Healthy Louisiana Claims Report

Response to Act 710 of the 2018 Regular Legislative Session

Calendar Year 2018 Quarters 1 – 3

Prepared by:

Louisiana Department of Health

Bureau of Health Services Financing

April 2019

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LOUISIANA DEPARTMENT OF HEALTH

Contents

Attachment: Burns & Associates, *Independent Study of Provider Claims Submitted to Medicaid Managed Care Organizations in the Healthy Louisiana Program*

Revision Log

Date	Section Changed	Description
5/7/2019	Executive Summary, Key Findings, Section 4: Top Reasons for Denied Claims	Updated top 5 CARCs for denied claims. An error in compiling data resulted in the inclusion of some incorrect CARCs in the initial report.
5/7/2019	Attachment pages III-38 – III-41 and Appendix D Exhibit III.10-Q1 thru Q3	Updated top 10 CARCs for denied claims. An error in compiling data resulted in the inclusion of some incorrect CARCs in the initial report.

Executive Summary

Background

On June 1, 2018, the Louisiana State Legislature passed Act No. 710 which requires reporting of data on healthcare provider claims submitted to Medicaid managed care organizations (MCOs). The legislation required the Louisiana Department of Health (LDH or "the Department") to produce and submit the "Healthy Louisiana Claims Report" to the Joint Legislative Committee on the Budget and to the House and Senate Committees on Health and Welfare.

The initial report was submitted to the Legislature on October 31, 2018. The information in that report covered trends on MCO claim payments and denials, on measures enumerated in law, during calendar year (CY) 2017. Subsequent reports are required to be submitted on a quarterly basis to the legislature. Each subsequent report must cover a more recent three-month period than the previous report. The subsequent quarterly reports must include the reporting on measures defined as an outcome of the findings from the initial report and discussed in consultation with Medicaid providers.

LDH met with providers representing hospitals, physicians and other acute care professionals, behavioral health and pharmacy prior to submitting the initial report for consultation and feedback. In February 2019, LDH reconvened this provider group to obtain feedback on the contents of ongoing quarterly reporting. A model of each exhibit included in this report was shared with the provider community to obtain feedback on format and content. After this was completed, LDH convened the MCOs and released a series of new reporting requirements for each MCO to submit to LDH in order to complete this report.

The report that accompanies this Executive Summary is the first quarterly installment. Based on feedback from stakeholders, it was agreed that the first quarterly update would include data for three quarters—namely, quarters (Q) 1, 2 and 3 of CY 2018. The 4th quarter 2018 data will be presented in a report to the Legislature by July 1, 2019. Beginning with the July 2019 report, a quarterly report will be submitted to the legislature each 90 days and will include data from the most recent four quarters. Therefore, the report to be delivered by October 1, 2019 will include data from Q2 through Q4 of 2018 and Q1 of 2019. It was agreed that although the Act only required a quarterly update on the most recent quarter, the ability to view a rolling four-quarter trend will allow for more meaningful analysis.

LDH engaged Burns & Associates (B&A), a health care consulting firm whose clients are Medicaid agencies, to assist in the ongoing data collection, analysis and trending of these measures. B&A also assisted LDH with the initial Act 710 report submission and provided recommendations for future reporting. LDH accepted these recommendations and worked with B&A on developing the new reporting requirements for the MCOs. In addition to assistance in writing the quarterly reports, B&A is conducting data validation on the information submitted by each MCO in the new reporting requirements released by LDH.

Report Contents

This report contains data from the five MCOs currently under contract to provide acute care, behavioral health and pharmacy services as well as a sixth managed care entity that is under contract to deliver dental benefits only:

Plan Name	Plan Type	Common Abbreviation
Aetna Better Health, Inc.	Managed care organization	ABH
Amerihealth Caritas Louisiana, Inc.	Managed care organization	ACLA
Healthy Blue	Managed care organization	HB
Louisiana Healthcare Connections, Inc.	Managed care organization	LHCC
UnitedHealthcare of Louisiana, Inc.	Managed care organization	UHC
MCNA Insurance Company, Inc.	Dental benefit program manager	MCNA

In the initial report, information reported was separated by behavioral health providers and non-behavioral health providers. In the quarterly updates, and upon consultation with the provider stakeholders, the information will now be reported on multiple provider type categories as shown below:

Acute Care Providers	**Behavioral Health**
Inpatient hospital	Mental or behavioral health rehabilitation
Outpatient hospital	Specialized behavioral health services
Home health	
Primary care providers	**Dental**
Pediatrician	Pediatric dental care
OB-GYN	Adult dental care
Therapists (physical, speech and occupational)	
Non-emergency medical transportation	
Medical equipment and supplies	**Pharmacy**
Other professional services not specified above	

The key measures that will be reported in each quarter include:

1. The percentage of claims submitted by providers that are accepted or rejected by the MCOs;
2. Of those claims accepted, the percentage of claims paid or denied by the MCOs;
3. The average time it takes each MCO to make the payment or denial decision on claims (turnaround time);
4. For those claims that are denied payment, the top reasons why the claims are denied;
5. The percentage of claims adjudicated (paid or denied) by the MCOs that are successfully submitted to LDH for use in the Medicaid data warehouse (at this point it is called an *encounter submission* to LDH); and
6. The average time it takes each MCO to send its encounter submissions to LDH.

For each of these key measures, LDH will report on results at the statewide level, at the individual MCO level, and at the individual provider category level.

Data is also being gathered by each MCO starting with the first quarter of 2019 related to each MCO's educational efforts with providers about claims submissions, with a particular focus on those providers that have a high claims denial rate. Once a sufficient volume of data has been reported on this activity, it will also be included in the quarterly reports to the legislature.

Key Findings

Measure #1: Claims Accepted and Rejected by the MCOs

- In the first three quarters of CY 2018, the claim rejection rate reported by the Medicaid MCOs was about 0.5 percent each quarter. Only one MCO had a rejection rate greater than 1.0 percent in any quarter (ACLA, Q3).

Measure #2: Claims Paid and Denied by the MCOs

- For claims that were accepted into the MCOs' claims adjudication systems, on average, the overall percentage of paid claims ranged between 81.6 percent and 83.0 percent in the first three quarters of 2018. The denial rates, therefore, were between 17.0 percent and 18.4 percent.
- The average claim denial rate ranged from an average of 14.8 percent for Aetna to an average rate of 18.7 percent for LHCC. These statistics exclude dental claims.
- More variation was found when the claim denial rates were examined by provider type:
    - The denial rates for inpatient hospital were higher (22.7 percent to 23.4 percent) than the overall average denial rate in all three quarters of 2018. The denial rate for outpatient hospital services, however, is much lower (near 9.5 percent) than the overall average denial rate.
    - The claim denial rates for most professional claim providers are below the overall MCO denied claim average. For example, primary care providers and pediatricians have a denial rate of about 10.0 percent, and OB-GYNs and therapists have a denial rate of about 12.0 percent.
    - The claim denial rates for behavioral health services are slightly higher than those found for most acute care services. For rehab services, the rate was between 10.4 percent and 13.1 percent in the three quarters reported. For mental/behavioral health services other than rehab, the denial rate was steady (between 14.5 percent and 14.8 percent each quarter).
    - There is a difference in the claim denial rates for dental services for children and adults. For children, the denial rate average was 8.2 percent for the three quarters reported; for adults, the average rate was 17.8 percent.
    - Nationally, pharmacy claim denial rates are always higher than other services, and Louisiana Medicaid is no exception. The denial rate was between 23.7 percent and 27.8 percent for the first three quarters of 2018. This is generally due to the different processing system for pharmacy claims, which are done at point-of-sale.

Measure #3: Average Time for the MCOs to Process Claims

LDH contractually requires that MCOs adjudicate (pay or deny) 99 percent of claims within 30 calendar days. The measurement for turnaround time (TAT) for adjudication is the number of days from receipt

of the claim by the MCO to the time in which the provider is paid or is notified that no payment will be made.

- The MCOs are meeting the target for adjudication within 30 days as set by LDH. In fact, the average TAT is much lower than the contractual requirement.
- The overall TAT for paid claims, all MCOs combined, is between 6.9 and 7.4 days in each quarter. For denied claims, the average is between 4.5 and 4.7 days.
- There is variation between the MCOs on these statistics. The lowest TAT for paid claims was reported by ACLA (near 3.3 day average each quarter). The highest TAT was reported by UHC (near 9.0 day average each quarter), but Healthy Blue and MCNA are similar to these values. The lowest TAT for denied claims is also ACLA (near 1.8 day average each quarter). The highest TAT was reported by MCNA (a range between 8.1 and 10.2 days each quarter). Further details are provided in the table below.

Turnaround Time for Claims Processing of Adjudicated Claims (using average days)
By MCO and By Quarter in 2018

		Adjudicated Within 30 days		Average Turnaround Time	
		Pct of Paid	Pct of Denied	Paid Claims	Denied Claims
ABH	Q1	99.9%	99.9%	4.4	4.1
	Q2	99.9%	99.7%	4.1	4.1
	Q3	99.6%	99.7%	4.4	4.1
ACLA	Q1	100.0%	100.0%	3.2	3.2
	Q2	100.0%	99.9%	3.5	3.6
	Q3	100.0%	99.9%	3.2	3.0
HB	Q1	99.8%	97.9%	9.2	4.8
	Q2	99.9%	99.8%	7.6	4.0
	Q3	99.9%	99.7%	7.8	4.2
LHCC	Q1	99.9%	99.5%	7.1	6.1
	Q2	99.6%	98.8%	6.6	6.0
	Q3	99.8%	99.5%	6.2	5.6
UHC	Q1	99.8%	99.4%	8.6	3.9
	Q2	100.0%	99.8%	9.2	3.5
	Q3	99.8%	99.3%	9.0	4.0
MCNA	Q1	99.9%	99.8%	7.9	8.8
	Q2	100.0%	100.0%	9.0	10.2
	Q3	100.0%	100.0%	7.3	8.1

- Claims adjudication average TATs vary by provider category.
    - For example, for inpatient hospital services, the average TAT is about 11.0 days each quarter for both paid and denied claims. For outpatient hospital services, the average TAT is closer to 7.1 days for paid claims and 9.7 days for denied claims.
    - The average TAT is lower for professional services and behavioral health services (for paid claims, 6.1 to 9.1 days based on provider category). The average TAT is similar for denied professional claims.
    - For dental services, the average TAT was between 7.3 and 9.0 days for paid claims.

- For pharmacy paid claims, the average TAT was a high of 7.4 days in Q1 2018 down to a low of 6.1 days in Q3 2018. For denied pharmacy claims, the average TAT is less than one day due to point-of-sale claims processing systems.

Measure #4: Top Reasons for Denied Claims

When a claim is adjudicated, the claims processor assigns one or more codes to indicate the reason(s) why the claim adjudicated the way it did. For medical and dental claims, there is a set of nationally-recognized Claim Adjustment Reason Codes (*CARCs*), which contains a total of about 280 reason codes. For pharmacy claims specifically, there are nearly 350 reason codes developed by the National Council for Prescription Drug Programs (*NCPDP)*.

- Although the order of the top 10 CARCs most frequently occurring on denied claims changed a bit across quarters when looking at all MCOs combined, nine of the 10 top CARCs were the same in all three quarters. The top five included the following:
  - 197: Precertification or authorization absent when it is required.
  - 97: The benefit for this service is included in the payment for another service.
  - 16: The claim lacks information or has a billing error which is needed for adjudication.
  - 198: Precertification or authorization exceeded.
  - 252: An attachment/other documentation is required to adjudicate this claim/service.
- The top five CARCs for each MCO are often in the top 10 CARCs statewide.
- Although the order of the top 10 NCPDPs for all MCOs changed a bit across the quarters, nine of the 10 top NCPDPs were the same in all three quarters. The top five were:
  - 88: Drug Utilization Review (DUR) reject error.
  - 79: Refill too soon.
  - 7J: Patient relationship code value not supported.
  - 7N: Plan ID qualifier value not supported.
  - 76: Plan limitations exceeded

Measure #5: Encounters Accepted and Rejected by LDH

- In the first three quarters of CY 2018, 94.4 percent to 96.2 percent of the encounters submitted by all MCOs combined were accepted by LDH.
- There were differences at the MCO level. All of UHC's encounters were accepted and most of Aetna's, LHCC's and MCNA's were accepted. Only 91.3 percent of ACLA's encounters (average over three quarters) were accepted and only 85.6 percent of Healthy Blue's encounters (average over three quarters) were accepted.

Measure #6: Average Time for MCOs to Submit Encounters

Like claims adjudication, a common benchmark to track the timeliness of encounter submissions is the average TAT. In the case of encounters, the average TAT measures the date from which the MCO gave

notice to the provider of payment or denial to the date that the encounter was submitted to LDH. A common benchmark used is that MCOs should submit encounters within 30 days of adjudication.

- When the encounters are accepted by LDH, Healthy Blue and MCNA each have the highest percentage submitted within 30 days (almost 100 percent).
- LHCC has the second highest TAT among the MCOs. There was slightly lower compliance in Q1, but in Q2 and Q3 more than 98 percent of institutional, 92 percent of professional, and 97 percent of pharmacy encounters were submitted within 30 days.
- UHC has had some challenges with meeting an average 30-day TAT for institutional and professional encounters in Q1 and pharmacy encounters in Q2.
- ACLA has had some challenges with meeting an average 30-day TAT for institutional encounters in Q3 and pharmacy encounters in Q1 and Q2.
- Aetna has not had specific issues with any specific claim type per se, but they do have a lower percentage of encounters submitted within 30 days for each claim type than many of its peers.

For a full analysis of each measure, see Burns & Associates' full report, attached herein.

Case Management

In addition to claims adjudication and encounter submission statistics, Act 710 requires the Department to report certain measures pertaining to case management in the Healthy Louisiana program:

> *E. The initial report and subsequent quarterly reports shall include the following information relating to case management delineated by a Medicaid managed care organization:*
>
> *(1) The total number of Medicaid enrollees receiving case management services.*
>
> (2) *The total number of Medicaid enrollees eligible for case management services*.

Each of the Healthy Louisiana plans is contractually required to develop and implement a case management program through a process which provides appropriate and medically-related services, social services, and/or basic and specialized behavioral health services for members that are identified as having special healthcare needs (SHCN) or who have high risk or unique, chronic, or complex needs.

The Department currently monitors the identification and assessment of members in need of case management services and those receiving case management services through MCO self-reported data provided on a quarterly basis. While there are specific contractual standards that require MCOs to complete an assessment of all individuals identified as having a special healthcare need within 30 days of identification, each MCO has their own policies and procedures for identification and assessment. As such, the reporting for case management has shown significant variation across MCOs. LDH has been working with the MCOs and various providers to increase the comparability of the data collected and more accurately reflect program participation.

The data presented below is representative of quarters 2 and 3 of CY 2018. This is the most current data available following the last revision to the case management report template. Data for quarter 1 of 2018 is not available, as the case management report template was not implemented until April 2018.

Healthy Louisiana Case Management Summary by MCO

	ABH	ACLA	HBL	LHCC	UHC
June 2018 (Q2 CY 2018)					
Eligible for Case Management (CM)	1,633	3,628	1,337	5,325	6,600
Enrolled in CM	1,138	3,240	449	3,342	1,245
Percent of eligibles enrolled in CM	69.7%	89.3%	33.6%	62.8%	18.9%
September 2018 (Q3 CY 2018)					
Eligible for Case Management (CM)	1,354	3,747	1,514	5,549	8,747
Enrolled in CM	995	3,225	603	3,563	1,252
Percent of eligibles enrolled in CM	73.4%	86.1%	39.8%	64.2%	14.3%

Source: 039 Case Management Reports

Data for June 2018 was also presented in the initial Healthy Louisiana Claims Report published in October 2018. The figures presented here differ from the figures initially reported, as Medicaid staff have continued to work with the MCOs to better align definitional discrepancies and produce consistent data that is comparable across MCOs.

Louisiana Department of Health
628 North Fourth Street, Baton Rouge, Louisiana 70802
(225) 342-9500
www.ldh.la.gov

www.facebook.com/LaHealthDept. www.twitter.com/LADeptHealth

INDEPENDENT STUDY OF PROVIDER CLAIMS SUBMITTED TO MEDICAID MANAGED CARE ORGANIZATIONS IN THE HEALTHY LOUISIANA PROGRAM

QUARTERLY UPDATE
PERIOD COVERING 1ST, 2ND AND 3RD QUARTERS
OF CALENDAR YEAR 2018

APRIL 8, 2019

BURNS & ASSOCIATES, INC.
Health Policy Consultants

3030 NORTH THIRD STREET, SUITE 200
PHOENIX, AZ 85012
(602) 241-8520

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SECTION I: INTRODUCTION

Legislative Overview

On June 1, 2018, the Louisiana State Legislature passed House Bill 734, which subsequently was enrolled and chaptered as Act No. 710 of the 2018 regular legislative session, which requires reporting of data on healthcare provider claims submitted to Medicaid managed care organizations (MCOs). The legislation required the Louisiana Department of Health ("the Department", or LDH) to produce and submit the "Healthy Louisiana Claims Report" to the Joint Legislative Committee on the Budget and to the House and Senate Committees on Health and Welfare.

The initial report covered claims paid during Calendar Year (CY) 2017. Subsequent reports are required to be submitted on a quarterly basis. Each subsequent report must cover a more recent three-month period than the previous report. Whereas the initial report presented detailed findings about CY 2017 claims on measures enumerated in law, the subsequent quarterly reports will include the reporting on measures that will be defined as an outcome of the findings from the initial report.

The Initial Report was submitted to the legislature on October 31, 2018. This is the first quarterly update report. Based on feedback from stakeholders, it was agreed that the first quarterly update would in fact include reporting on three quarters—namely, Calendar Quarters 1, 2 and 3 in CY 2018. The 4th Quarter 2018 data will be presented in a report to the Legislature by July 1, 2019. From there on, a quarterly report will be submitted to the Legislature each 90 days and will report on data from the most recent four quarters. Therefore, the report to be delivered by October 1, 2019 will include data from Q2 through Q4 of 2018 and Q1 of 2019.

Required Reporting for the Initial Report

In the initial report, information was reported on for behavioral health providers separately from non-behavioral health providers. The type of information reported included the following:

- The total number and dollar amount of claims based on the claim status, such as rejected claims, voided claims, duplicate claims, adjusted claims, adjudicated claims and pended claims;
- The total number and dollar amount of claims denied divided by the total number and dollar amount of claims adjudicated;
- The total number and dollar amount of claims for which there was at least one service line denied on the claim; and
- Information on the five billing providers (de-identified in the report) with the highest number of total denied claims (expressed as a ratio to the total claims adjudicated for the provider).

The Department was also required to include in the report the action steps that it will take in order to address:

- The five most common reasons for denial of claims submitted by healthcare providers (behavioral and non-behavioral health providers separately) and the educational efforts the Department and/or the MCOs will undertake to educate the providers with the highest number of denied claims.
- The methods used to ensure that provider education includes the root cause for the denial reasons and actions to address those causes.
- Claims denied in error by the Medicaid MCOs.

In addition to reporting information on MCO claims adjudication, the Act requires that the Department report on:

- The total number of encounters submitted by each Medicaid MCO to the Department or its designee;
- The total number of encounters submitted by each Medicaid MCO that are not accepted by the Department or its designee;
- The total number of Medicaid enrollees eligible to receive case management services; and
- The total number of Medicaid enrollees receiving case management services.

Steps in Claims Processing and Encounter Submissions

In a typical claims processing system, a provider will submit a claim for services rendered to the payer (in this case, the MCO) using one of the standardized claim formats that have been established nationally. Although it is still possible for claims to be submitted on paper, the vast majority of claims are now submitted in a standardized electronic format.

There are four primary claim "form" types (either in paper or electronic format):

- The *UB-04, or electronic 837I*, is the claim type for institutional providers to submit on. This includes hospitals, nursing homes and home health agencies.

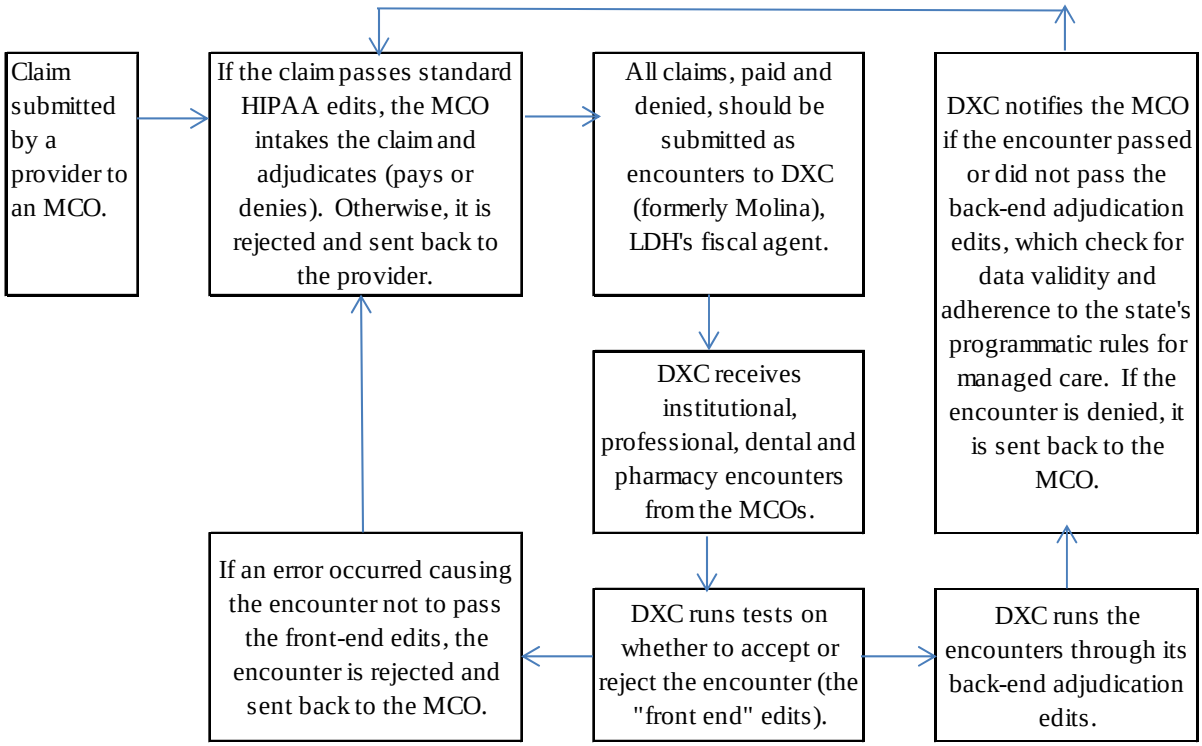
- The *CMS-1500, or electronic 837P*, is the claim type for professional service providers to submit on. This includes a wide array of providers such as physicians, clinics, mental health providers, therapists, transportation providers, suppliers of medical equipment and supplies.

- The paper and *electronic 837D* version of the *dental claim form* were developed and endorsed by a working group sponsored by the American Dental Association and is specific to dental services.

- *Pharmacy claims* are now universally submitted in electronic format also using a format for 837 transactions like the 837I and 837P. The standards for submitted pharmacy claims were developed in collaboration with the National Council for Prescription Drug Programs (NCPDP).

Exhibit I.1 on the next page summarizes how claims are submitted to Medicaid MCOs in Louisiana and, in turn, the process in which the MCOs submit encounters to the Department's fiscal agent, DXC (formerly Molina).

Exhibit I.1
Submission, Validation and Processing Flow of Managed Care Claims and Encounters



Terminology Used in this Report

A ***claim*** is the bill that the health care provider submits to the payer (in this case, the MCO). An ***encounter*** is the transaction that contains information from the claim that is submitted by the MCO to the Department.

A claim can be assigned different attributes based on the status of what is being submitted (or returned).

- An *original claim* indicates the first submission made by the provider to the payer.
- At times, there may be a need to make adjustments to the original submission. If the provider does this, then the claim may be tagged as an *adjusted claim*.
- In other situations, the provider realizes that the submission was sent in error or needs to be completely changed. Therefore, claims may be flagged as *voided claims*. Immediately after, there may be a *replacement claim* (but not necessarily).

When a claim is submitted to a payer, there are standards that must be upheld such as the minimum information that is required, the valid values to put in fields, etc. The Health Insurance Portability and Accountability Act (HIPAA) mandated the minimum criteria required on claims submissions. As a result, claims processors conduct "front-end" edits upon receipt of a claim to ensure that the claim passes "the HIPAA edits". If a claim does not pass these front-end edits, the claim is flagged as a *rejected claim*. Typically, there is little information retained by payers on rejected claims.

Assuming that a claim passes the front-end edits and gets "through the door", the claims processor will then conduct *adjudication* on the claim. An *adjudication status* of paid or denied is assigned to the claim. However, this status can be (and usually is) assigned at two different levels:

- A *header claim status* means the status assigned to a claim across all services reported on the claim (since a single claim can contain more than one service billed on it).
- A *detail claim status* means the status assigned to the individual service lines that are billed on a claim.

It is customary for claims processing systems to track the claim status at both levels. When the status is at the header level:

- A *paid status* usually means that at least one service line on the claim was paid.
- A *denied status* usually means that every service line on the claim was denied.

At the detail level, however, the status could be paid or denied, and the status of the individual detail line may differ from the header status. For example, a professional claim contains five service lines. The first four are paid. The fifth service is denied. Each service line will have its own claim status but the header claim status will be paid.

It is important to factor this information in when analyzing claims and claim trends. The question to ask is if the claim counts shown represent the count of header records or of individual service lines. The count of header lines may be a fraction of the total detail service lines.

The Department has asked the MCOs to report all information on claims adjudication at the service (detail line) level with one exception. For inpatient services, payment is made by LDH and its MCOs on only one line of the claim (the room and board line). Therefore, for inpatient hospital claims, only one service line is reported for each claim. The information shown in this report is reported at the service (detail line) level.

For a brief period, claims may be assigned a *pended status*. This means that the payer has not yet decided whether to pay or deny the claim (or claim line). Payers will assign a pended status to claims that require additional research or require manual review. For example, claims may pend because a medical review is required before payment is allowed; or, it could be that a provider is on a list that requires manual review because the provider had previously been identified as submitting potentially inaccurate bills in the past. Claims adjudication systems may assign claims to a pended status for as little as a few minutes or as much as multiple days depending upon the reason the adjudication process was suspended. Each claims processor sets its own criteria for assigning claims to a pended status.

The *turnaround time* factors in any time that a claim is pended. This is the term used to describe the length of time it takes for payers to adjudicate claims. In this study, the average turnaround time represents the time from receipt of the claim by the MCO to the time of notification to the provider (pay or deny).

When a claim is adjudicated, the claims processor will assign codes to indicate the reason(s) for why the claim adjudicated the way it did. Many payers will design codes specific to their own organization. However, there are a set of national codes that have been developed:

- For medical and dental claims, there is set of nationally-recognized Claim Adjustment Reason Codes (*CARCs*), about 280 reason codes in all.
- For pharmacy claims specifically, there are nearly 350 reason codes developed by the *NCPDP*.

