R	Prescription/Service Reference Number Qualifier Submitted Not Covered	.	.	1	.	.	1
AK	M/I Software Vendor/Certification ID	1	.	.	.	.	1
DT	M/I Unit Dose Indicator	.	.	1	.	.	1
EA	M/I Originally Prescribed Product/Service Code	.	.	.	.	1	1
EY	M/I Provider ID Qualifier	.	.	.	.	1	1
M9		.	.	1	.	.	1
MX		.	.	1	.	.	1
PC	M/I Claim Segment	.	.	1	.	.	1
PD	M/I Clinical Segment	.	.	1	.	.	1
PH	M/I DUR/PPS Segment	.	.	1	.	.	1
R1	Other Amount Claimed Submitted Count Does Not Match Number Of Repetitions	.	.	1	.	.	1
RN	Plan Limits Exceeded On Intended Partial Fill Values	.	.	1	.	.	1
TOTAL		389,031	1,238,826	1,583,200	2,235,154	1,258,905	6,705,116

Source: 173 Denied Claims Report

[1]As individual claims may have multiple denial codes, the total denial count by denial code will be greater than the count of claims denied.