The reason codes describe information on both paid claims and denied claims. The LDH requires the contracted MCOs to submit information on the CARCs and NCPDP codes that pertain to situations when claim lines are denied. The frequency of CARCs and NCPDP codes for denied services were examined in this study. A service line on a claim may have more than one CARC or NCPDP code as well. The full listing of CARCs and NCPDP codes appear in *Appendix B and Appendix C*, respectively.

Findings from Initial Report Covering Calendar Year 2017

Some key findings in the initial report related to the information reviewed for CY 2017 claims and encounters is highlighted below:

- The rate of rejected claims as a percent of total claims submitted is very low (approximately 1%).
- For those claims accepted by the MCOs, the weighted average denial rates were
    - 8% for institutional (mostly hospital) claims, with MCOs ranging from 7% to 11%
    - 12% for professional (e.g. physician) claims, with MCOs ranging from 9% to 14%
    - 5% for dental claims
    - 27% for pharmacy claims, with MCOs ranging from 16% to 36%. The high incidence of denied pharmacy claims is consistent with national trends. This reflects pharmacists at point-of-sale who often try to key in the same script multiple times.
- The average turnaround time (TAT) for the MCOs to adjudicate claims after receipt from the provider was often less than 10 days but almost always less than 15 days with just two exceptions.
    - For institutional claims, Aetna had an average TAT of 25.5 days, UHC's average was 26.6 days.
    - For professional claims, Aetna had an average TAT of 21.9 days.
- There was no distinction in the TAT between paid and denied claims for institutional and dental claims, but the TAT for denied professional claims was five days greater than paid claims.
- The top five denial reason codes for institutional and professional claims represented near 50% of all denial CARC occurrences (out of more than 250 types of CARCs). For dental claims, the top five represented 71% of all CARC occurrences. For pharmacy, the top five NCPDP codes represented 64% of all denial codes (out of approximately 350 NCPDP codes).

Follow-up Consultation with Providers and the MCOs

The provider community was consulted on the results of the initial Healthy Louisiana Claims Report prior to its submission to the Legislature. After the publication, both the providers and the MCOs were convened in separate meetings to review the measures that will be reported on each quarter in the quarterly update reports. Some measures that were included in the initial report were removed from ongoing quarterly reporting, but new measures have also been added. The updated list of measures was developed to provide the most meaningful information to the provider community, LDH and the MCOs.

LDH has retained Burns & Associates (B&A) to assist with ongoing reporting related to the Act. B&A assisted LDH by conducting the independent study for the initial period of CY 2017. B&A worked with LDH to develop new reporting templates for the MCOs to submit information related to claims adjudication and encounter submissions each quarter. B&A facilitated a webinar with providers on February 8, 2019 to obtain their feedback on the new reports as well as the layout of the exhibits that

appear in this report. After making some modifications, B&A then conducted a webinar with the MCOs to introduce the new reports on February 27, 2019. The first set of information was then due to LDH from the MCOs using these new reports on March 20, 2019.

Recommendations Implemented Since Initial Report

LDH has taken action on the following recommendations put forth by B&A in the initial Healthy Louisiana Claims Report:

- Recommendation 1: LDH should develop a common set of definitions for claims adjudication terms that would be used by all MCOs as well as the LDH fee-for-service payment system. **Completed**. This recommendation was accepted and the definitions now appear in the instructions for the new report templates used for Act 710 reporting.

- Recommendation 2: LDH should develop a common set of definitions for encounter adjudication terms that would be used by all MCOs as well as LDH. **Completed**. This recommendation was accepted and the definitions now appear in the instructions for the new report templates.

- Recommendation 3: LDH should build guidance or requirements about the expectations that the MCOs will perform root cause analyses pertaining to claims adjudication and/or encounter submissions. **In process.** This recommendation was accepted. The new report templates require the MCOs to report on top denial reasons by provider type which will help assist with conducting root cause analysis. The MCOs are also required to report the number of providers with high denial rates segmented by provider Medicaid claims volume (small, mid-size, large) to understand which providers within a specialty are most impacted by the denial rate. LDH is in the process of setting expectations for how the MCOs will use this information with respect to provider education.

- Recommendation 4: LDH should review the MCO reports that focus on claims and consider modifying, consolidating or eliminating existing reports. LDH should also consider adding a report on encounter submissions. **Completed.** LDH worked with B&A to develop the new report templates that the MCOs are required to submit each quarter to comply with the Act.

- Recommendation 5: For any new measures or reports that get introduced as part of quarterly reporting by this Act, LDH should convene all of the MCOs to review the new report templates, to confirm understanding of the specifications, and to vet the instructions. **Completed.** This was done as part of the February 27, 2019 webinar and follow-up responses to questions from the MCOs.

- Recommendation 6: LDH should develop an audit protocol and conduct a periodic audit of a sample of claims denied by the MCOs to ensure that the claims are not being denied in error by the MCO. **In process.** LDH concurs with this recommendation and is in the process of developing a protocol for use later in 2019.

SECTION II: CONSTRUCT OF THE QUARTERLY UPDATE REPORT

Six new reports have been designed specifically for the quarterly report updates. LDH requires that each MCO submit these six reports on a quarterly basis.

There will be a lag time between the claims adjudication period and the date that the MCOs will submit the reports to LDH as allowed by the Act. For example, the results from the claims adjudication period January 1 – March 31, 2019 will be due to LDH by July 31, 2019.

The MCOs analyzed in this review include:

- Aetna
- Amerihealth Caritas Louisiana (ACLA)
- HealthyBlue
- Louisiana Health Care Connections (LHCC)
- United Healthcare (UHC)
- Managed Care of North America (MCNA), for dental services only

Measures that will be Reported Each Quarter

Starting with this report, the Healthy Louisiana Claims Report quarterly updates will be delivered in the same format each quarter. The key measures that will be tracked on an ongoing basis include:

- The rate of claims accepted and rejected by each MCO
- The rate of accepted claims that are paid and denied by each MCO
- The timeliness (turnaround time) for each MCO to adjudicate claims
- The top reasons why claims are being denied at each MCO
- Provider education efforts (beginning with report period CY 2019 Q1)
- The rate of encounters accepted and rejected by LDH for each MCO
- The timeliness for each MCO to submit encounters to LDH on its adjudicated claims

Provider Categories

Act 710 required that behavioral health providers be reported discretely from non-behavioral health providers in the initial report. This will be continued in all quarterly updates. In consultation with stakeholders, LDH also agreed that there be further segmentation of the non-behavioral health providers for discrete reporting. The provider categories that will be reported on an ongoing basis are:

Institutional Claim Type (837I)	**Professional Claim Type (837P)**
Inpatient hospital	Primary care
Outpatient hospital	Pediatrician
Home health	OB-GYN
All other services submitted on an institutional claim not specified above	Therapists (physical, speech and occupational)
	Non-emergency medical transportation
Dental Claims (MCNA Only)*	Medical equipment and supplies
Pediatric dental care	Mental or behavioral health rehabilitation
Adult denture services	Specialized behavioral health services
Pharmacy Claims	All other services submitted on a professional claim not specified above
(no additional breakouts)	

*MCO value-added dental services are included in the Professional Services category.

The map of LDH provider type and specialty codes into each of the categories mentioned above appears in *Appendix A.*

How This Report is Organized

Section III contains the results related to MCO claims adjudication measures. In the future, this section will also include information related to MCO provider education pertaining to claim submissions. Section IV reports on the results of findings related to MCO encounter submissions.

There are 15 exhibits that will be reported on in each quarterly report—11 pertain to claims adjudication, one pertains to provider education and three pertain to encounter submissions. The format for each exhibit will remain consistent with each quarterly report to allow for ease in trending results over time.

In some exhibits, data will be displayed for the most recent four quarters. For this initial quarterly update, only three quarters are shown (Q1 through Q3 2018). In the next edition of this quarterly update, Q4 2018 data will be added. In the subsequent edition, Q1 2018 data will be dropped and Q1 2019 data will be added.

Other exhibits will display only the data from the most recent quarter. Because LDH is making up for three quarters all at once in this quarterly update, for this report only, some reports are shown three times. One report shows Q1 2018 results only, the second report shows Q2 2018 results only, and the third report shows Q3 2018 results only.

Appendix D provides the numeric values for the exhibits shown in the body of the report in a graphical format. *Appendix E* provides a 1-page summary for each of the 16 provider categories. The summaries in this appendix compile information from the 16 exhibits in the body of the report but focus on a single provider specialty on each page.

Limitations of the Data

In its review of the reports submitted by each MCO to LDH for this quarterly update, Burns & Associates (B&A) would like the reader to keep in mind two known limitation of the data reported:

1. All data is self-reported by the MCOs to LDH. B&A provided assistance to LDH by validating the data as it was submitted. In some situations, MCOs were asked to verify specific values that were reported to confirm their accuracy if the initial submission deviated from trends reported by other MCOs or the same MCO in a prior period (CY 2017). In some cases, the MCOs did provide updated information after further research into the matter.

2. The Act requested information on the dollar amount of denied claims. If a claim is denied, then the payment will be $0. B&A tested multiple ways in which to derive a "would have paid" amount if the denied claim had been paid. This method was shared in a meeting with the provider community. There are multiple limitations to computing a "would have paid" amount.

    - First, some denied claims would never pay anything because they are exact duplicates of a claim previously submitted. B&A attempts to quantify the value within the dollar amount of denied claims reported since this value is, in essence, $0.
    - Second, there are multiple methods in which to derive a dollar amount of a "would have paid" if the claim had a paid status. B&A tested two in particular. Ultimately, B&A

selected an approach that estimates the value of each denied claim by applying a value to it that is the average value of every paid claim in that category.

Although this method allows for some precision, there could have been further precision by pricing each denied service based on the rate that LDH pays for the service. It was deemed that none of these methods truly reflects "lost" payments since the claims in question were denied for a reason and the payment should be $0. The value of denied claims, therefore, should be reviewed with caution. It is of the opinion of the B&A reviewers that the values shown for denied claims should not be considered as "lost" money to providers but, rather, as an opportunity for improvements in the accuracy and completeness of provider claims submissions.

SECTION III: FINDINGS RELATED TO MCO CLAIMS ADJUDICATION

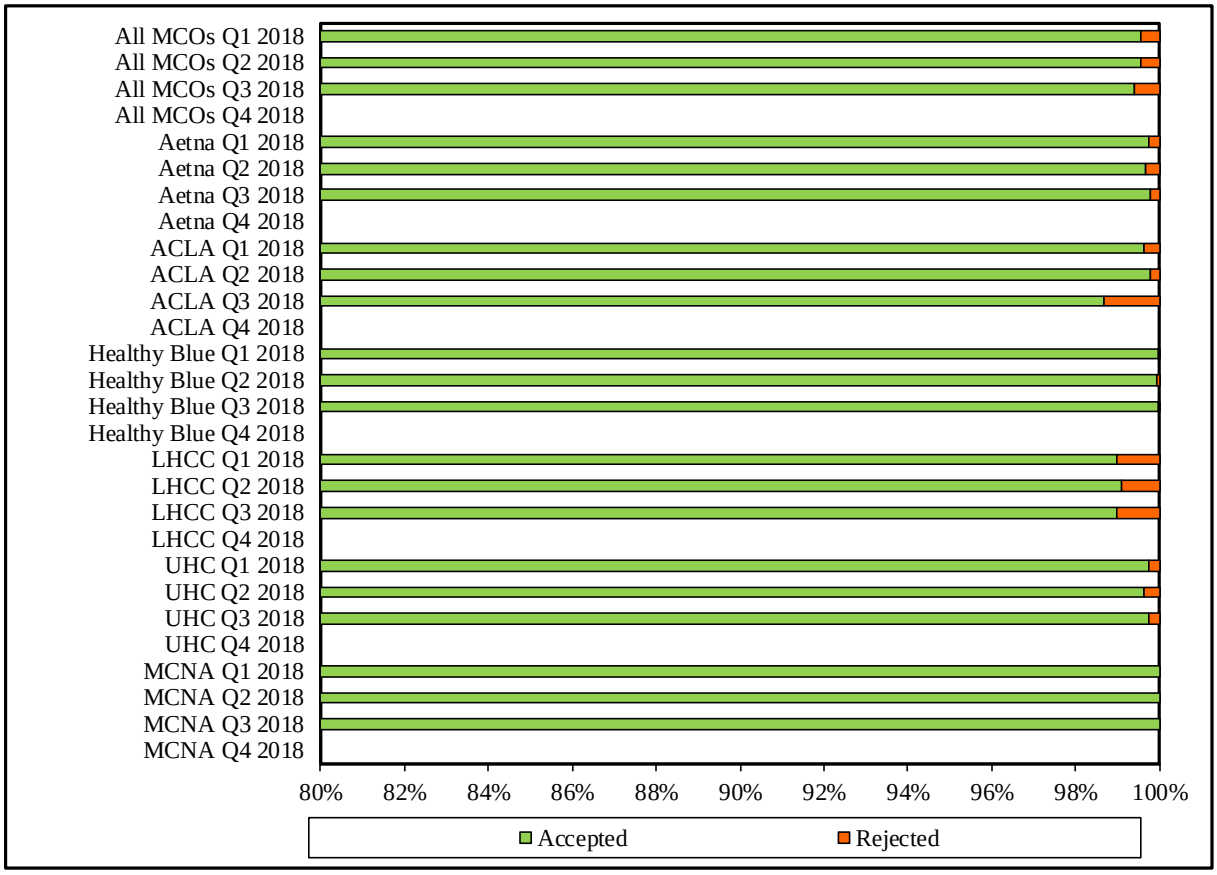
The LDH's contracted MCOs adjudicated between 22.6 and 24.1 million claim service lines in each of the first three quarters of Calendar Year (CY) 2018. The MCOs themselves adjudicate medical claims (those billed in the institutional claims, or 837I, format and those billed in the professional claims, or 837P, format). MCNA adjudicates almost all of the dental claims for the Medicaid program. Each MCO contracts with a pharmacy benefit manager to adjudicate the pharmacy claims.

The exhibits in this section show information from the first three quarters of CY 2018. In the quarterly update that will be submitted to the Legislature by July 1, the 4th Quarter data will be added.

Claims Accepted and Rejected by the MCOs

In the first three quarters of Calendar Year (CY) 2018, the claims rejection rate reported by the Medicaid MCOs was near 0.5% each quarter. Only one MCO had a rejection rate greater than 1.0% in any quarter (ACLA, Q3).

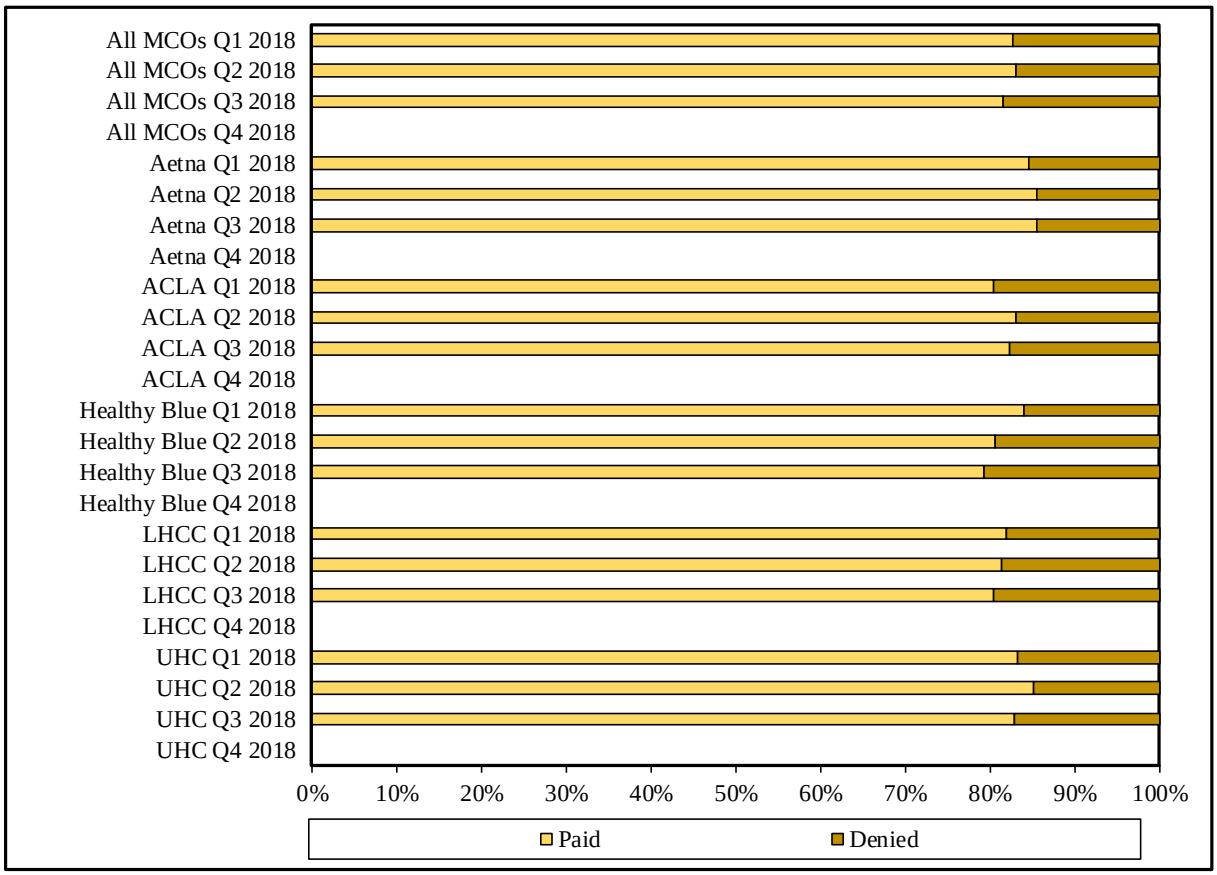
Exhibit III.1
Claim Accepted and Rejected Rate
All Claim Types
By MCO and By Quarter



Claims Paid and Denied by the MCOs

For those claims that were accepted into the MCO's claims adjudication system, on average, the overall rate of paid claims was between 81.6% and 83.0% in the first three quarters of 2018. The denial rates, therefore, were between 17.0% and 18.4%. The range across the MCOs for the three quarters was from an average denial rate of 14.8% for Aetna to an average rate of 18.7% for LHCC. These statistics exclude MCNA dental claims, which can be found in Exhibit III.3C in categories Dental – Children and Dental – Adult.

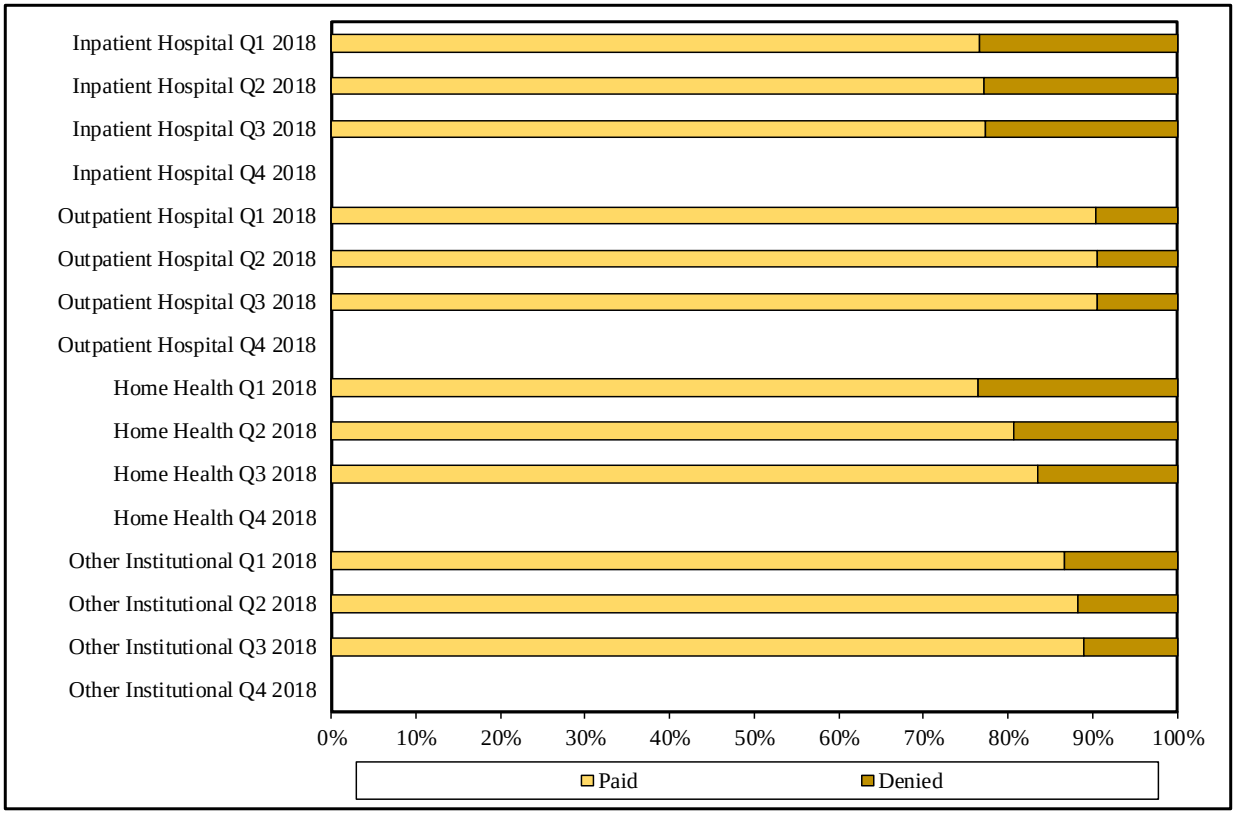
Exhibit III.2
Claim Status for Adjudicated Claims
All Claim Types
By MCO and By Quarter



There is more variation found when the claims denial rates are examined by provider type. Exhibits III.3A, III.3B and III.3C on the following pages break out the approval and denial rates by provider type and by the first three quarters in CY 2018. Exhibit III.3A shows the providers that bill on the institutional, or 837I, claim type. Exhibit III.3B shows the providers that bill on the professional, or 837P, claim type. Exhibit III.3C shows specialized providers such as behavioral health, dental and pharmacy.

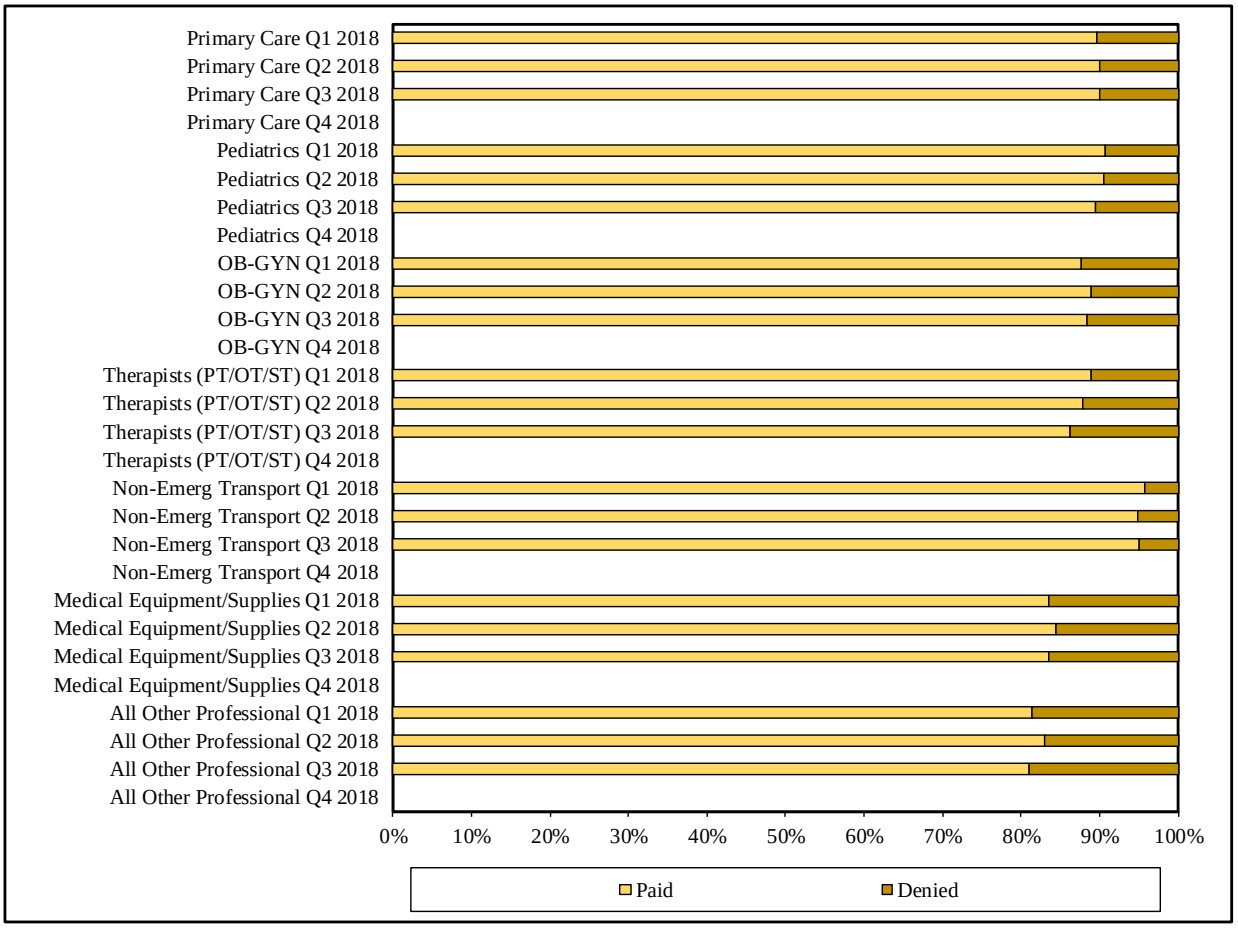
In Exhibit III.3A below, it was found that the denial rates for inpatient hospital were higher (22.7% to 23.4%) than the overall denial average rate (17.0% to 18.4%) in all three quarters of 2018 reported so far. Home health agencies also had a higher-than-average denial rate in Quarters 1 and 2, but not in Quarter 3, of 2018. Interestingly, the denial rate for outpatient hospital services is much lower (near 9.5%) than the overall average denial rate.

Exhibit III.3A
Claim Status for Adjudicated Claims
Institutional Providers
For All MCOs Combined By Quarter



The claims denial rates for a most professional claim providers are below the overall MCO denied claim average. For example, primary care providers and pediatricians have a denial rate closer to 10.0%. OB-GYNs and therapists have a denial rate closer to 12.0%. Non-emergency medical transportation denial rates are the lowest of any provider type at about 5.0%. Two groups in this exhibit have claim denial rates higher than the overall MCO average. For medical equipment and supplies, the average denied claims rate is 16.1% over the three quarters shown. For the All Other Professionals group, the average denied claims rate is 18.2%.

Exhibit III.3B
Claim Status for Adjudicated Claims
Professional Service Providers
For All MCOs Combined By Quarter

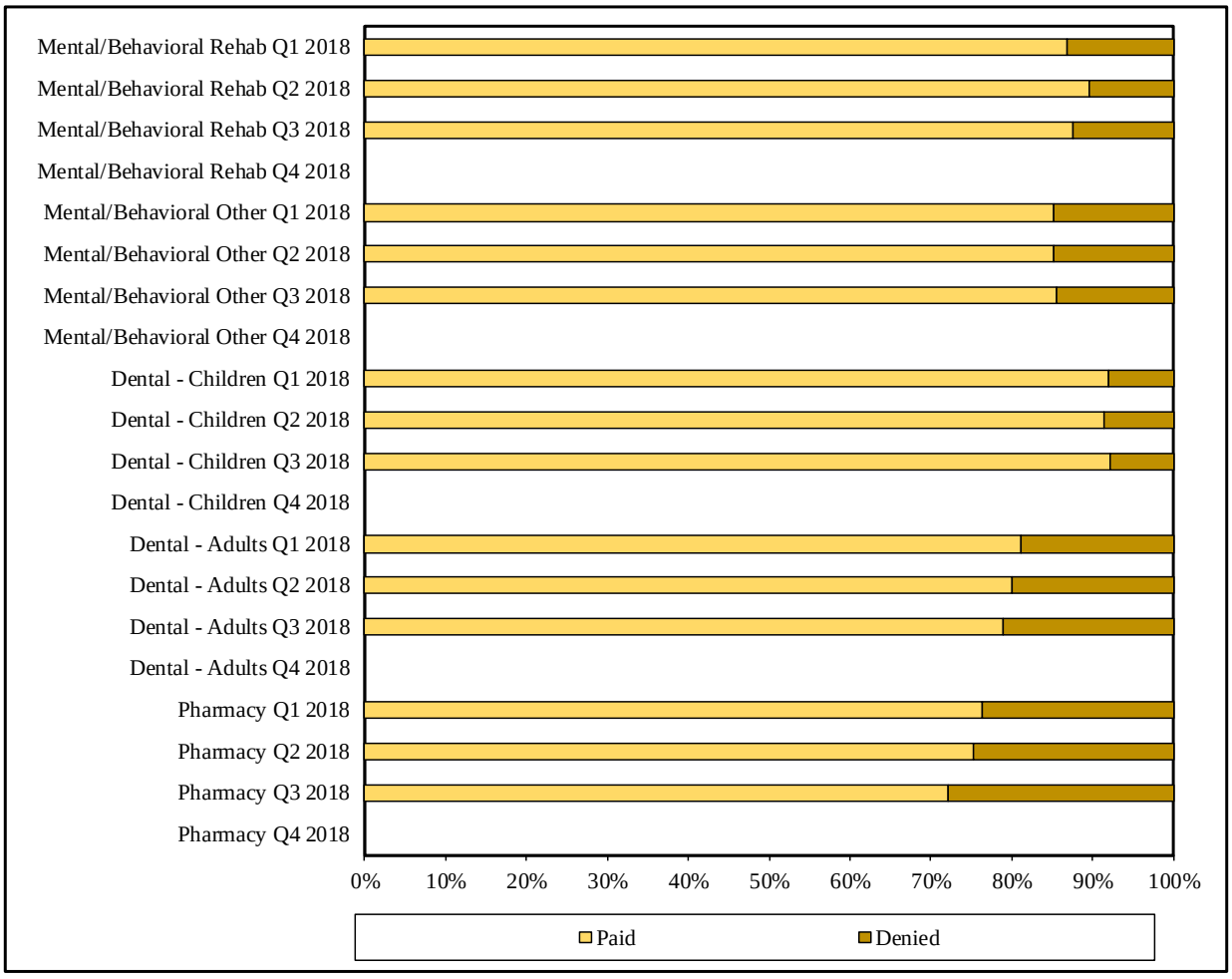


The claims denial rates for behavioral health services are slightly higher than those found for most acute care services on the previous pages. For rehab services, the claims denial rate was between 10.4% and 13.1% in the three quarters reported. For mental/behavioral health services other than rehab, the claims denial rate was steady (between 14.5% and 14.8% each quarter).

There is a difference in the claim denial rates for dental services for children and adults. For children, the denial rate average was 8.2% for the three quarters reported; for adults, the average rate was 17.8%.

Pharmacy claim denial rates are always higher than other services and Louisiana Medicaid is no exception. The denial rate was between 23.7% and 27.8% for the first three quarters of 2018.

Exhibit III.3C
Claim Status for Adjudicated Claims
Behavioral Health, Dental and Pharmacy
For All MCOs Combined By Quarter



The exhibits on the next nine pages further break down the claim paid and denied rates, but in these exhibits the breakdown is for each provider type by each of the MCOs. The purpose of these exhibits is to determine if the claims denial rate for a provider type is consistent across MCOs or if it varies. For this quarterly report update only, there are nine exhibits instead of three because this report contains data on three quarters that have not been previously reported.

Exhibits III.4A Q1 through Q3 correlate with the information shown in Exhibit III.3A (institutional providers). Exhibits III.4B Q1 through Q3 correlate with the information shown in Exhibit III.3B (professional providers). Exhibits III.4C Q1 through Q3 correlate with the information shown in Exhibit III.3C (behavioral health, dental, pharmacy).

The key findings from all nine exhibits appearing on pages III-7 through III-15 are summarized here for convenience:

Provider type	**Percentage of MCO Payments Q1 to Q3**	**Variation Across Quarters?**	**Variation Across MCOs?**	**If Variation Across MCOs, range of Denial Rates**
Inpatient Hospital	16.0%	Not much	No except Healthy Blue	Healthy Blue sometimes five percentage points above others
Outpatient Hospital	22.8%	Not much	No	---
Home Health	0.4%	High	Yes	ACLA and UHC had higher denial rates in the Q1 and Q2
Other Institutional	0.2%	Some	Yes	ACLA and LHCC have high claims denial rates
Primary Care	3.7%	Not much	Yes	Aetna lowest (4%-6% in 2 qtrs) and ACLA highest (12%-14%)
Pediatrics	2.3%	Yes	Yes	Aetna lowest (4.0% in Q1) and UHC highest (13.9% in Q3)
OB-GYN	4.3%	Some	Yes	UHC lowest (near 7.5% each qtr), ACLA highest (12.6%-16.2%)
Therapists	1.5%	Yes	Yes	Aetna is much higher than all other MCOs, UHC is lowest
Non-emergency Transportation	0.8%	Yes, due to low volume	Yes	Aetna and LHCC were near 1% some quarters, but others near 15%
Medical Equipment and Supplies	0.2%	Yes, due to low volume	Yes	Some MCOs have denial rates >10% higher than MCO average
Other Professional	0.6%	Some	Yes	Varies from low of 13.9% (Healthy Blue, Q2) to 22.9% (ACLA, Q1)
Behavioral Health Rehab	1.4%	Some	Yes	ACLA under 10% in two quarters, yet Aetna closer to 29% each qtr
Behavioral Health Other	17.2%	Not much except Aetna	Yes	ACLA 10%-12% each quarter, but Aetna significantly higher than others
Dental – Children	2.3%	No	N/A, all MCNA	---
Dental – Adult	0.6%	No	N/A, all MCNA	---
Pharmacy	25.6%	Not much except Healthy Blue	Yes	Aetna lowest (near 20% each qtr) while Healthy Blue highest (above 30% in two quarters)

Exhibit III.4A- Q1
Claim Status for Adjudicated Claims
By Provider Specialty - Institutional Providers
By MCO for Q1 2018 Adjudicated Claims

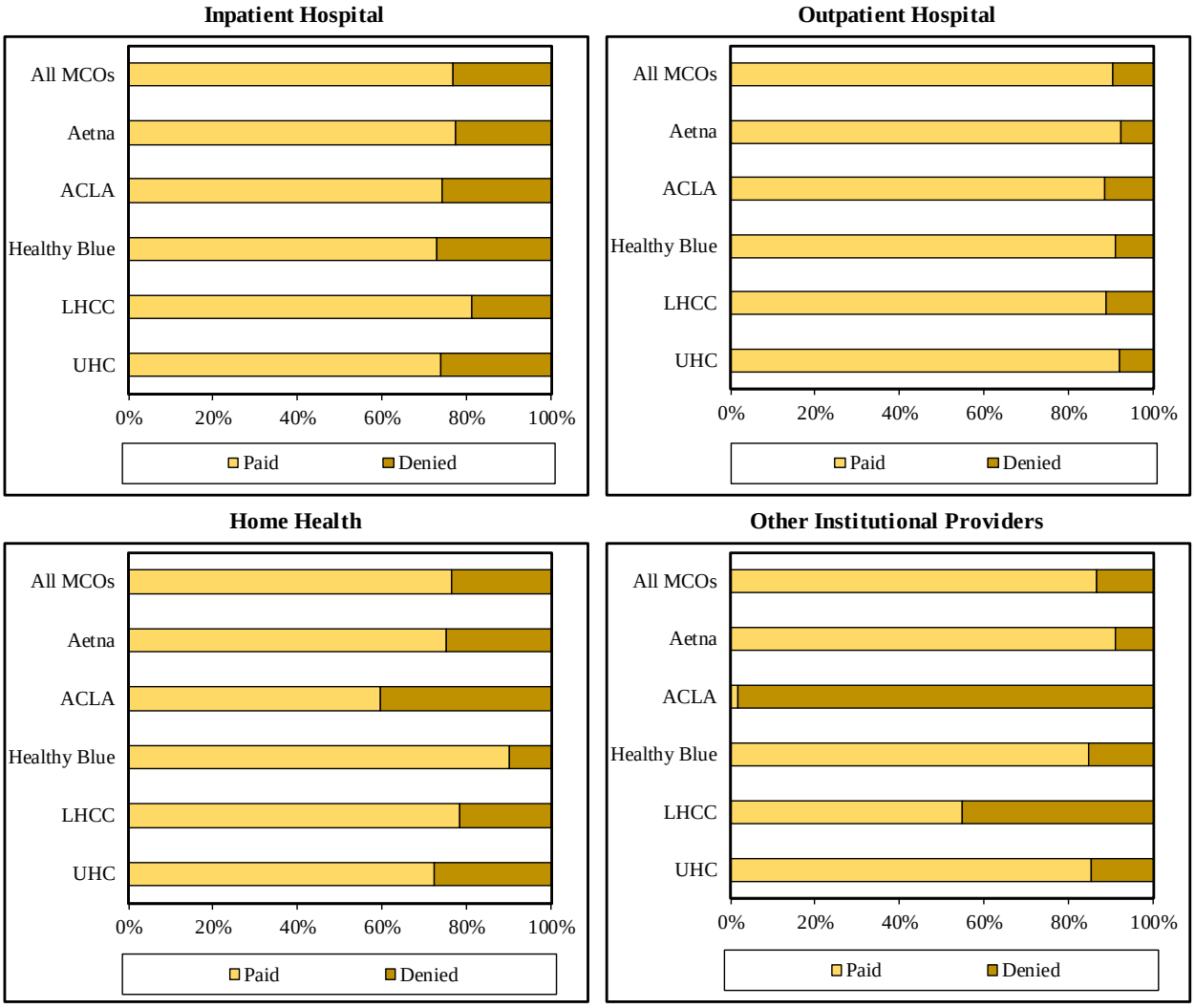


Exhibit III.4A- Q2
Claim Status for Adjudicated Claims
By Provider Specialty - Institutional Providers
By MCO for Q2 2018 Adjudicated Claims

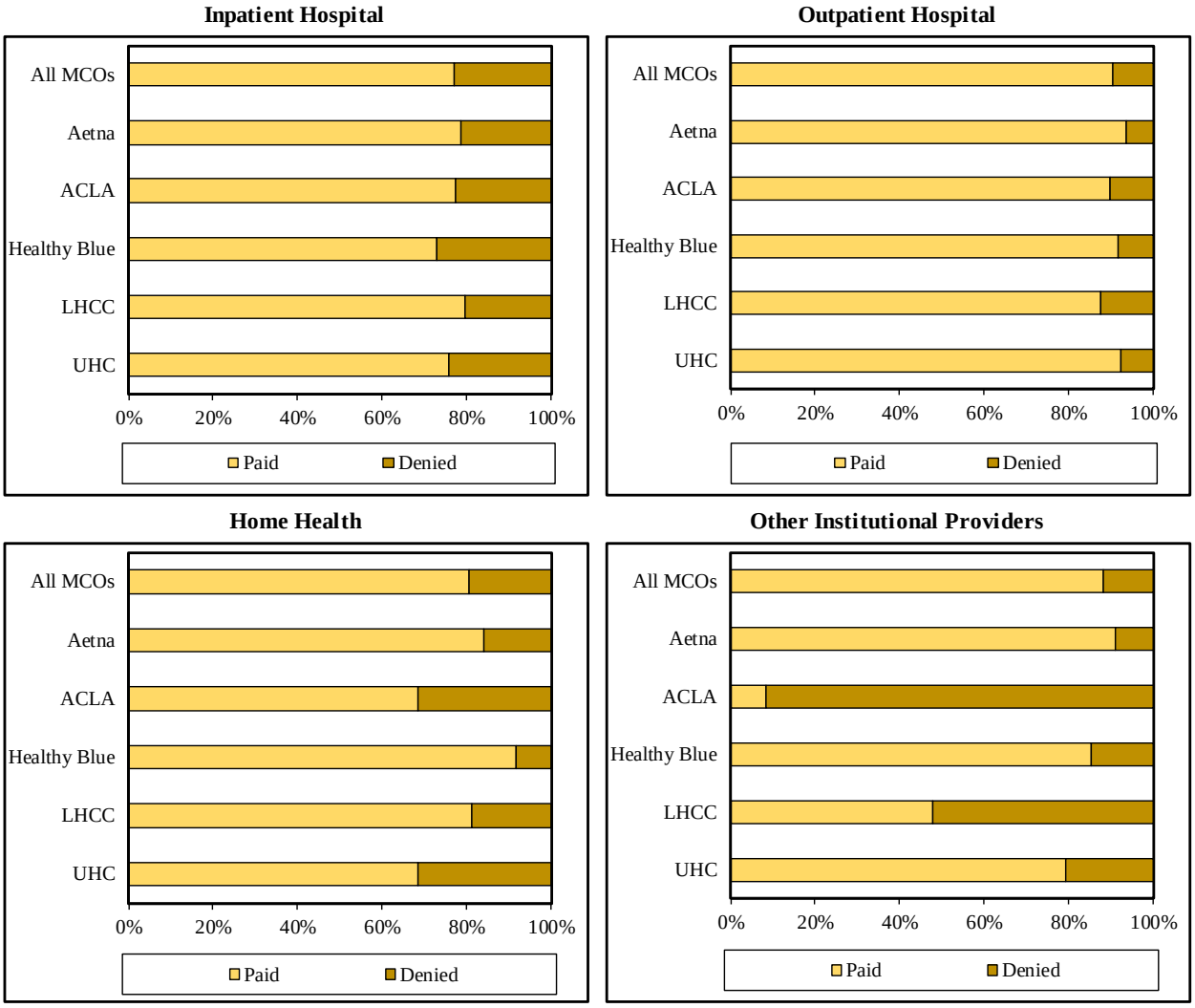


Exhibit III.4A- Q3
Claim Status for Adjudicated Claims
By Provider Specialty - Institutional Providers
By MCO for Q3 2018 Adjudicated Claims

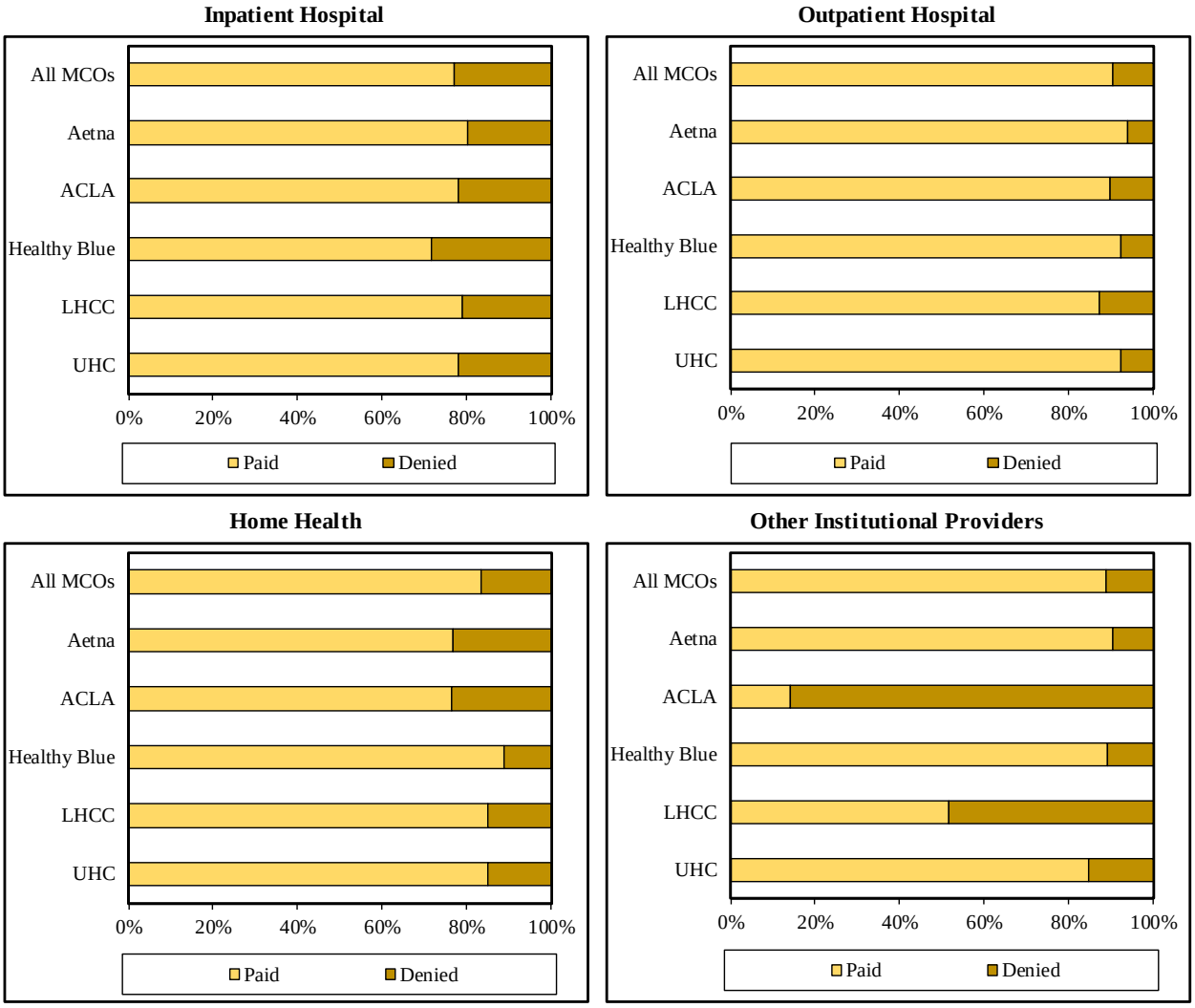
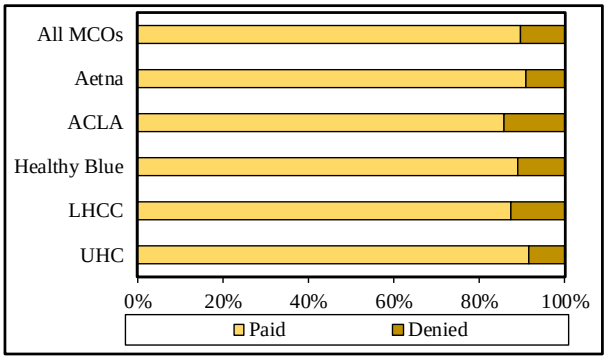
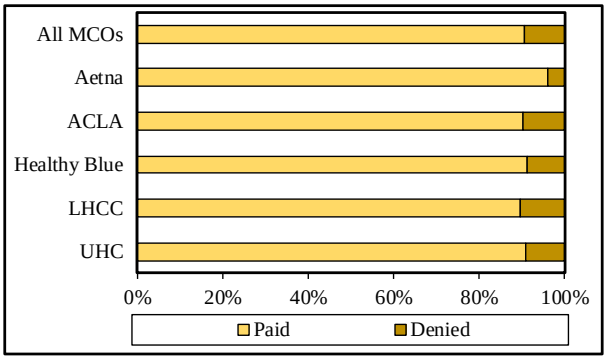


Exhibit III.4B- Q1
Claim Status for Adjudicated Claims
By Provider Specialty - Professional Service Providers
By MCO for Q1 2018 Adjudicated Claims

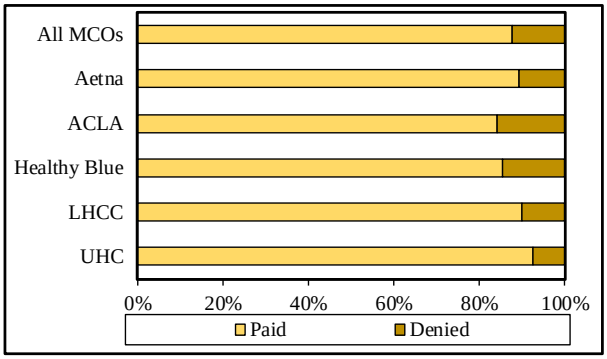
Primary Care



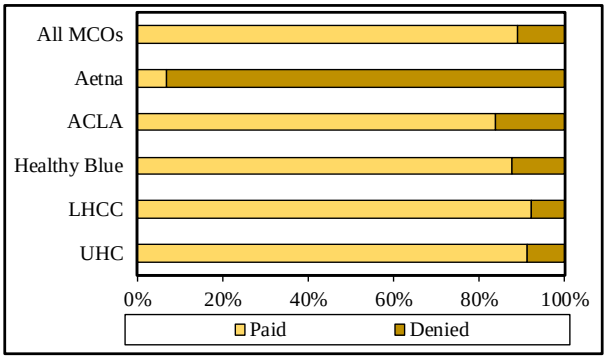
Pediatrics



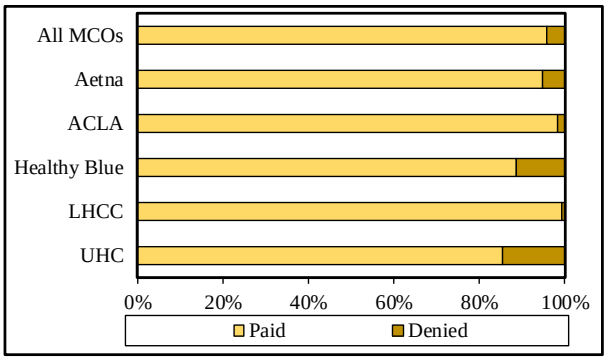
OB-GYN



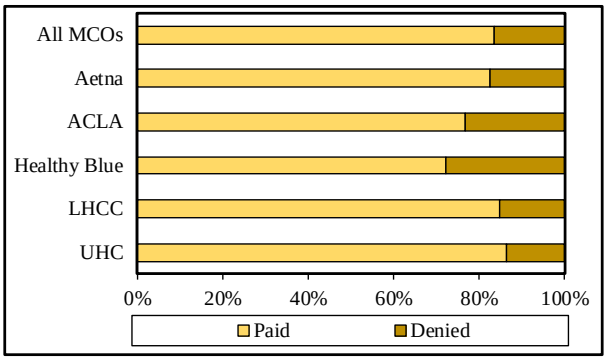
Therapists (Physical, Occupational, Speech)



Non-Emergency Medical Transportation



Medical Equipment & Supplies



All Other Professional Services excluding BH and Dental

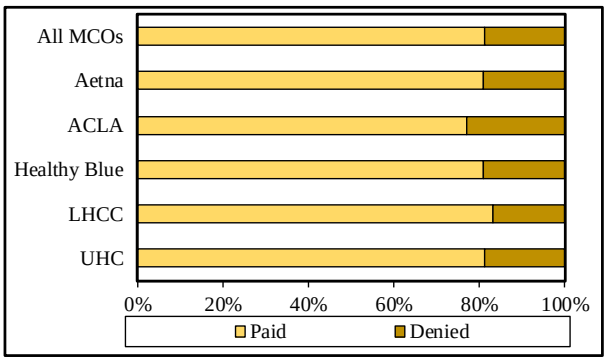
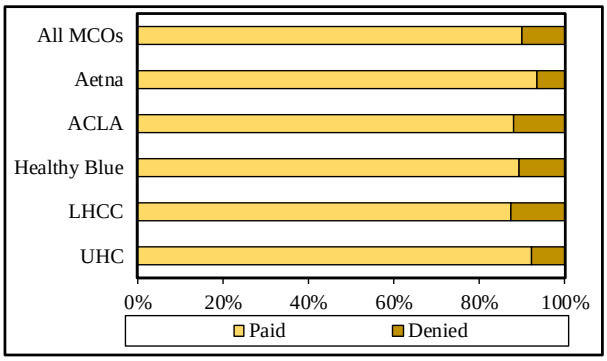
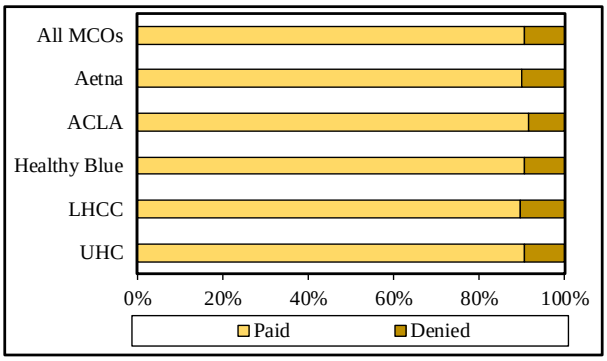


Exhibit III.4B- Q2
Claim Status for Adjudicated Claims
By Provider Specialty - Professional Service Providers
By MCO for Q2 2018 Adjudicated Claims

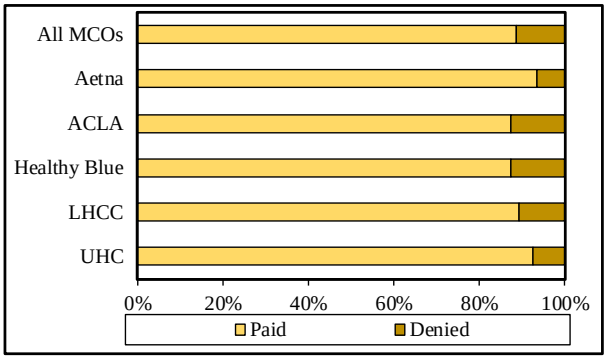
Primary Care



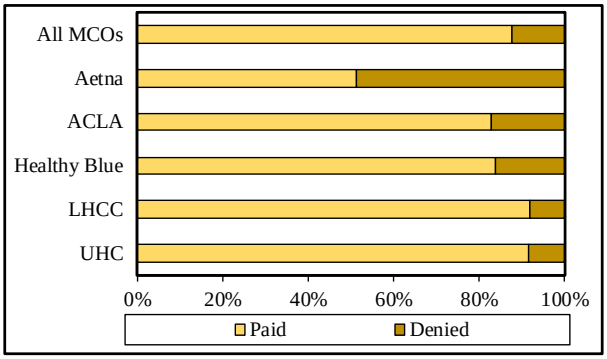
Pediatrics



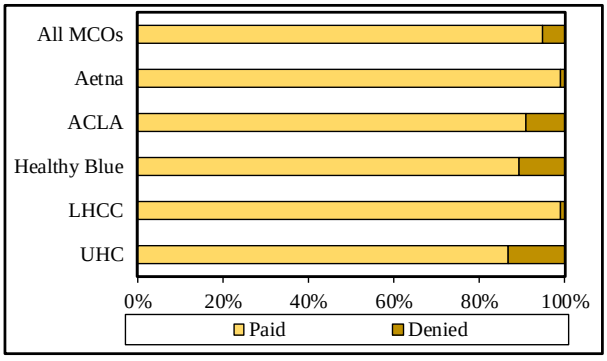
OB-GYN



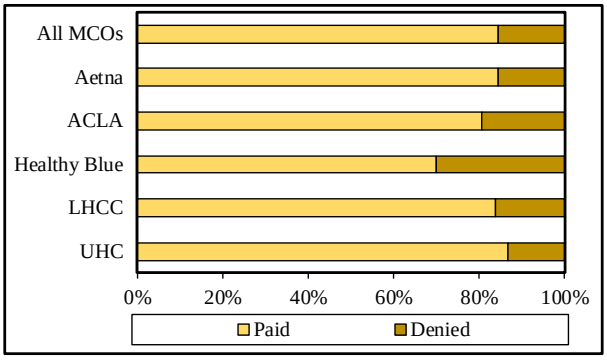
Therapists (Physical, Occupational, Speech)



Non-Emergency Medical Transportation



Medical Equipment & Supplies



All Other Professional Services excluding BH and Dental

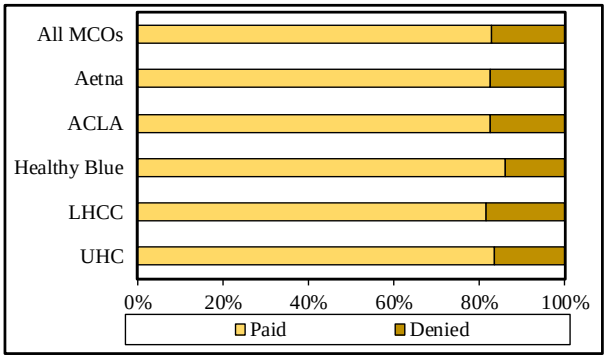
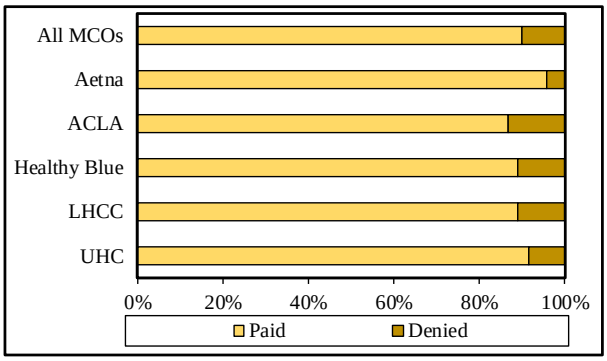
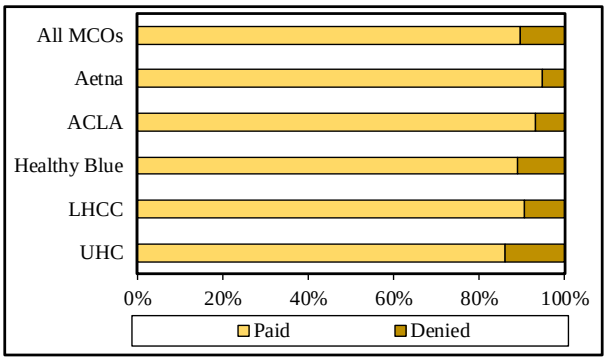


Exhibit III.4B- Q3
Claim Status for Adjudicated Claims
By Provider Specialty - Professional Service Providers
By MCO for Q3 2018 Adjudicated Claims

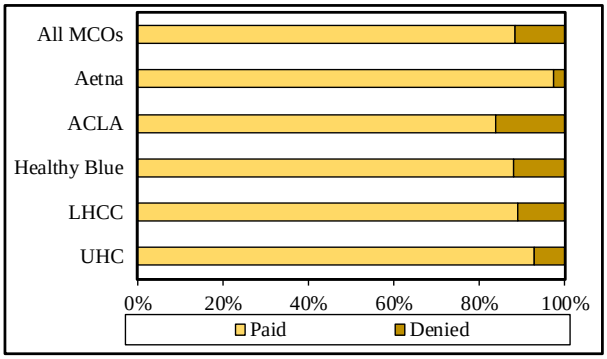
Primary Care



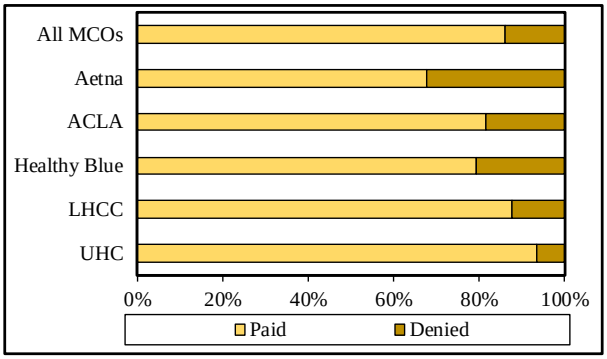
Pediatrics



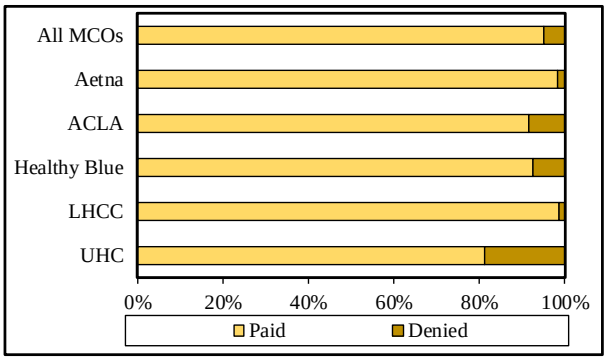
OB-GYN



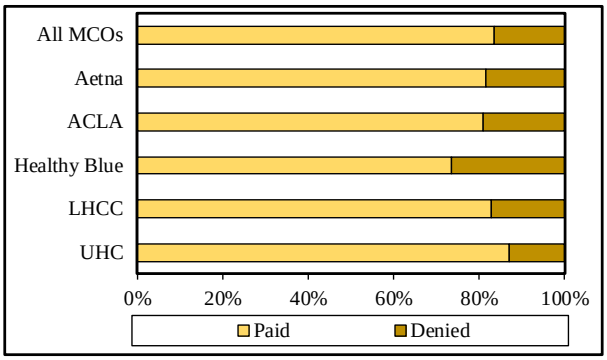
Therapists (Physical, Occupational, Speech)



Non-Emergency Medical Transportation



Medical Equipment & Supplies



All Other Professional Services excluding BH and Dental

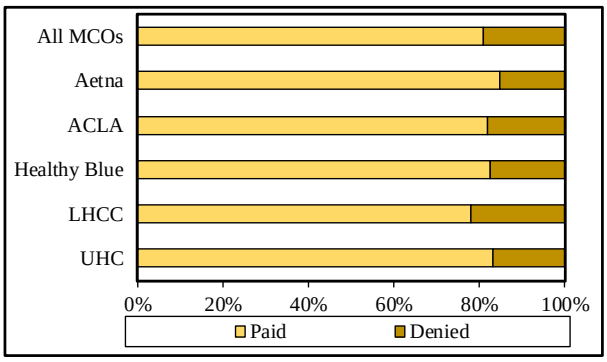


Exhibit III.4C- Q1
Claim Status for Adjudicated Claims
By Provider Specialty - Behavioral Health, Dental and Pharmacy
By MCO for Q1 2018 Adjudicated Claims

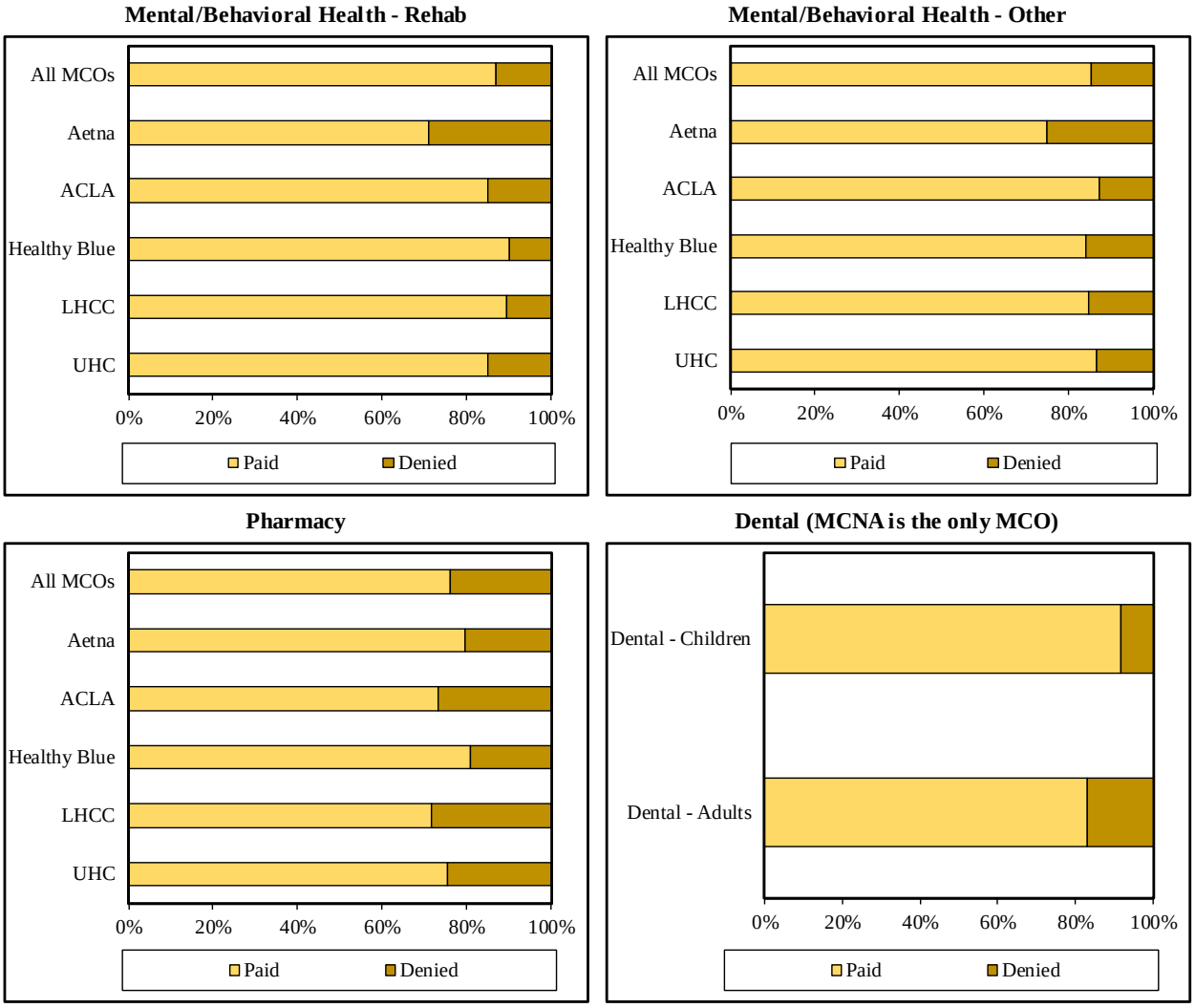
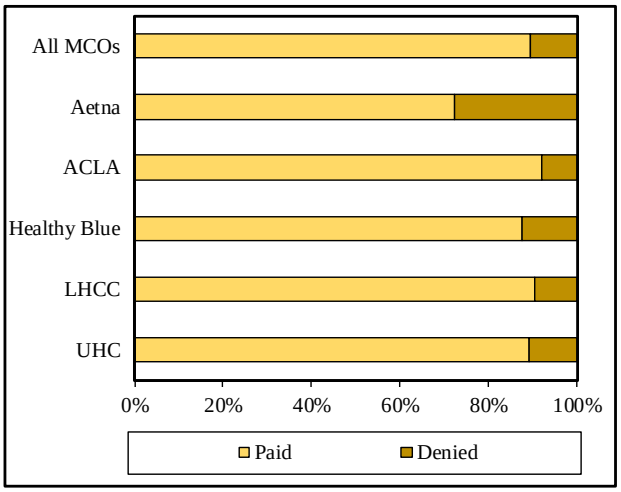
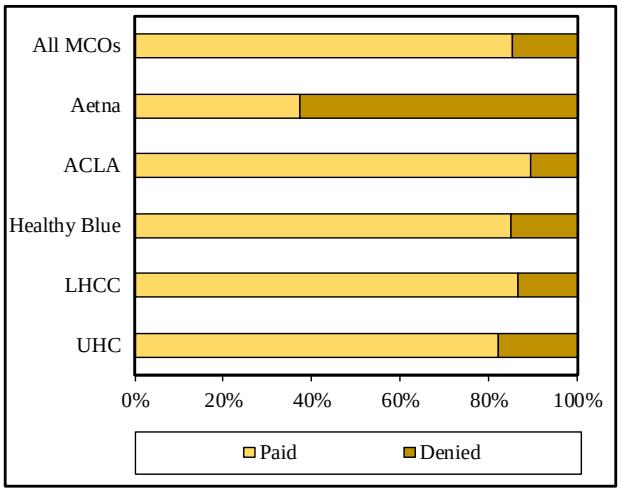


Exhibit III.4C- Q2
Claim Status for Adjudicated Claims
By Provider Specialty - Behavioral Health, Dental and Pharmacy
By MCO for Q2 2018 Adjudicated Claims

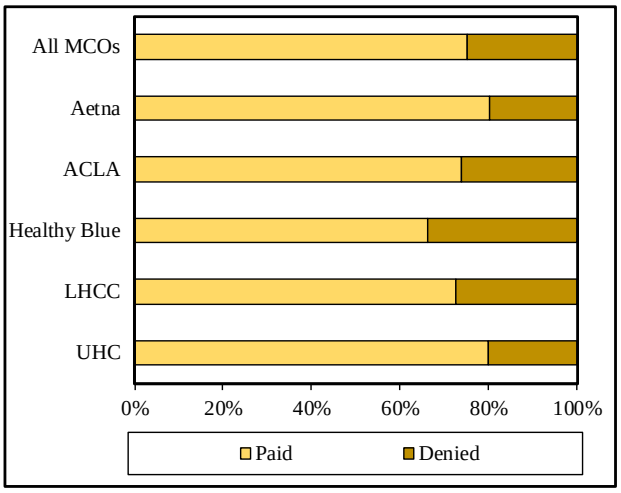
Mental/Behavioral Health - Rehab



Mental/Behavioral Health - Other



Pharmacy



Dental (MCNA is the only MCO)

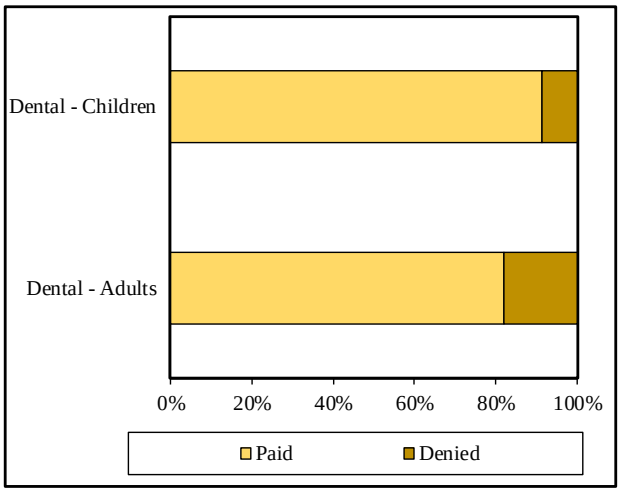
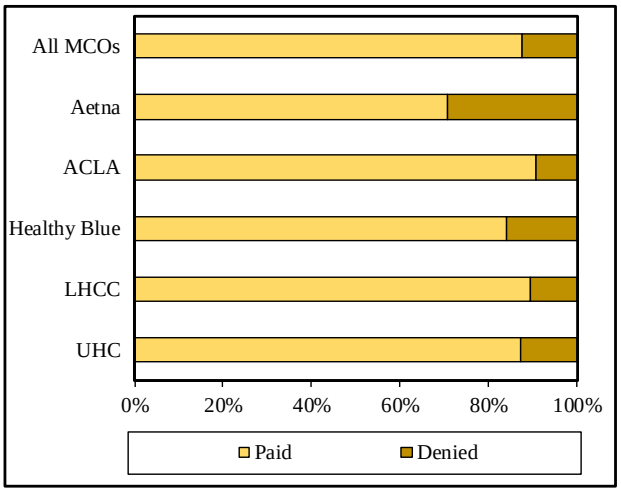
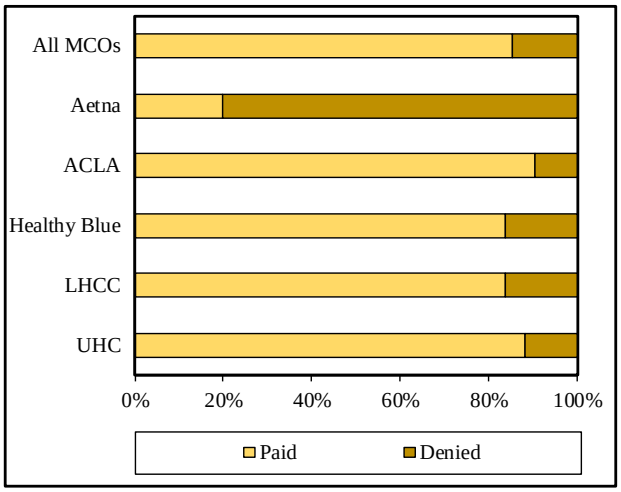


Exhibit III.4C- Q3
Claim Status for Adjudicated Claims
By Provider Specialty - Behavioral Health, Dental and Pharmacy
By MCO for Q3 2018 Adjudicated Claims

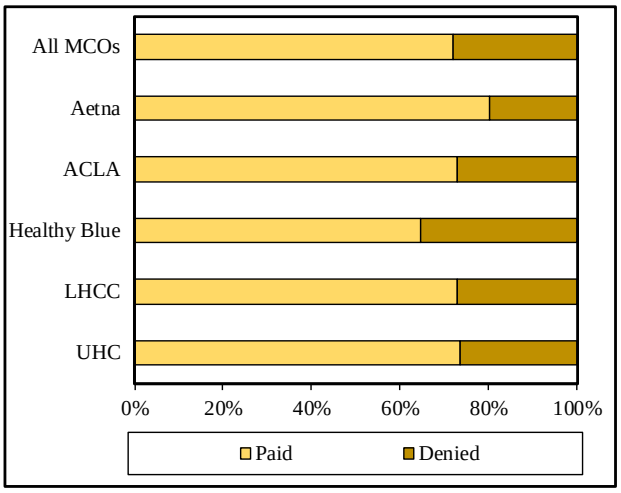
Mental/Behavioral Health - Rehab



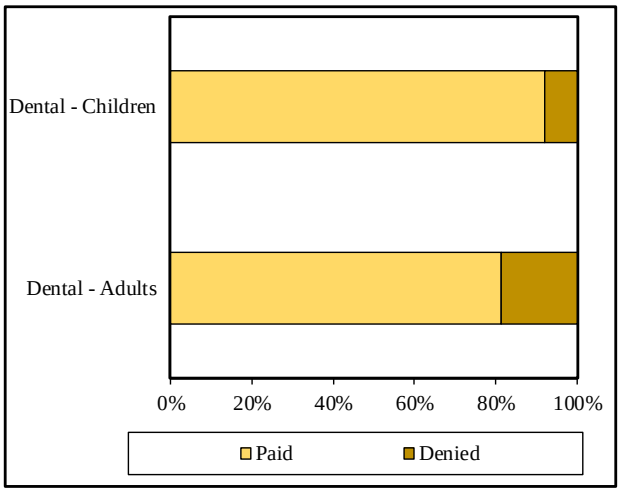
Mental/Behavioral Health - Other



Pharmacy



Dental (MCNA is the only MCO)



The Act requires that LDH provide an assigned value to each of the claims that were denied by the MCOs. As discussed in the Limitations of the Data section on page II-2, there are hundreds of edits that are in place at each MCO to ensure that claims are adjudicated properly. Claims may be denied for a number of reasons, but just to name a few:

- Claim submitted is an exact duplicate of another claim submitted;
- The service billed is not a covered service in the Medicaid program;
- The units billed for a covered service exceeds the number of units allowed (e.g., chiropractic visits, number of eyeglasses each year); and
- The service billed requires an authorization by the MCO before the service is rendered and an authorization was not received for the service.

In some of these situations, the claim that was denied could never have received a payment (e.g., exact duplicate submitted). In other situations, the claim that was denied may have received payment if other business rules were followed (e.g., the authorization that was required was obtained).

Because there is such a variety of denial reasons that are based on the circumstances of each claim, it is not appropriate to unilaterally assume that every denied claim could have been paid or should have been paid. With this in mind, B&A tabulated the information on denied claims from each MCO and attempted to assign a value to each denied claim without inferring if the claim could have been paid or should have been paid.

To do this, B&A examined each of the 16 provider specialties separately. Within each category, the MCO reported the number of claims paid and the total payments made. B&A computed an average payment per claim. Then, the MCOs reported the number of denied claims in the provider specialty. B&A used the average payment per claim in the provider specialty and multiplied this by the number of denied claims to impute a value for the denied claims.

It is important to apply this formula at the provider specialty level (as opposed to all claims combined) due to the wide range of reimbursement paid to each provider type. For example, in Q1 2018, the average payment for paid inpatient hospital claims was $5,108; for primary care, it was $103.

B&A not only computed an average payment per claim for each provider specialty separately, but also for each MCO within the provider type as well as a separate value for each calendar quarter.

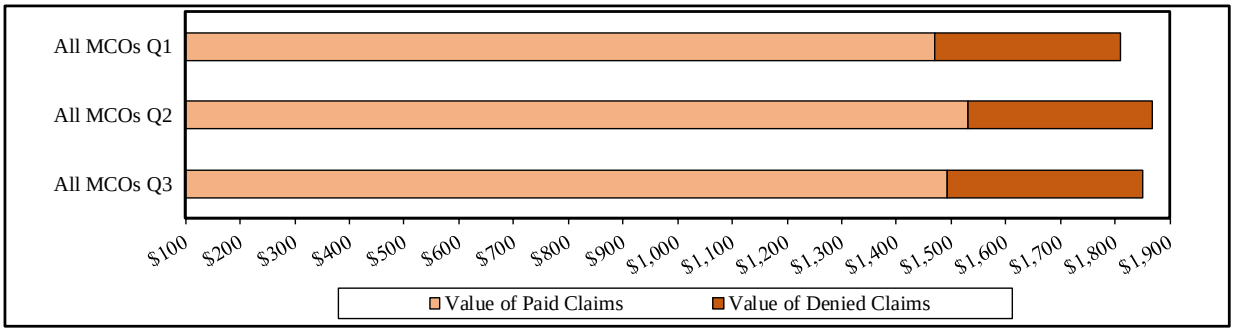
Exhibit III.5 which appears on the next page summarizes the total dollar values of paid claims and denied claims by MCO and by quarter. The detailed information for each provider specialty by MCO and by quarter appears on Appendix D.

The denied claims account for between 18.0% and 19.3% of the sum of paid and denied values each quarter. This equates to between $335 and $337 million. When reviewed by claim type category, of the total denied values assigned,

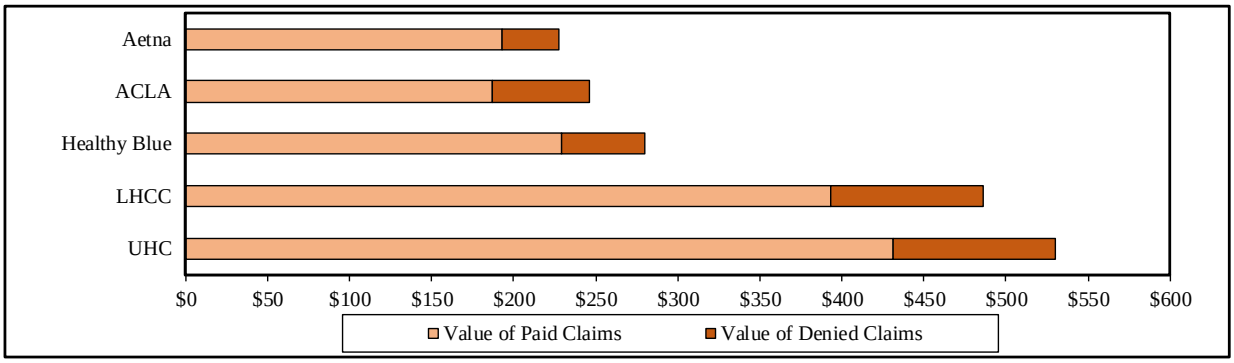
- Institutional claim providers represent from 32% to 36% of the total dollars
- Professional claim providers represent from 25% to 27% of the total dollars
- Pharmacy claim providers represent from 35% to 42% of the total dollars

At the MCO level, Aetna, ACLA and Healthy Blue have a higher proportion of denied claim value among institutional claim providers. UHC has a higher proportion among pharmacy claims. LHCC's denied claim values are the most equally distributed across the three claim types among all of the MCOs.

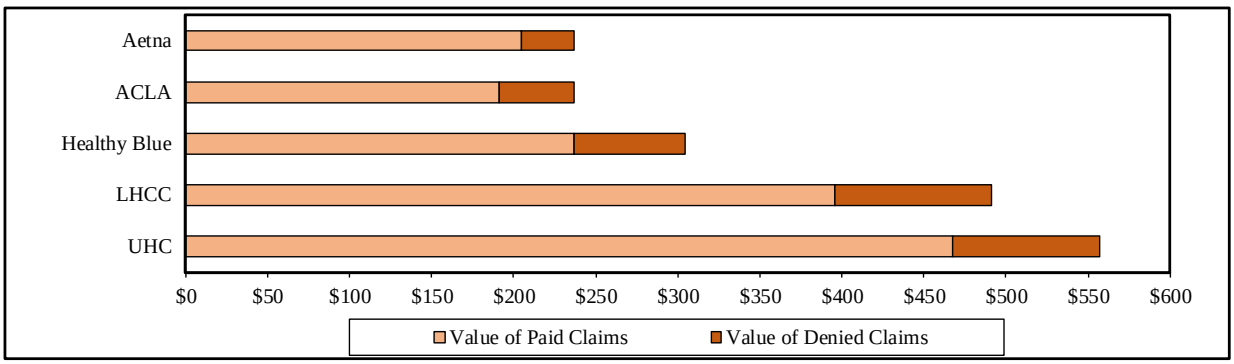
Exhibit III.5
Value of Paid and Denied Claims
By MCO for Q1, Q2 and Q3 2018 Adjudicated Claims
The dollar values in the stacked bar represent hundreds of millions



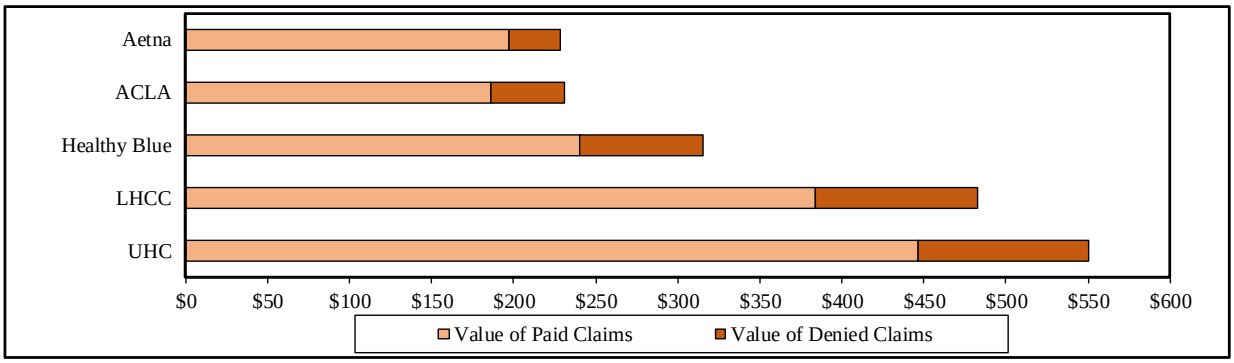
Q1 2018 Adjudicated Claims Only



Q2 2018 Adjudicated Claims Only



Q3 2018 Adjudicated Claims Only



MCNA is the MCO that provides dental coverage only.
Their total expenditures are approx. $37M per quarter. They have been excluded from this exhibit.

LDH required the MCOs to further segment each provider specialty's denied claims based on Medicaid volume. The purpose of this is to inform where provider education on claims billing may be of greatest need. For each of the 16 provider specialties, the MCOs divided the specialty into three sub-groups:

- The providers that billed less than 100 claims to the MCO in the quarter ("low")
- The providers that billed between 101 and 250 claims to the MCO in the quarter ("medium")
- The providers that billed more than 250 claims to the MCO in the quarter ("high")

The data submitted by the MCOs was then examined to determine if, for example, a higher proportion of providers with high Medicaid volume had high denial rates compared to those with low Medicaid volume. High denial rate was defined as any provider that had more than 10% of their claims denied by the MCO in the quarter. Statistics were then run to determine what percentage of providers within each group had a high claims denial rate (that is, more than 10%).

The key findings from this study appear in Exhibit III.6 on the next page. The details behind these findings for each MCO in each quarter appear in Appendix D.

With 14 provider specialties (excluding dental) and three groupings within each specialty (low volume, medium volume, high volume), there can be as many as 42 provider/volume groupings to examine. These are then examined for each of the five MCOs (excluding MCNA), so 42 groupings for five MCOs is 210 groupings. The other two provider specialties are specific to dental and specific to MCNA, so this adds six more groupings. That means a total of 216 groupings were examined for each quarter.

B&A reviewed each of the 216 groupings for whether more than half of the providers within the group had a claims denial rate above 50%. There were many provider/volume combinations where the volume of providers was too small (5 or less) to make an assessment.

Exhibit III.6 shows the instances where the MCO denied more than 10% of the claims for more than half of the providers in the Medicaid volume group. In the exhibit, a Y indicates that at least half of the providers in the provider/volume group had a 10% denial rate or greater. An N indicated that less than half had a 10% denial rate or greater. A – indicates that the sample was too small to study. Within each of the quarters examined, the sample was too small for close to 50 of the provider/volume combinations.

There has been some improvement in Quarters 2 and 3 in the number of combinations where a majority of providers had a denial rate above 10%. This is indicated by the number of N values as shown in the table below. The counts represent all MCOs combined.

	Number of cells with a Y value	Number of cells with a N value	Number of cells with a -- value
Q1 2018	87	80	49
Q2 2018	71	97	48
Q3 2018	74	98	44

Although there was no obvious pattern when reviewing the results in Exhibit III.6, some notable findings were that many of the larger-volume hospitals have a lower denial rate than smaller-volume hospitals (both inpatient and outpatient services). A majority of primary care, pediatrician and OB-GYN providers have a denied claims rate below 10% as indicated by the N values shown on their rows. There are fewer behavioral health providers offering rehab services with a high denial rate than there are providers offering services other than rehab. Also, a majority of dental providers have a denied claims rate below 10%. It is important to note that some providers could be counted in multiple provider categories, particularly hospital, behavioral health and dental.

Exhibit III.6
Examination of Individual Providers Who Billed an MCO that Had More Than 10% of their Claims Denied

Legend

Y means that more than 50% of the providers in this group had 10% or more of their claims denied by the MCO
N means that less than 50% of the providers in this group had 10% or more of their claims denied by the MCO
-- means that the number of providers in the category is too small (5 or less) to make a finding

Provider Category	Group Based on Volume	Aetna			ACLA			HBL			LHCC			UHC			MCNA		
		Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3
Inpatient Hospital	Low	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y			
	Medium	Y	Y	Y	--	--	--	Y	N	N	Y	N	N	Y	N	N			
	High	Y	Y	Y	--	--	--	--	--	--	--	--	--	--	--	--			
Outpatient Hospital	Low	Y	N	N	N	N	N	N	N	N	Y	Y	Y	Y	Y	Y			
	Medium	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y			
	High	Y	N	N	Y	N	N	N	N	N	Y	Y	Y	N	N	N			
Home Health	Low	Y	Y	Y	Y	N	N	N	N	Y	Y	Y	N	Y	Y	N			
	Medium	Y	Y	Y	--	--	--	N	N	N	Y	Y	N	--	--	--			
	High	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--			
Other Institutional Providers	Low	Y	Y	Y	Y	Y	Y	N	N	N	Y	Y	Y	N	N	N			
	Medium	Y	Y	Y	--	--	--	N	N	N	--	--	Y	Y	Y	Y			
	High	Y	Y	Y	--	--	--	N	N	N	--	--	Y	--	--	Y			
Primary Care	Low	Y	N	N	N	N	N	N	N	N	N	N	N	Y	Y	Y			
	Medium	Y	--	--	Y	Y	Y	N	N	N	N	N	N	N	N	N			
	High	--	--	--	--	--	--	N	N	N	N	Y	N	N	N	N			
Pediatrics	Low	Y	Y	Y	N	N	N	N	N	N	N	N	N	Y	Y	Y			
	Medium	--	--	--	Y	Y	Y	N	N	N	N	N	N	N	N	N			
	High	--	--	--	--	--	--	N	N	N	N	N	N	N	N	N			
OB-GYN	Low	--	--	--	N	N	N	Y	N	N	N	N	N	Y	Y	Y			
	Medium	--	--	--	Y	Y	Y	N	N	N	N	N	N	N	N	N			
	High	--	--	--	--	--	--	Y	N	N	N	Y	--	N	N	N			
Therapists	Low	--	--	--	N	N	Y	N	N	Y	N	N	N	N	Y	N			
	Medium	--	--	--	--	--	--	Y	Y	Y	Y	Y	N	N	Y	N			
	High	--	--	--	--	--	--	--	--	--	--	--	--	N	N	N			
Non-Emergency Transportation	Low	N	N	N	N	N	N	N	N	N	N	N	N	N	N	Y			
	Medium	N	N	N	N	N	N	--	Y	N	N	N	N	Y	Y	Y			
	High	N	N	N	--	N	N	--	N	N	N	N	N	--	--	--			
Medical Equipment/ Supplies	Low	Y	Y	Y	Y	Y	Y	Y	Y	N	N	N	N	Y	Y	Y			
	Medium	Y	Y	Y	Y	Y	Y	--	--	--	Y	Y	Y	N	N	N			
	High	Y	--	Y	--	--	--	--	--	--	N	Y	Y	Y	N	N			
All Other Professional Provid.	Low	--	N	N	N	N	N	N	N	N	N	N	N	Y	N	Y			
	Medium	--	N	N	Y	Y	Y	N	N	N	N	N	N	Y	N	Y			
	High	--	N	N	Y	Y	Y	Y	N	N	N	N	Y	N	Y	N			
Behavioral Health Rehab	Low	Y	Y	Y	N	N	N	N	N	N	Y	Y	N	Y	Y	Y			
	Medium	Y	--	--	Y	Y	Y	N	N	N	N	N	N	N	N	N			
	High	N	--	--	--	--	--	N	N	N	N	N	N	N	N	N			
Behavioral Health All Other	Low	--	--	--	N	N	N	N	N	N	N	N	N	Y	N	Y			
	Medium	--	--	--	Y	--	Y	N	N	N	N	N	N	Y	N	Y			
	High	--	--	--	--	--	--	N	N	N	N	Y	Y	N	Y	N			
Dental - Children	Low																N	N	N
	Medium																N	N	N
	High																Y	N	N
Dental - Adults	Low																Y	N	N
	Medium																Y	N	N
	High																--	--	--
Pharmacy	Low	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Y	Y	Y	Y			
	Medium	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y			
	High	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y			

Timeliness of Claims Adjudication by the MCOs

LDH requires that 99% of claims be adjudicated within 30 calendar days. An adjudicated claim could mean a decision to either pay or to deny. The measurement for turnaround time (TAT) for adjudication is the number of days from receipt of the claim by the MCO to the date on which the provider is paid or is notified that no payment will be made.

Exhibit III.7A below shows that the MCOs are meeting the target for adjudication within 30 days as set by LDH. In fact, the average TAT is much lower than the contractual requirement.

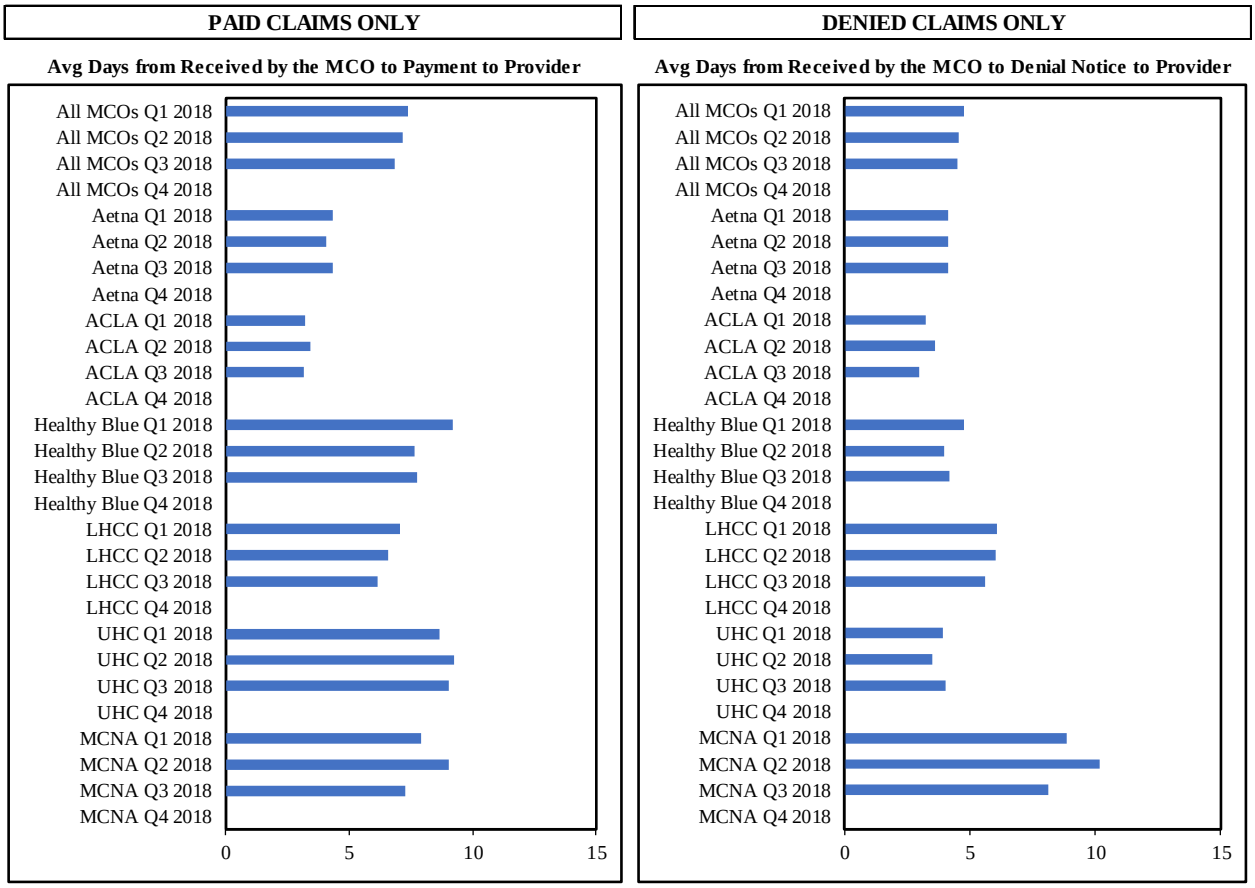
Exhibit III.7A
Turnaround Time for Claims Processing of Adjudicated Claims (using average days)
All Claim Types
By MCO and By Quarter

		Adjudicated Within 30 days		Avg Turnaround Time	
		Pct of Paid	Pct of Denied	Paid Claims	Denied Claims
Aetna	Q1	99.9%	99.9%	4.4	4.1
	Q2	99.9%	99.7%	4.1	4.1
	Q3	99.6%	99.7%	4.4	4.1
ACLA	Q1	100.0%	100.0%	3.2	3.2
	Q2	100.0%	99.9%	3.5	3.6
	Q3	100.0%	99.9%	3.2	3.0
HealthyBlue	Q1	99.8%	97.9%	9.2	4.8
	Q2	99.9%	99.8%	7.6	4.0
	Q3	99.9%	99.7%	7.8	4.2
LHCC	Q1	99.9%	99.5%	7.1	6.1
	Q2	99.6%	98.8%	6.6	6.0
	Q3	99.8%	99.5%	6.2	5.6
UHC	Q1	99.8%	99.4%	8.6	3.9
	Q2	100.0%	99.8%	9.2	3.5
	Q3	99.8%	99.3%	9.0	4.0
MCNA	Q1	99.9%	99.8%	7.9	8.8
	Q2	100.0%	100.0%	9.0	10.2
	Q3	100.0%	100.0%	7.3	8.1

Exhibit III.7B below compares the TAT between paid claims and denied claims for each MCO by quarter. The overall TAT for paid claims, all MCOs combined, is between 6.9 and 7.4 days in each quarter. For denied claims, the average is between 4.5 and 4.7 days.

There is variation between the MCOs on these statistics. The lowest TAT for paid claims was reported by ACLA (near 3.3 day average each quarter). The highest TAT was reported by United (near 9.0 days each quarter), but Healthy Blue and MCNA are similar to these values. The lowest TAT for denied claims is also ACLA (near 3.3 day average each quarter). The highest TAT was reported by MCNA (a range between 8.1 and 10.2 days each quarter).

Exhibit III.7B
Turnaround Time for Claims Processing of Adjudicated Claims (using average days)
All Claim Types
By MCO and By Quarter



The TAT is influenced in large part by the type of service being delivered and the volume for that service. In other words, a service with a low turnaround time (e.g., pharmacy) can influence the MCO's overall average TAT due to the higher volume of pharmacy claims.

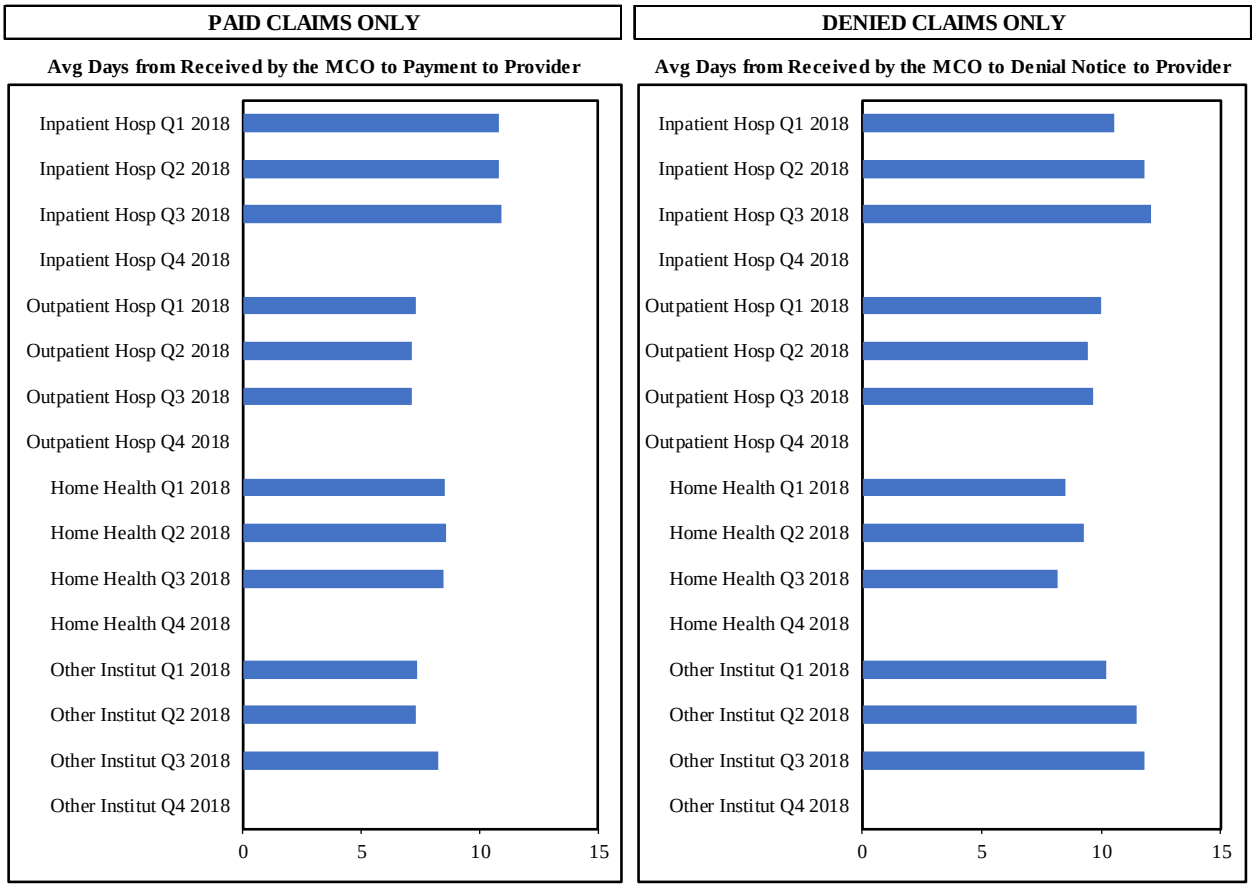
Because of this, the TAT trends were also examined at the provider type level. The same categories shown here are the providers shown earlier in this section measuring the rate of paid and denied claims.

Exhibits III.8A, III.8B and III.8C on the following pages break out the TAT by provider type and by the first three quarters in CY 2018. Exhibit III.8A shows the providers that bill on the institutional, or 837I,

claim type. Exhibit III.8B shows the providers that bill on the professional, or 837P, claim type. Exhibit III.8C shows specialized providers such as behavioral health, dental and pharmacy.

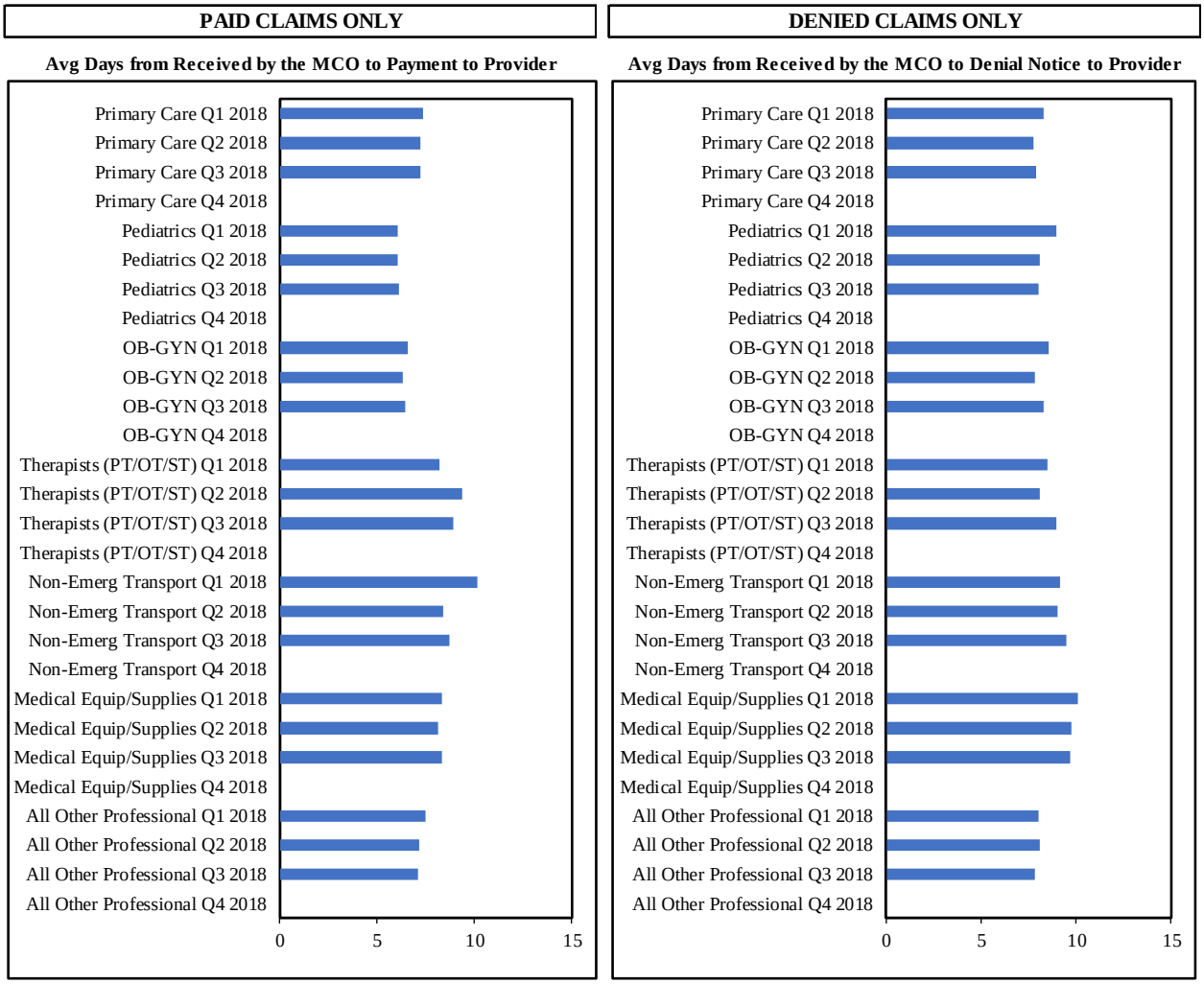
In Exhibit III.8A below, it was found that the TAT is highest for inpatient hospital services than other institutional provider services. For inpatient, the average TAT is near 11.0 days each quarter for both paid and denied claims. For outpatient services, the average TAT is closer to 7.2 days for paid claims and 9.7 days for denied claims. The volume is much lower for home health services where the average TAT is close to 8.5 days for both paid and denied claims. For other institutional providers, the average TAT is near 7.6 days for paid claims and 11.2 days for denied claims.

Exhibit III.8A
Turnaround Time for Claims Processing of Adjudicated Claims (using average days)
Institutional Providers
By All MCOs Combined By Quarter



Among the seven professional service provider type categories examined, the average TAT did not change significantly across the first three quarters of CY 2018. Further, the average TAT does not vary significantly across the provider types. The lowest average TAT for paid claims was for pediatrics (average 6.1 days across the quarters) and the highest was for non-emergency transportation (average 9.1 days across the quarters). The average TAT is similar for denied claims within a provider type to what was found for paid claims, or it may be slightly higher (e.g., pediatrics and OB-GYN).

Exhibit III.8B
Turnaround Time for Claims Processing of Adjudicated Claims (using average days)
Professional Service Providers
By All MCOs Combined By Quarter

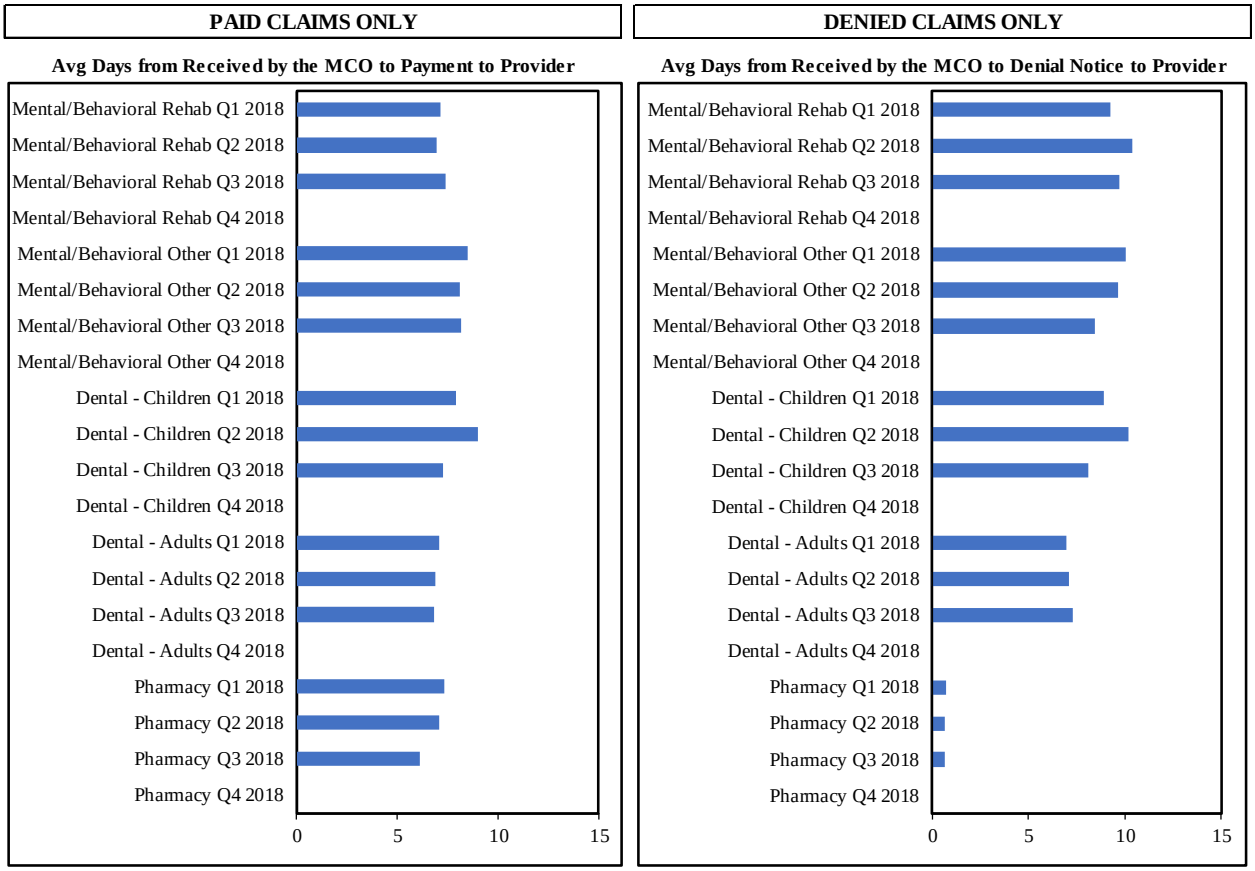


The average TAT for behavioral health and dental services follow similar patterns to what was found for professional services. The average TAT for paid claims for mental health rehab services was near 7.1 days each quarter. For non-rehab services, the average TAT was near 8.3 days each quarter. For both of these services, the average TAT for denied claims is one to two days greater than the average TAT for paid claims.

The findings for dental services are similar for children and adults because MCNA is adjudicating both sets of these service claims. The average TAT is seven to nine days for both paid claims and denied claims.

The average TAT for paid pharmacy claims was a high of 7.4 days in Q1 2018 down to a low of 6.1 days in Q3 2018. The average TAT for denied pharmacy claims is less than one day.

Exhibit III.8C
Turnaround Time for Claims Processing of Adjudicated Claims (using average days)
Behavioral Health, Dental and Pharmacy
By All MCOs Combined By Quarter



The exhibits on the next 12 pages further break down the paid and denied average TATs, but in these exhibits the breakdown is for each provider type by each of the MCOs. The purpose of these exhibits is to determine if the TAT is consistent across MCOs or if it varies. For this quarterly report update only, there are 12 exhibits instead of four because three different quarters are being reported simultaneously in this report.

Exhibits III.9A Q1 through Q3 correlate with the information shown in Exhibit III.8A (institutional providers). Because of the number of provider types, Exhibits III.9B Q1 through Q3 and III.9C Q1 though Q3 correlate with the information shown in Exhibit III.8B (professional providers). Exhibits III.9D Q1 through Q3 correlate with the information shown in Exhibit III.8C (behavioral health, dental, pharmacy).

The key findings from all 12 exhibits appearing on pages III-26 through III-37 are summarized here for convenience:

Provider Category	**Lowest Value, TAT Paid Claims, Any Qtr**	**MCO with Lowest TAT, Paid**	**Highest Value, TAT Paid Claims, Any Qtr**	**MCO with Highest TAT, Paid**	**Highest Value, TAT Denied, Any Qtr**	**MCO with Highest TAT, Denied**
Inpatient Hospital	6.7	ACLA	23.0	Aetna	16.4	UHC
Outpatient Hospital	3.7	ACLA	9.2	LHCC	14.3	HealthyBlue
Home Health	4.1	ACLA	10.1	LHCC	11.4	LHCC
Other Institutional	4.7	ACLA	9.9	LHCC	15.6	UHC
Primary Care	3.2	ACLA	8.6	LHCC	10.0	HealthyBlue
Pediatrics	3.2	ACLA	8.5	LHCC	11.9	LHCC
OB-GYN	3.7	ACLA	8.6	LHCC	11.3	UHC
Therapists	5.2	ACLA	14.5	LHCC	14.7	Aetna
Non-emergency Transportation	1.0	Aetna	11.5	LHCC	12.5	LHCC
Medical Equipment and Supplies	4.0	ACLA	10.6	LHCC	15.9	LHCC
Other Professional	3.9	ACLA	8.9	LHCC	9.5	LHCC
Behavioral Health Rehab	4.4	ACLA	9.8	UHC	11.6	UHC
Behavioral Health Other	3.5	ACLA	13.1	UHC	18.0	Aetna
Dental – Children	7.3	MCNA	9.0	MCNA	10.2	MCNA
Dental – Adult	7.7	MCNA	10.3	MCNA	9.8	MCNA
Pharmacy	Less than 1 day	ACLA, Aetna	13.8	HealthyBlue	All MCOs are 1 day or less	

Exhibit III.9A- Q1
Turnaround Time for Claims Processing of Adjudicated Claims (using average days)
By Provider Specialty - Institutional Providers
By MCO for Q1 2018 Adjudicated Claims

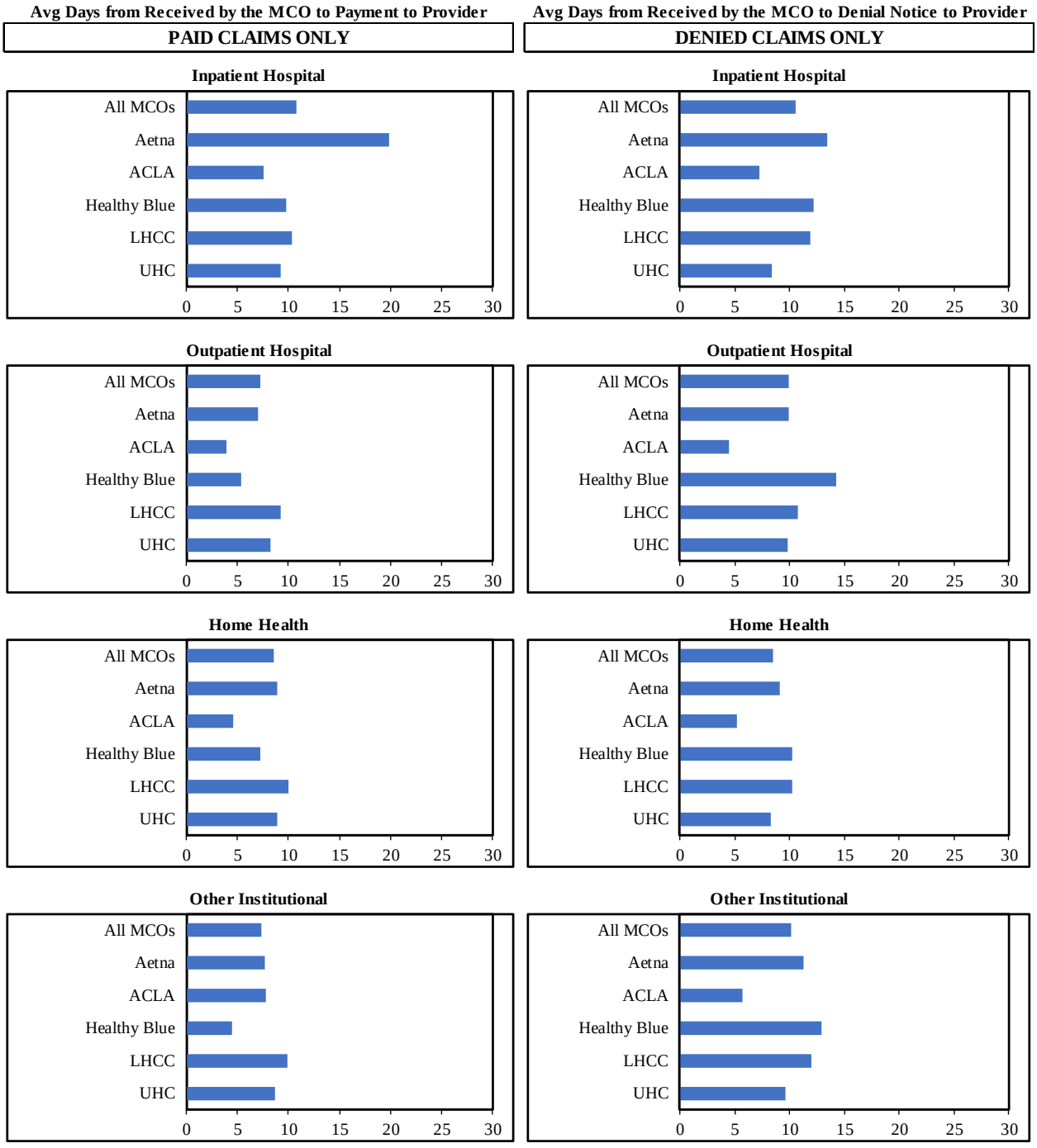
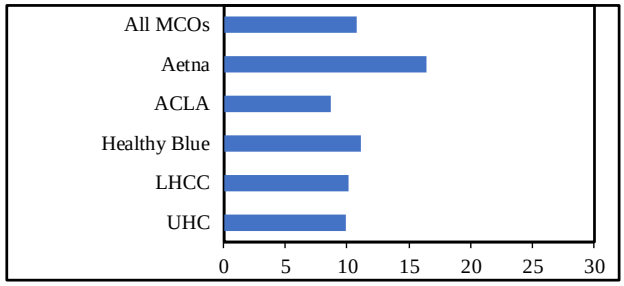
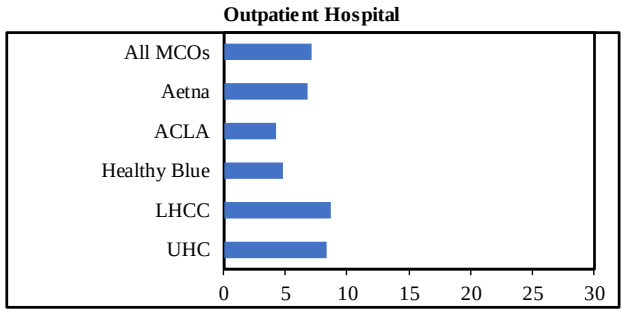
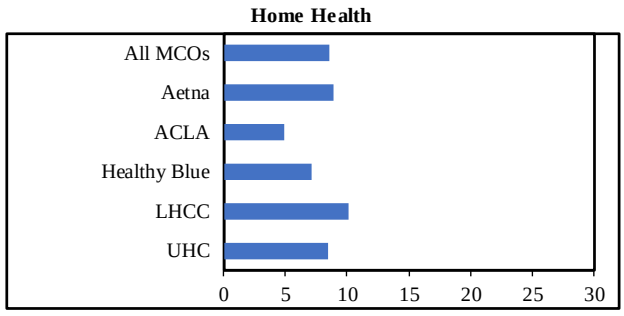


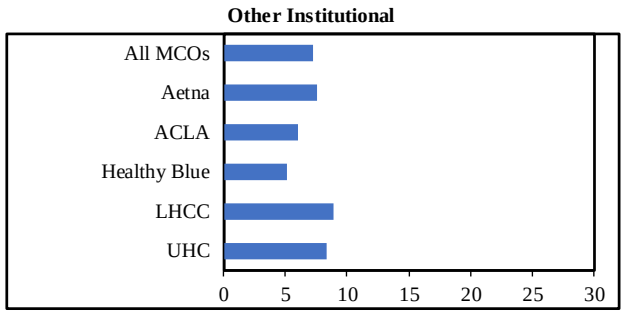
Exhibit III.9A- Q2
Turnaround Time for Claims Processing of Adjudicated Claims (using average days)
By Provider Specialty - Institutional Providers
By MCO for Q2 2018 Adjudicated Claims

Avg Days from Received by the MCO to Payment to Provider
PAID CLAIMS ONLY

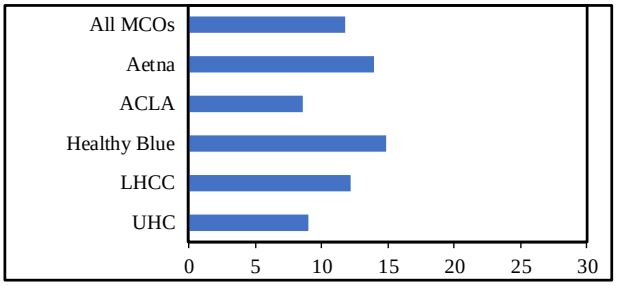


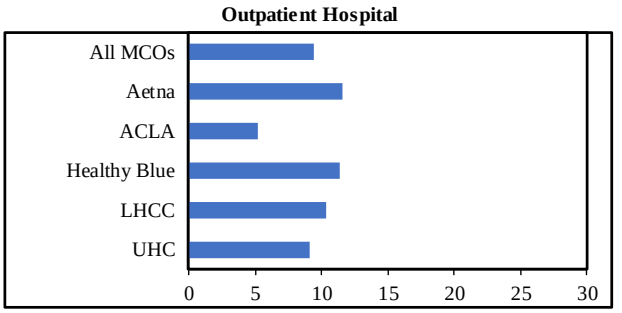


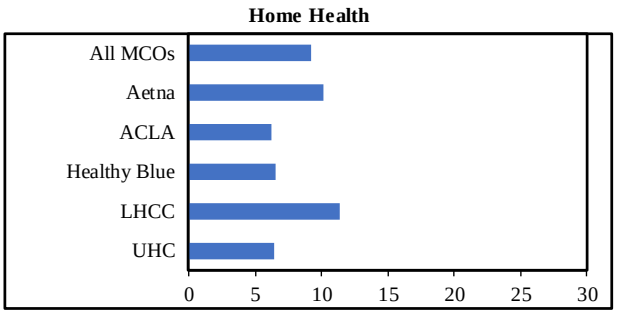




Avg Days from Received by the MCO to Denial Notice to Provider
DENIED CLAIMS ONLY







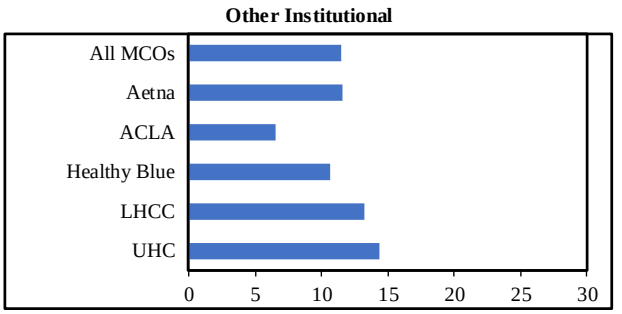
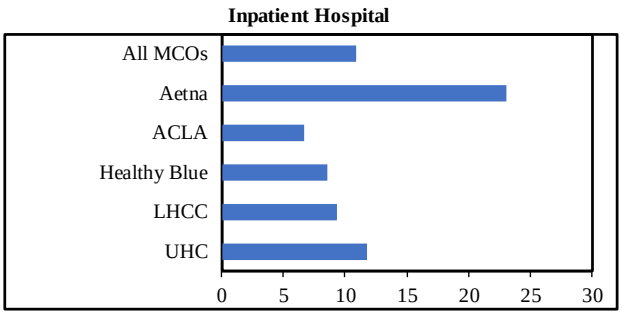
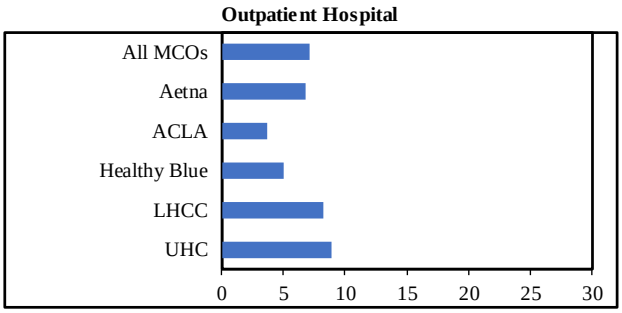
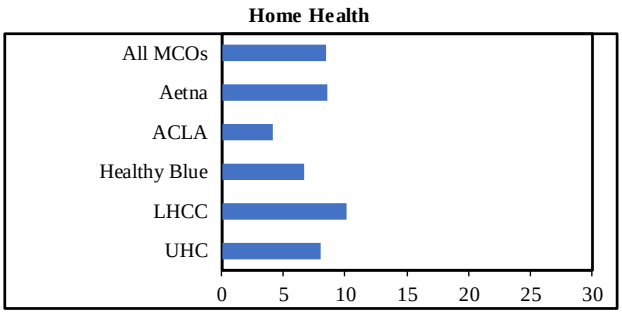


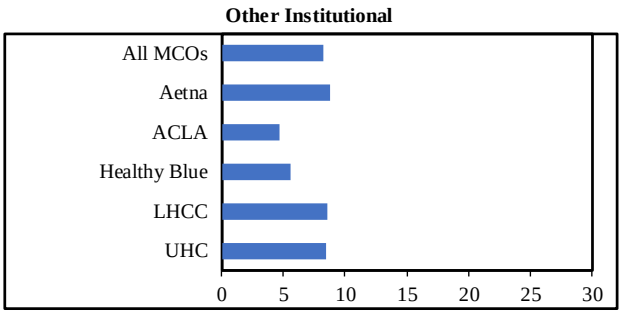
Exhibit III.9A- Q3
Turnaround Time for Claims Processing of Adjudicated Claims (using average days)
By Provider Specialty - Institutional Providers
By MCO for Q3 2018 Adjudicated Claims

Avg Days from Received by the MCO to Payment to Provider
PAID CLAIMS ONLY

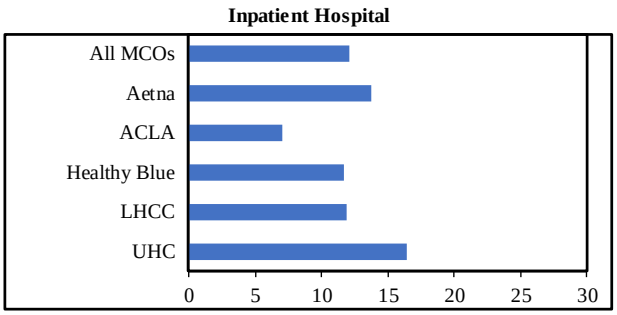


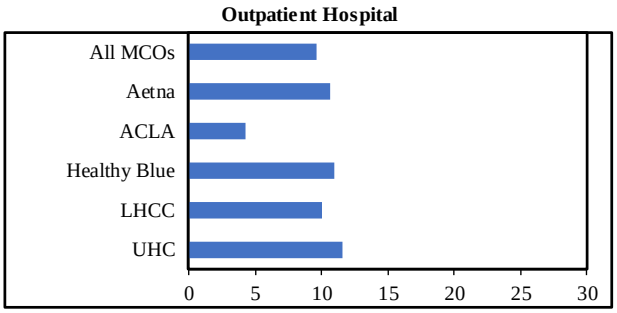


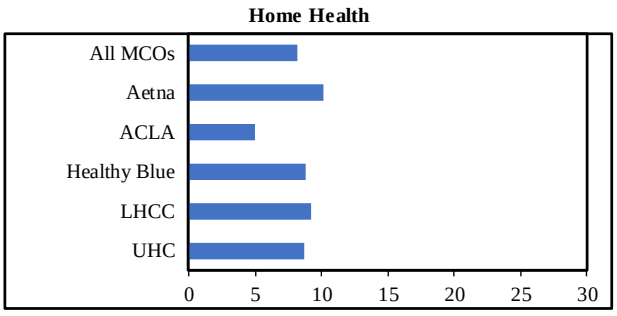




Avg Days from Received by the MCO to Denial Notice to Provider
DENIED CLAIMS ONLY







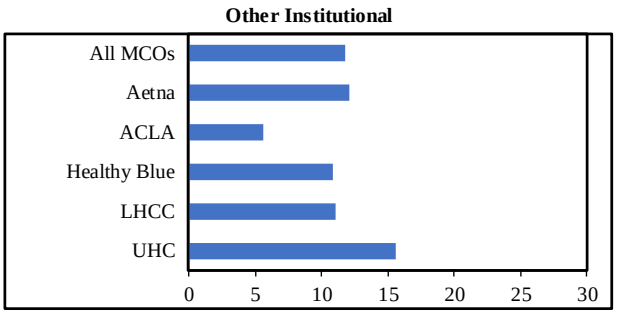


Exhibit III.9B- Q1
Turnaround Time for Claims Processing of Adjudicated Claims (using average days)
By Provider Specialty - Professional Providers, Part 1
By MCO for Q1 2018 Adjudicated Claims

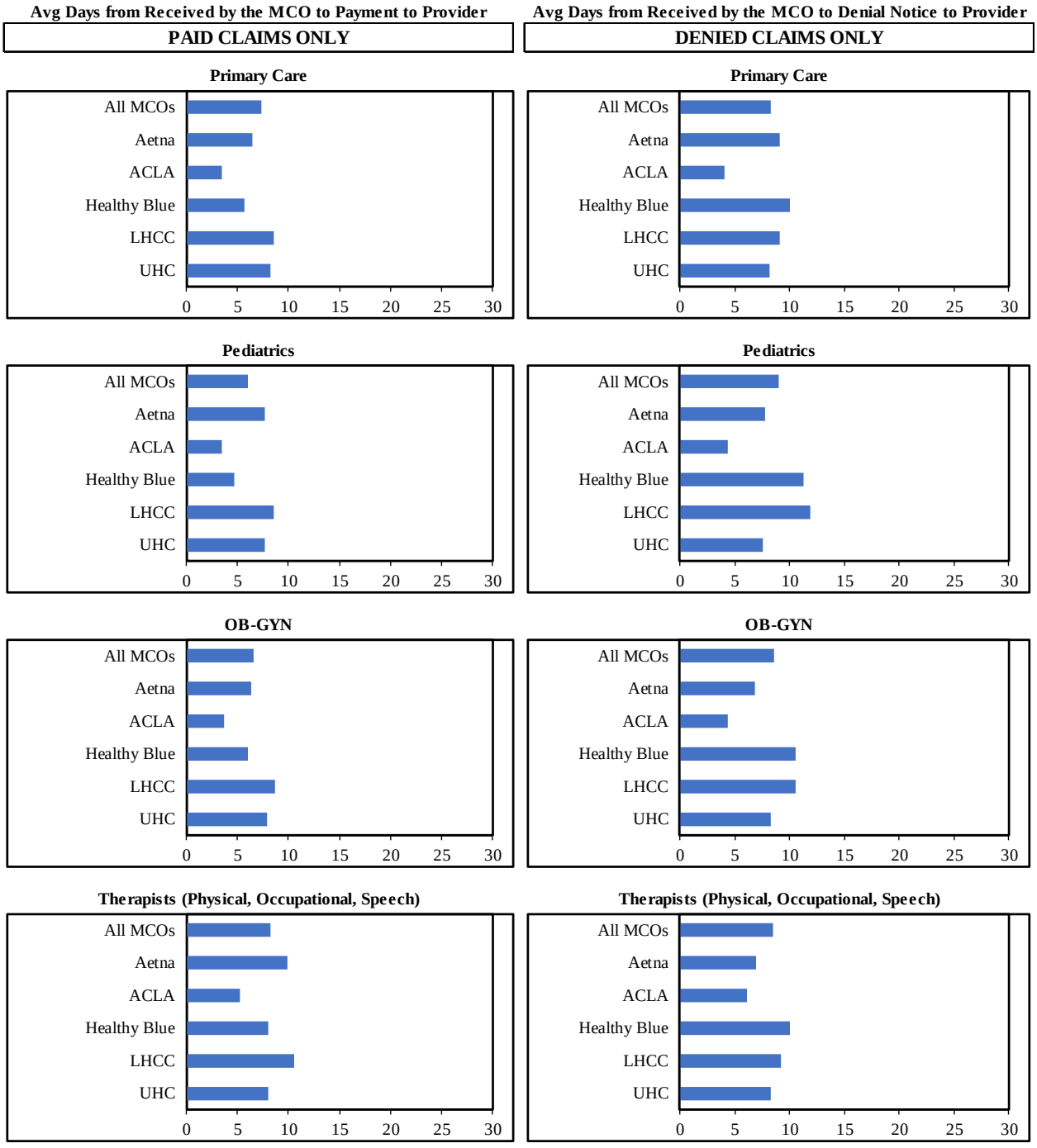


Exhibit III.9B- Q2
Turnaround Time for Claims Processing of Adjudicated Claims (using average days)
By Provider Specialty - Professional Providers, Part 1
By MCO for Q2 2018 Adjudicated Claims

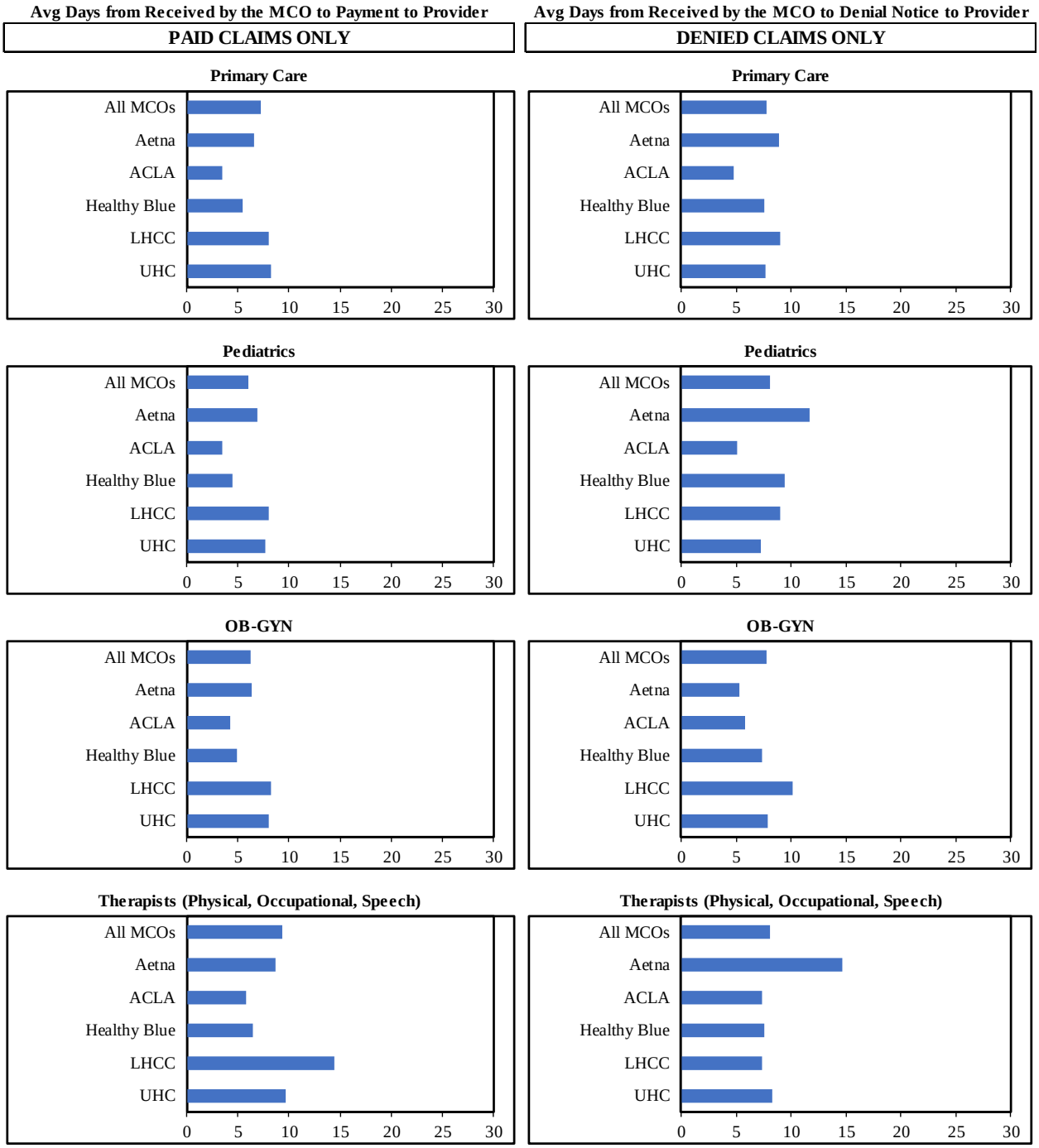
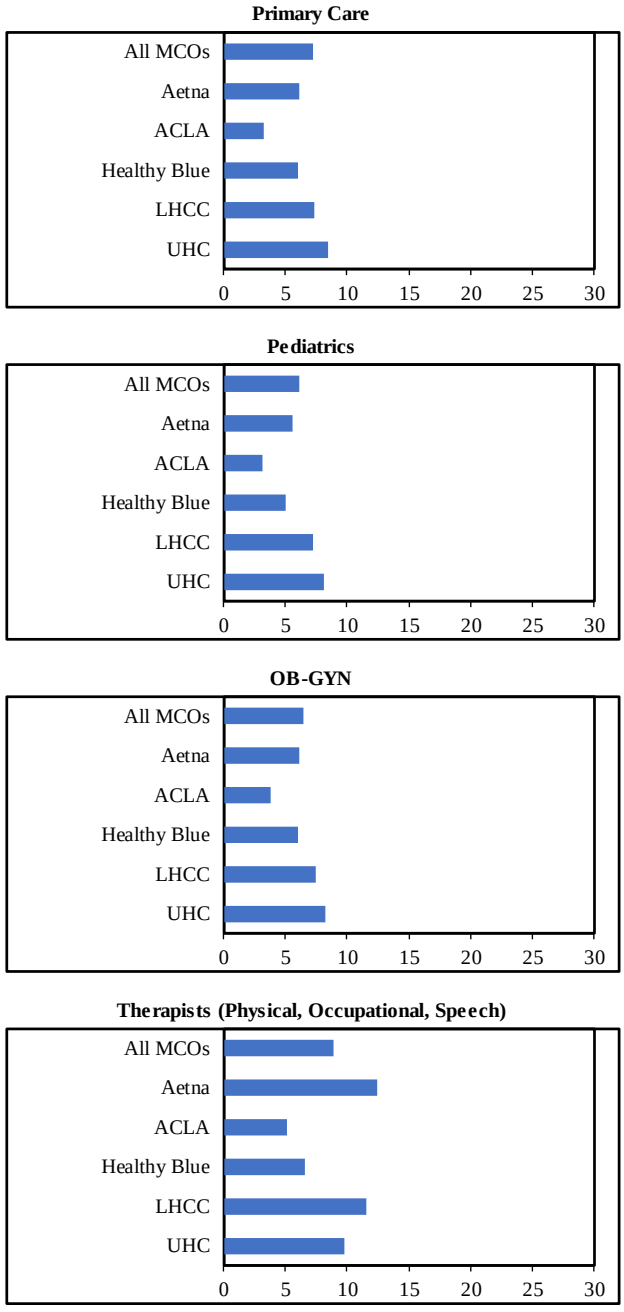


Exhibit III.9B- Q3
Turnaround Time for Claims Processing of Adjudicated Claims (using average days)
By Provider Specialty - Professional Providers, Part 1
By MCO for Q3 2018 Adjudicated Claims

Avg Days from Received by the MCO to Payment to Provider
PAID CLAIMS ONLY



Avg Days from Received by the MCO to Denial Notice to Provider
DENIED CLAIMS ONLY

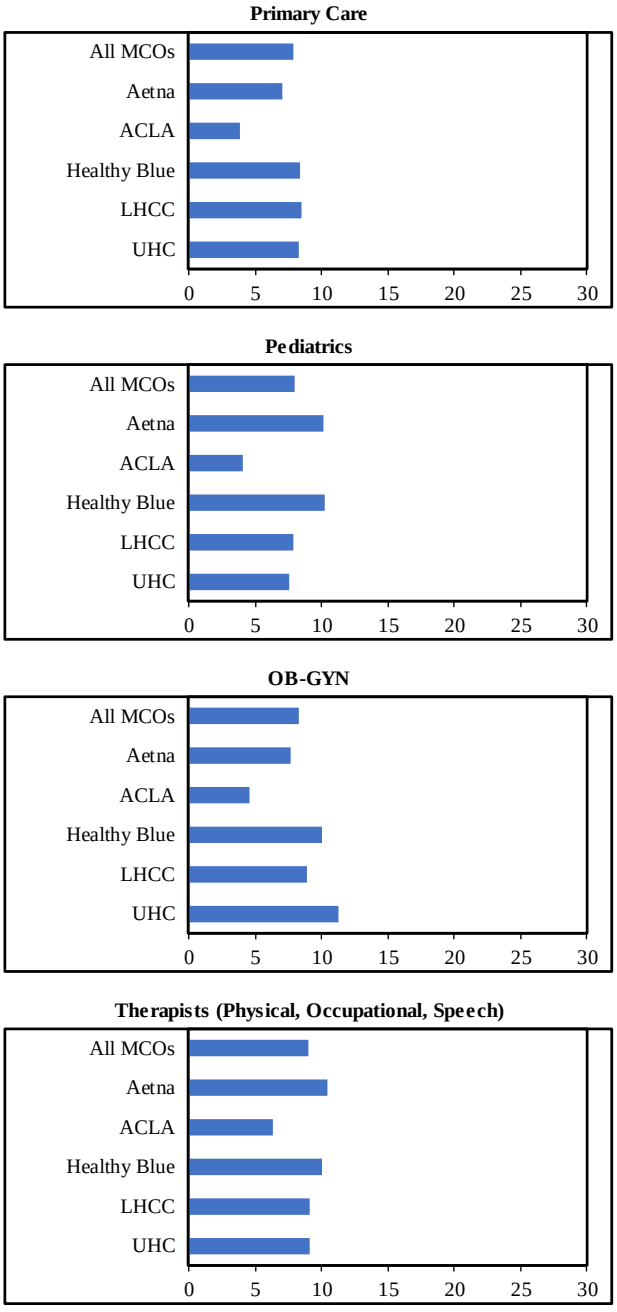


Exhibit III.9C- Q1
Turnaround Time for Claims Processing of Adjudicated Claims (using average days)
By Provider Specialty - Professional Providers, Part 2
By MCO for Q1 2018 Adjudicated Claims

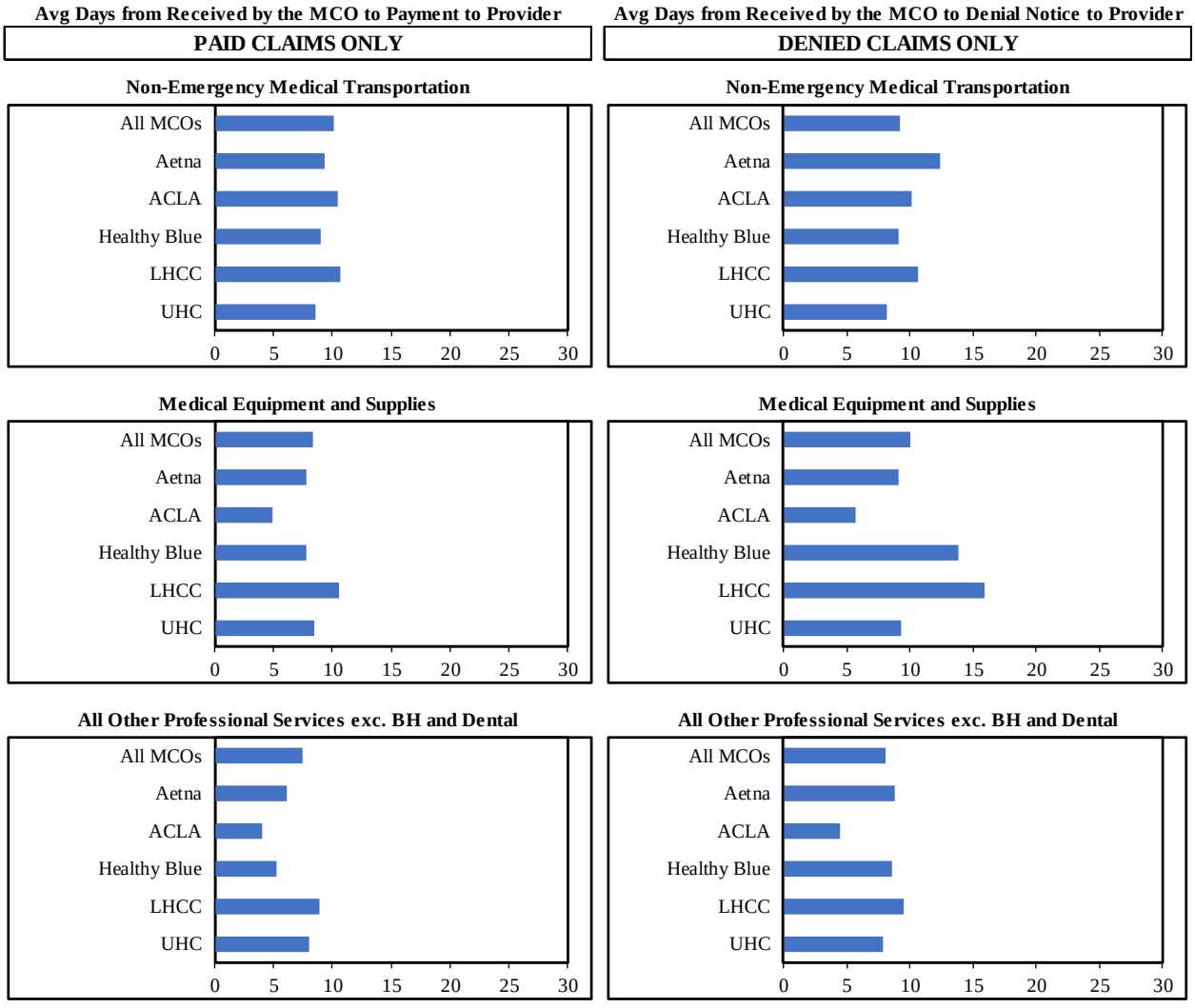


Exhibit III.9C- Q2
Turnaround Time for Claims Processing of Adjudicated Claims (using average days)
By Provider Specialty - Professional Providers, Part 2
By MCO for Q2 2018 Adjudicated Claims

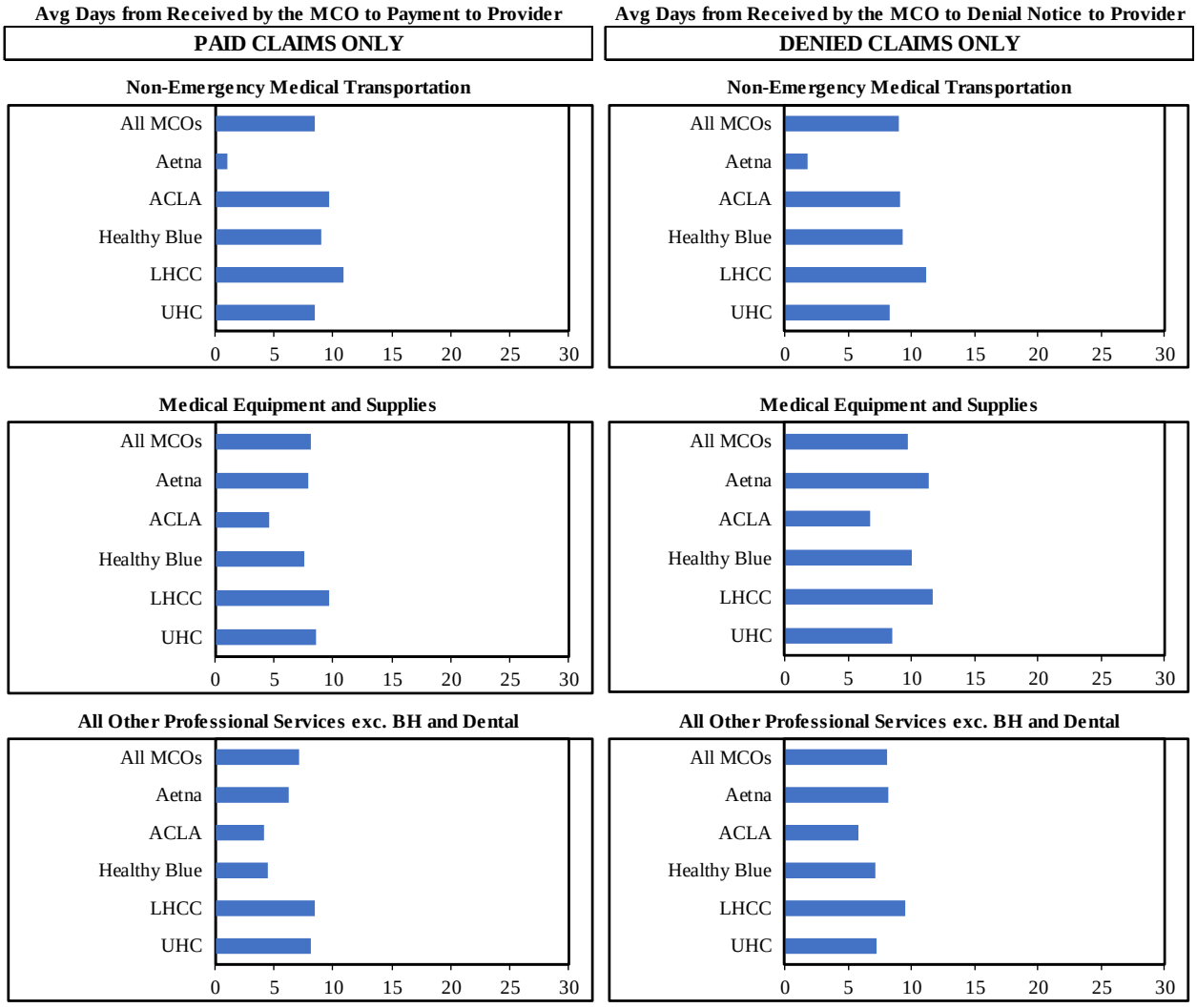
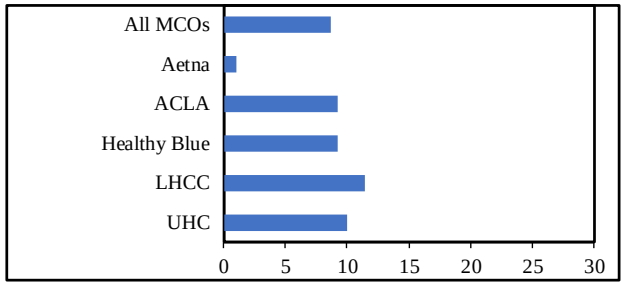
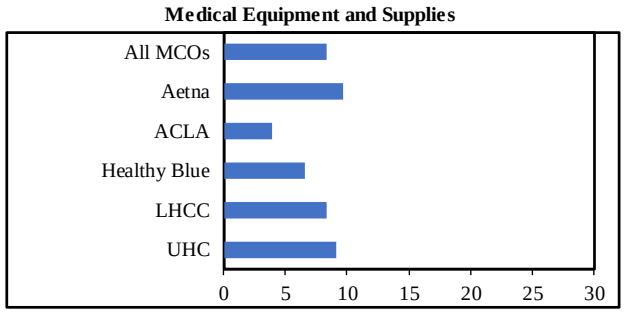
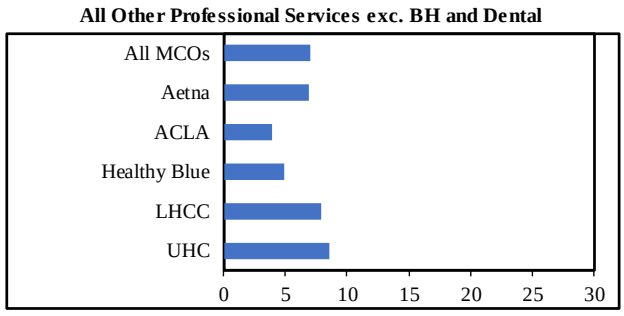


Exhibit III.9C- Q3
Turnaround Time for Claims Processing of Adjudicated Claims (using average days)
By Provider Specialty - Professional Providers, Part 2
By MCO for Q3 2018 Adjudicated Claims

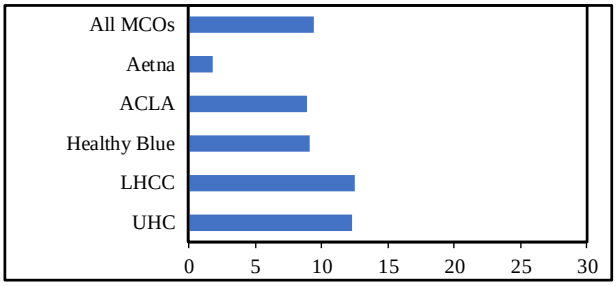
Avg Days from Received by the MCO to Payment to Provider
PAID CLAIMS ONLY

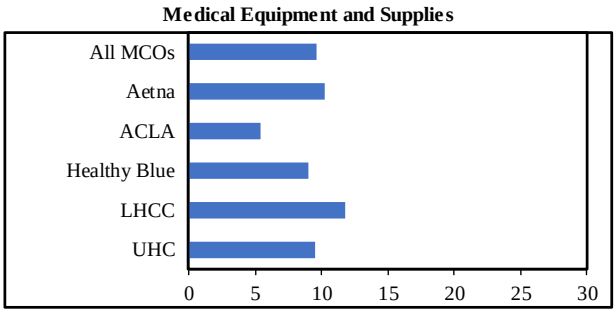






Avg Days from Received by the MCO to Denial Notice to Provider
DENIED CLAIMS ONLY





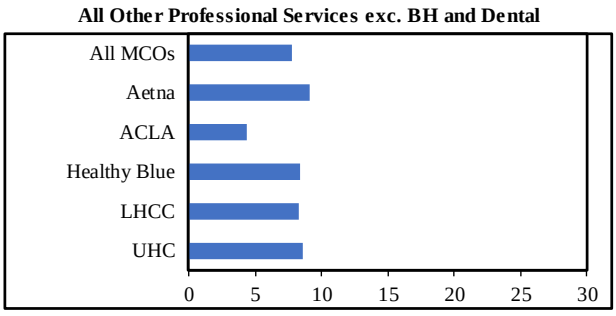
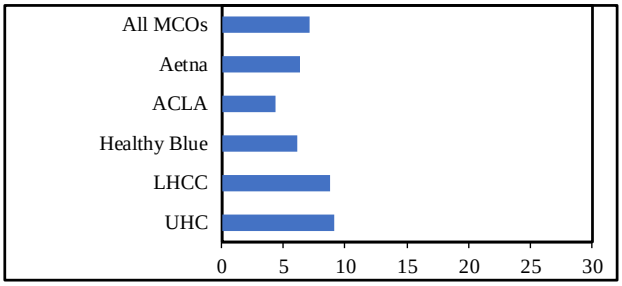
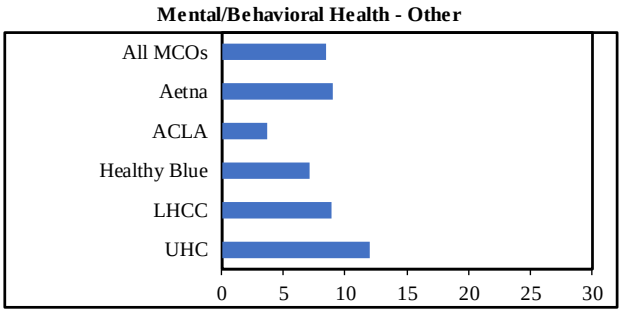
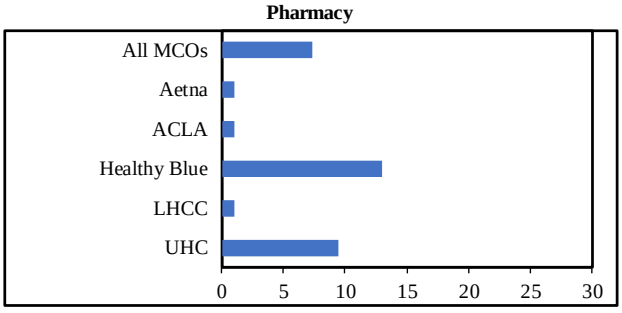


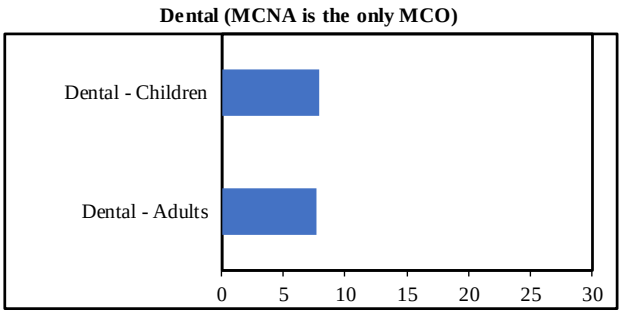
Exhibit III.9D- Q1
Turnaround Time for Claims Processing of Adjudicated Claims (using average days)
By Provider Specialty - Behavioral Health, Dental and Pharmacy
By MCO for Q1 2018 Adjudicated Claims

Avg Days from Received by the MCO to Payment to Provider
PAID CLAIMS ONLY

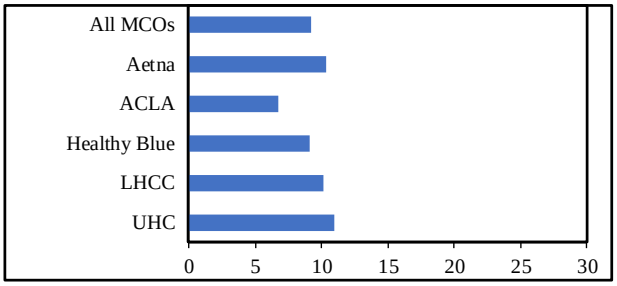


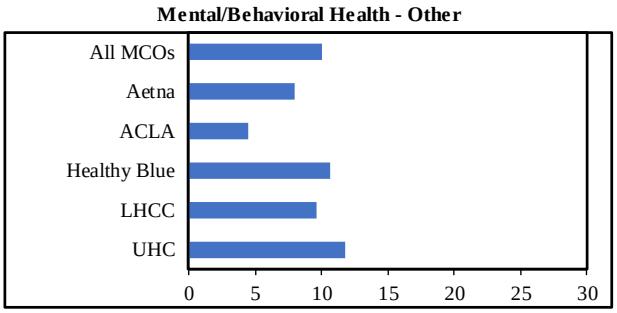


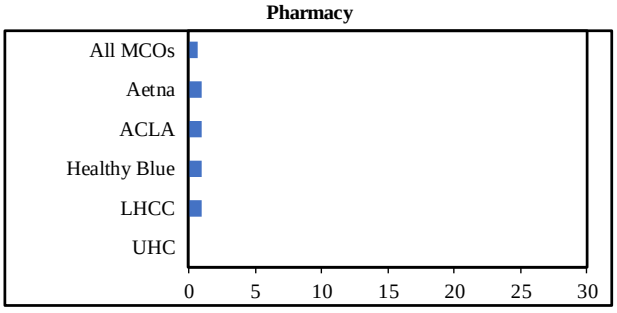




Avg Days from Received by the MCO to Denial Notice to Provider
DENIED CLAIMS ONLY







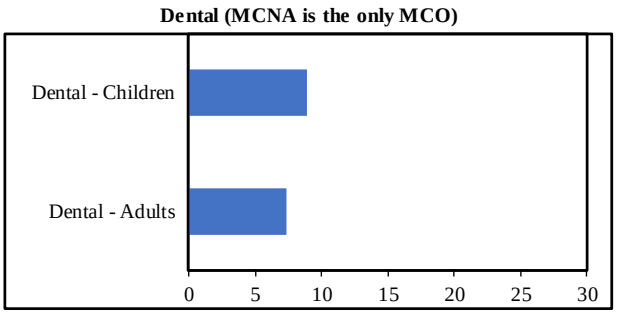
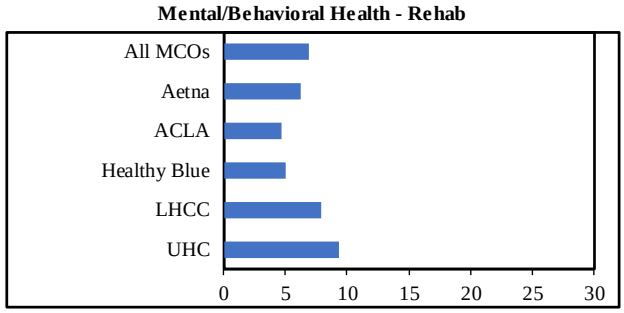
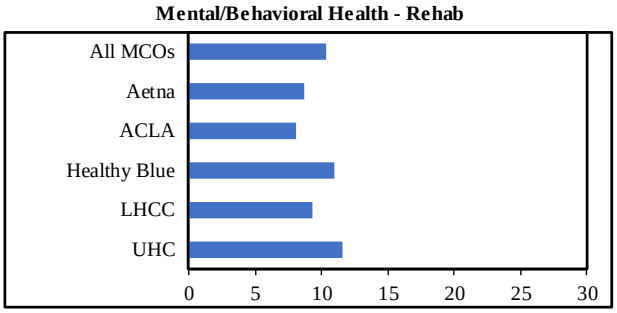


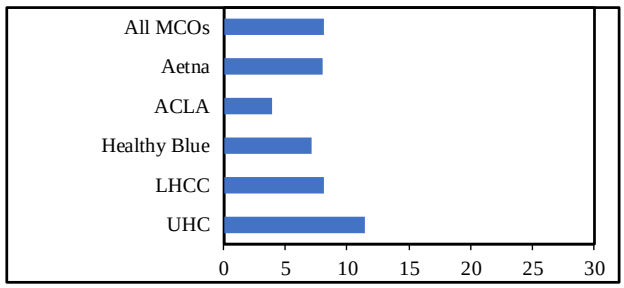
Exhibit III.9D- Q2
Turnaround Time for Claims Processing of Adjudicated Claims (using average days)
By Provider Specialty - Behavioral Health, Dental and Pharmacy
By MCO for Q2 2018 Adjudicated Claims

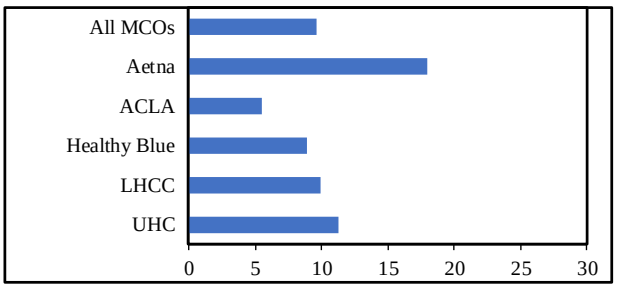
Avg Days from Received by the MCO to Payment to Provider
PAID CLAIMS ONLY

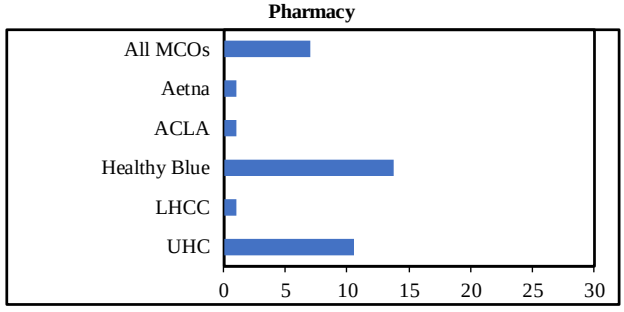
Avg Days from Received by the MCO to Denial Notice to Provider
DENIED CLAIMS ONLY

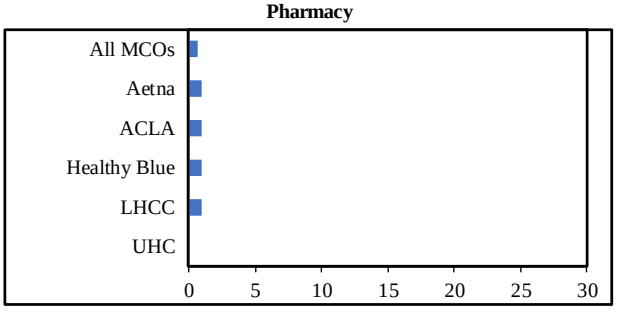


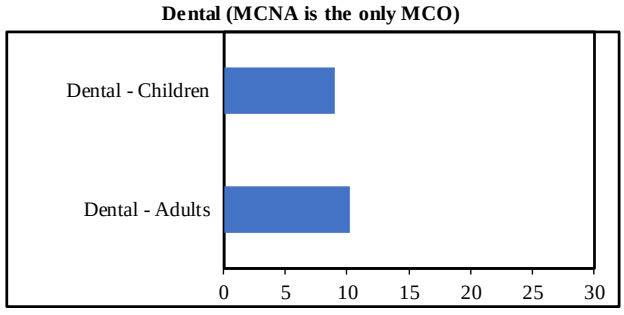












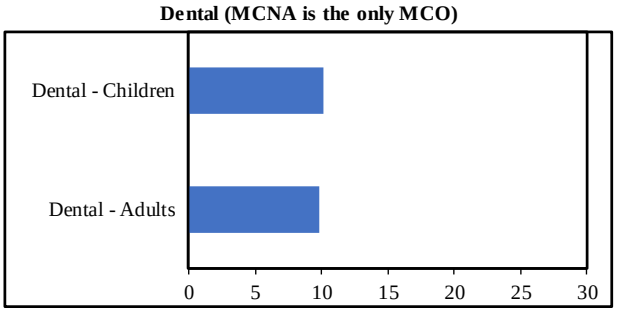
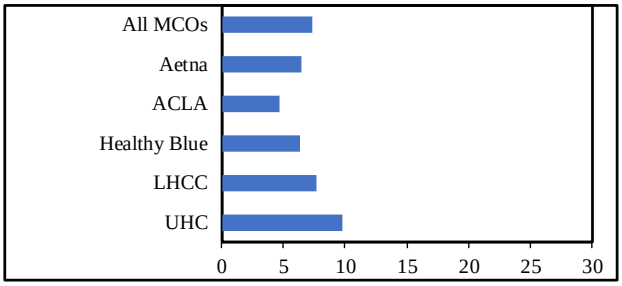
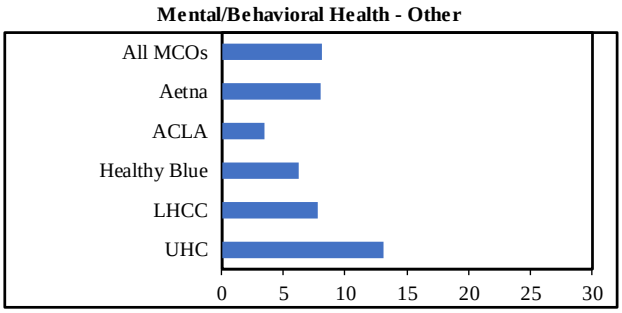
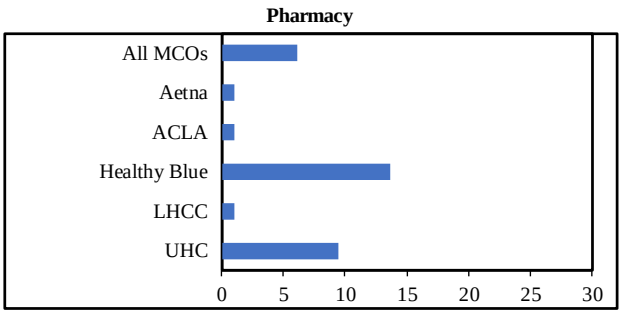


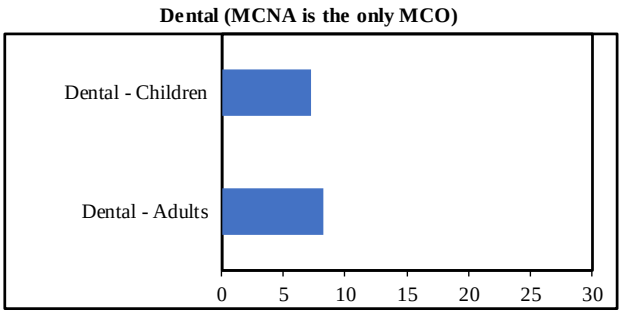
Exhibit III.9D- Q3
Turnaround Time for Claims Processing of Adjudicated Claims (using average days)
By Provider Specialty - Behavioral Health, Dental and Pharmacy
By MCO for Q3 2018 Adjudicated Claims

Avg Days from Received by the MCO to Payment to Provider
PAID CLAIMS ONLY

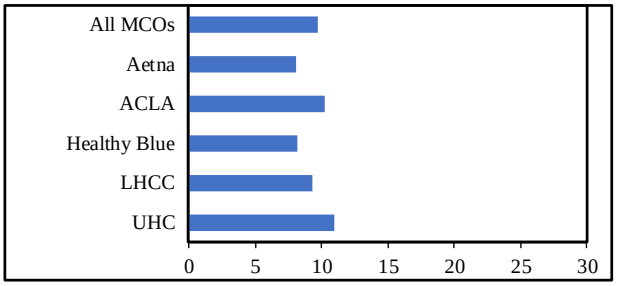


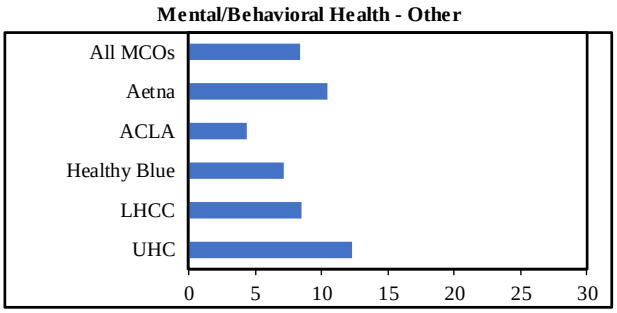


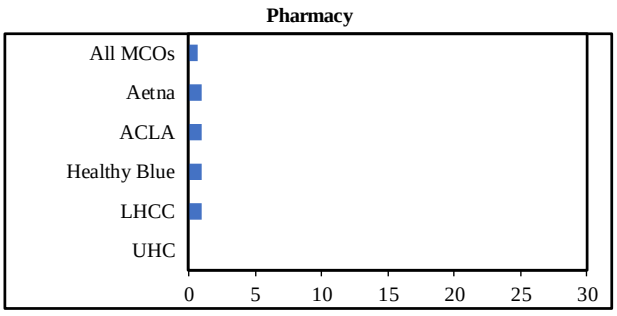


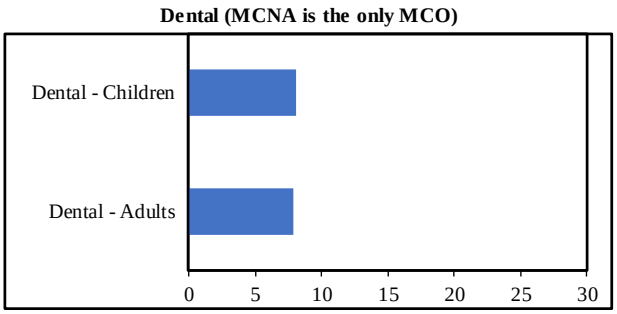


Avg Days from Received by the MCO to Denial Notice to Provider
DENIED CLAIMS ONLY









Reasons for Claim Denials by the MCOs

As stated in Section I, when a claim is adjudicated, the claims processor will assign codes to indicate the reason(s) for why the claim adjudicated the way it did. For medical and dental claims, there is a set of nationally-recognized Claim Adjustment Reason Codes (*CARCs*), about 280 reason codes in all. For pharmacy claims specifically, there are nearly 350 reason codes developed by the *NCPDP*.

The MCOs report to LDH the occurrence of each CARC or NCPDP code on adjudicated claims. For denied claims, the count of each CARC or NCPDP code was tabulated by MCO in each of the first three quarters of CY 2018.

There are three Exhibit III.10 reports that appear starting on the next page. The first exhibit reports data on Q1 2018, the second exhibit data on Q2 2018, and the third exhibit data on Q3 2018. Beginning with the report that will be submitted on July 1, 2019, only the most recent quarter (in that case, Q4) will be reported.

The Exhibit III.10 reports show the top 10 CARCs for medical claims across all MCOs and the top 10 NCPDP codes for pharmacy claims across all MCOs. Some key findings on CARCs appear below:

- In Q1 2018, all of Aetna's, ACLA's and UHC's top 5 CARC codes were in the top 10 for All MCOs. Four of LHCC's, and three of Healthy Blue's were in the top 5 CARCs in the All MCO top 10. MCNA only had one of its top 5 in the All MCO top 10.
- These findings were the same in Q2 2018 except that only four of Aetna's and Healthy Blue's, and three of LHCC's top 5 CARCs were in the All MCO top 10.
- The findings in Q3 2018 were the same as what was found in Q2, except only three of Healthy Blue's top 5 CARCs were in the All MCO Top 10.
- Although the order of the top 10 CARCs for All MCOs may have changed a bit across the quarters, eight of the ten top CARCs were the same in all three quarters. The top five included the following:
    - 197: Precertification or authorization absent when it is required.
    - 16: The claim lacks information or has a billing error which is needed for adjudication.
    - 96: Non-covered charge(s).
    - 97: The benefit for this service is included in the payment for another service.
    - 252: An attachment/other documentation is required to adjudicate this claim/service.

Some key findings on NCPDPs appear below:

- In Q1 2018, all of LHCC's and UHC's top 5 NCPDP codes were also in the top 10 for All MCOs. Four of Aetna's top 5 NCPDPs were in the All MCO top 10. ACLA had three of its top 5 NCPDPs in the All MCO top 10. Healthy Blue had none.
- The findings in Q2 2018 were similar except that only four of LHCC's top 5 NCPDPs were in the All MCO top 10 and only one of ACLA's.
- The Q3 findings showed the most similarity between each MCO's top 5 NCPCPs and the top 10 All MCO codes. Healthy Blue, however, continued to have none of its top codes in the top 10.
- Although the order of the top 10 NCPDPs for All MCOs may have changed a bit across the quarters, nine of the ten top CARCs were the same in all three quarters. The top five were:
    - 88: DUR reject error.
    - 79: Refill too soon.
    - 7J: Patient relationship code value not supported.
    - 7N: Plan ID qualifier value not supported.
    - 76: Plan limitations exceeded.

Exhibit III.10- Q1
Details on Reasons for Denied Claims
By MCO for Q1 2018 Adjudicated Claims

For Medical Claims		Rank Among	Ranking					
CARC	Description	All MCOs	Aetna	ACLA	Healthy Blue	LHCC	UHC	MCNA
197	Precertification/authorization/notification absent.	1	5	4	1	1	1	
16	Claim/service lacks information or has submission/billing error(s)	2	1	2		5		
96	Non-covered charge(s).	3		1		3	2	
252	An attachment/other documentation is required to adjudicate this claim/service.	4		3	3		4	
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	5	4	5			3	
18	Exact duplicate claim/service	6	3			2	5	2
256	Service not payable per managed care contract.	7			2			
29	The time limit for filing has expired.	8						
234	This procedure is not paid separately.	9	2					
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	10						

For Pharmacy Claims		Rank Among	Ranking				
NCPDP	Description	All MCOs	Aetna	ACLA	Healthy Blue	LHCC	UHC
88	DUR Reject Error	1					1
7J	Patient Relationship Code Value Not Supported	2				1	
79	Refill Too Soon	3	1	1			4
76	Plan Limitations Exceeded	4	4	3			2
7A	Provider Does Not Match Authorization On File	5				2	
7Ø	Product/Service Not Covered – Plan/Benefit Exclusion	6	2	2			3
7N	Patient ID Qualifier Value Not Supported	7				3	
4X	M/I Patient Residence	8				4	
19	M/I Days Supply	9				5	5
75	Prior Authorization Required	10	5				

Note: “M/I” = Missing or Invalid

Exhibit III.10- Q2
Details on Reasons for Denied Claims
By MCO for Q2 2018 Adjudicated Claims

For Medical Claims		Rank Among	Ranking					
CARC	Description	All MCOs	Aetna	ACLA	Healthy Blue	LHCC	UHC	MCNA
197	Precertification/authorization/notification absent.	1		3	1	1	2	
96	Non-covered charge(s).	2	5	1		3	1	
252	An attachment/other documentation is required to adjudicate this claim/service.	3		2	3		4	
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	4	3	4			3	
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	5	1	5				
18	Exact duplicate claim/service.	6	2			2	5	2
29	The time limit for filing has expired.	7						
256	Service not payable per managed care contract.	8			2			
27	Expenses incurred after coverage terminated.	9						
109	Claim/service not covered by this payer/contractor.	10			4			

For Pharmacy Claims		Rank Among	Ranking				
NCPDP	Description	All MCOs	Aetna	ACLA	Healthy Blue	LHCC	UHC
88	DUR Reject Error	1					1
79	Refill Too Soon	2	1				4
7J	Patient Relationship Code Value Not Supported	3				1	
7N	Patient ID Qualifier Value Not Supported	4				2	
76	Plan Limitations Exceeded	5	4				2
39	M/I Diagnosis Code	6		4		4	
7Ø	Product/Service Not Covered – Plan/Benefit Exclusion	7	2				3
7A	Provider Does Not Match Authorization On File	8				3	
19	M/I Days Supply	9					
75	Prior Authorization Required	10	5				5

Exhibit III.10- Q3
Details on Reasons for Denied Claims
By MCO for Q2 2018 Adjudicated Claims

For Medical Claims		Rank Among	Ranking					
CARC	Description	All MCOs	Aetna	ACLA	Healthy Blue	LHCC	UHC	MCNA
197	Precertification/authorization/notification absent.	1		3	1	1	1	
96	Non-covered charge(s).	2	5	1		4	2	
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	3	1	2				
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	4	2	5			3	
252	An attachment/other documentation is required to adjudicate this claim/service.	5		4	3		4	
18	Exact duplicate claim/service.	6	3			2	5	2
256	Service not payable per managed care contract.	7			2			
27	Expenses incurred after coverage terminated.	8						
29	The time limit for filing has expired.	9						
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	10						

For Pharmacy Claims		Rank Among	Ranking				
NCPDP	Description	All MCOs	Aetna	ACLA	Healthy Blue	LHCC	UHC
88	DUR Reject Error	1					1
79	Refill Too Soon	2	1	1			4
7J	Patient Relationship Code Value Not Supported	3				1	
76	Plan Limitations Exceeded	4	4	2			3
7N	Patient ID Qualifier Value Not Supported	5				2	
7Ø	Product/Service Not Covered – Plan/Benefit Exclusion	6	2	3			2
39	M/I Diagnosis Code	7		4		4	
7A	Provider Does Not Match Authorization On File	8				3	
19	M/I Days Supply	9				5	
75	Prior Authorization Required	10	5				5

The previous exhibits showed that the top ten denial CARCs are consistent across quarters and were often the top CARCs for each MCO as well. The top five CARCs for each MCO were further reviewed to determine if the same CARCs are appearing on denied claims for all of the provider types that are included in this study.

Exhibits III.11A through III.11F that appear on the following pages show the results when the top CARCs are distributed by provider type for each MCO. The results from Q1 through Q3 2018 all appear on the same page for the purpose of analyzing trends. Each exhibit shows data for a single MCO:

- Exhibit III.11A shows Aetna's CARCs
- Exhibit III.11B shows ACLA's CARCs
- Exhibit III.11C shows Healthy Blue's CARCs
- Exhibit III.11D shows LHCC's CARCs
- Exhibit III.11E shows UHC's CARCs
- Exhibit III.11F shows MCNA's CARCs

Key findings from each of these exhibits are shown below:

- For Aetna (Exhibit III.11A), CARC 16 (claim lacks information or has billing error) appears as the top CARC in every quarter and across every provider type. CARC 18 (exact duplicate) is the 2nd or 3rd highest CARC in volume each quarter and was found for every provider type. In Q2 and Q3, the top 5 CARCs were the same for Aetna. Three of these also appeared in the top 5 in Q1.

- For ACLA (Exhibit III.11B), CARC 96 (non-covered charges) appears as the top CARC in every quarter and across almost every provider type. ACLA did not have CARC 18 in its top 5 CARCs, but like Aetna, CARC 16 was a top CARC and appeared in many provider types. CARC 252 (an attachment or other documentation is required to adjudicate the claim) appeared in the top 5 in every quarter.

- For Healthy Blue (Exhibit III.11C), CARC 197 (precertification or authorization absent) was the top CARC in all three quarters and appeared in every provider type. CARC 256 (service not payable per managed care contract) was the 2nd highest CARC in volume and appeared for most provider types. Like ACLA, CARC 252 was also common for Healthy Blue, ranking 3rd each quarter.

- For LHCC (Exhibit III.11D), CARC 197 was also the top CARC in all three quarters. The 2nd highest in volume was CARC 18, then CARC 96. It is notable that although CARC 197 was the highest-volume CARC, it did not appear for every provider type like it did for Healthy Blue.

- For UHC (Exhibit III.11E), CARC 197 is the top CARC in two of the three quarters. The 2nd highest-volume CARC for two of the three quarters was CARC 96. CARC 97 (the benefit for this service is included in the payment for another service) was also one of the top two in each quarter for UHC. This CARC only appears in UHC's and Aetna's top 5 and not for other MCOs.

- For MCNA (Exhibit III.11F), the top five CARCs appear in the same order for adult and pediatric dental services. For these services, CARC 1 (deductible amount) was the top CARC reported.

Exhibit III.11A
Details on Reasons for Denied Medical Claims
By Provider Category for Q1, Q2 and Q3 2018 Adjudicated Claims
Top 5 Denial Codes for Aetna

An X indicates that this denial reason is also in the Top 5 for the provider category.

CARC	Description	Inpatient Hospital	Outpatient Hospital	Home Health	Other Institutional	Primary Care	Pediatrics	OB-GYN	Therapists	Non-Emerg Transport	Medical Equipment	Other Professional	Mental/Behavioral - Rehab	Mental/Behavioral - Other	Adult Dental	Pediatric Dental
Aetna Q1																
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjud	X	X	X	X	X	X	X	X	X	X	X	X	X		
234	This procedure is not paid separately. At least one Remark Code must be provided (may l		X		X									X		
18	Exact duplicate claim/service (Use only with Group Code OA except where state workers	X	X	X	X	X		X	X	X	X	X	X	X		
97	The benefit for this service is included in the payment/allowance for another service/proced	X	X	X	X	X	X	X	X	X	X	X		X		
197	Precertification/authorization/notification absent.	X							X	X	X	X		X		
Aetna Q2																
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjud	X	X	X	X	X	X	X	X	X	X	X	X	X		
18	Exact duplicate claim/service (Use only with Group Code OA except where state workers	X	X	X	X	X	X	X	X	X	X	X	X	X		
97	The benefit for this service is included in the payment/allowance for another service/proced	X	X	X	X	X	X	X	X	X	X	X		X		
147	Provider contracted/negotiated rate expired or not on file.	X		X	X	X	X	X			X			X		
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised			X	X	X	X	X			X	X		X		
Aetna Q3																
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjud	X	X	X	X	X	X	X	X	X	X	X	X	X		
97	The benefit for this service is included in the payment/allowance for another service/proced	X	X	X	X	X	X	X	X	X	X	X		X		
18	Exact duplicate claim/service (Use only with Group Code OA except where state workers	X	X	X	X	X	X	X	X	X	X	X	X	X		
147	Provider contracted/negotiated rate expired or not on file.			X	X	X	X				X			X		
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised			X	X	X	X				X	X		X		

Exhibit III.11B
Details on Reasons for Denied Medical Claims
By Provider Category for Q1, Q2 and Q3 2018 Adjudicated Claims
Top 5 Denial Codes for ACLA

An X indicates that this denial reason is also in the Top 5 for the provider category.

CARC	Description	Inpatient Hospital	Outpatient Hospital	Home Health	Other Institutional	Primary Care	Pediatrics	OB-GYN	Therapists	Non-Emerg Transport	Medical Equipment	Other Professional	Mental/Behavioral - Rehab	Mental/Behavioral - Other	Adult Dental	Pediatric Dental
ACLA Q1																
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised	X	X	X	X	X	X	X	X	X	X	X		X		
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjud		X			X	X	X	X	X	X	X				
252	An attachment/other documentation is required to adjudicate this claim/service. At least on		X			X		X			X	X	X			
197	Precertification/authorization/notification absent.	X		X				X	X		X	X	X			
97	The benefit for this service is included in the payment/allowance for another service/proced		X			X	X					X		X		
ACLA Q2																
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised	X	X	X	X	X	X	X	X		X	X	X	X		
252	An attachment/other documentation is required to adjudicate this claim/service. At least on		X			X	X	X		X	X	X		X		
197	Precertification/authorization/notification absent.	X				X		X	X		X	X	X	X		
97	The benefit for this service is included in the payment/allowance for another service/proced		X			X	X					X				
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjud		X		X			X	X	X	X		X			
ACLA Q3																
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised	X	X	X	X	X	X	X	X	X	X	X	X	X		
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjud		X			X	X	X	X	X	X	X	X			
197	Precertification/authorization/notification absent.	X		X		X	X	X	X		X	X	X			
252	An attachment/other documentation is required to adjudicate this claim/service. At least on		X	X		X		X	X			X		X		
97	The benefit for this service is included in the payment/allowance for another service/proced		X		X	X	X					X		X		

Exhibit III.11C
Details on Reasons for Denied Medical Claims
By Provider Category for Q1, Q2 and Q3 2018 Adjudicated Claims
Top 5 Denial Codes for Healthy Blue

An X indicates that this denial reason is also in the Top 5 for the provider category.

CARC	Description	Inpatient Hospital	Outpatient Hospital	Home Health	Other Institutional	Primary Care	Pediatrics	OB-GYN	Therapists	Non-Emerg Transport	Medical Equipment	Other Professional	Mental/Behavioral - Rehab	Mental/Behavioral - Other	Adult Dental	Pediatric Dental
Healthy Blue Q1																
197	Precertification/authorization/notification absent.	X	X	X	X	X	X	X	X	X	X	X	X	X		
256	Service not payable per managed care contract.		X	X	X	X	X	X	X	X	X	X		X		
252	An attachment/other documentation is required to adjudicate this claim/service. At least on	X	X	X	X	X	X	X	X	X	X	X	X	X		
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the	X	X		X	X				X		X		X		
119	Benefit maximum for this time period or occurrence has been reached.					X		X		X				X		
Healthy Blue Q2																
197	Precertification/authorization/notification absent.	X	X	X	X	X	X	X	X	X	X	X	X	X		
256	Service not payable per managed care contract.		X	X	X	X	X	X	X	X	X	X		X		
252	An attachment/other documentation is required to adjudicate this claim/service. At least on	X	X	X	X	X	X	X	X	X	X	X	X	X		
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the	X	X	X	X	X			X	X		X		X		
119	Benefit maximum for this time period or occurrence has been reached.			X				X		X						
Healthy Blue Q3																
197	Precertification/authorization/notification absent.	X	X	X	X	X	X	X	X	X	X	X	X	X		
256	Service not payable per managed care contract.		X	X	X	X	X	X	X	X	X	X		X		
252	An attachment/other documentation is required to adjudicate this claim/service. At least on	X	X	X	X	X	X	X	X	X	X	X		X		
119	Benefit maximum for this time period or occurrence has been reached.							X		X			X			
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the	X	X		X	X			X	X		X		X		

Exhibit III.11D
Details on Reasons for Denied Medical Claims
By Provider Category for Q1, Q2 and Q3 2018 Adjudicated Claims
Top 5 Denial Codes for LHCC

An X indicates that this denial reason is also in the Top 5 for the provider category.

CARC	Description	Inpatient Hospital	Outpatient Hospital	Home Health	Other Institutional	Primary Care	Pediatrics	OB-GYN	Therapists	Non-Emerg Transport	Medical Equipment	Other Professional	Mental/Behavioral - Rehab	Mental/Behavioral - Other	Adult Dental	Pediatric Dental
LHCC Q1																
197	Precertification/authorization/notification absent.	X		X	X				X		X	X	X	X		
18	Exact duplicate claim/service (Use only with Group Code OA except where state workers	X	X	X		X	X		X			X	X	X		
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised		X	X	X	X	X	X				X				
49	This is a non-covered service because it is a routine/preventive exam or a diagnostic/scree											X				
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjud	X	X	X	X					X	X		X	X		
LHCC Q2																
197	Precertification/authorization/notification absent.	X		X						X	X	X	X	X		
18	Exact duplicate claim/service (Use only with Group Code OA except where state workers	X	X	X		X	X		X	X	X	X	X	X		
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised		X	X	X	X	X	X		X		X				
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of					X	X	X		X		X	X			
246	This non-payable code is for required reporting only.					X		X		X						
LHCC Q3																
197	Precertification/authorization/notification absent.	X		X	X					X	X	X	X	X		
18	Exact duplicate claim/service (Use only with Group Code OA except where state workers	X	X	X	X		X		X	X	X	X	X	X		
222	Exceeds the contracted maximum number of hours/days/units by this provider for this perio									X	X	X				
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised		X		X	X		X		X						
204	This service/equipment/drug is not covered under the patient's current benefit plan		X	X	X			X		X		X				

Exhibit III.11E
Details on Reasons for Denied Medical Claims
By Provider Category for Q1, Q2 and Q3 2018 Adjudicated Claims
Top 5 Denial Codes for UHC

An X indicates that this denial reason is also in the Top 5 for the provider category.

CARC	Description	Inpatient Hospital	Outpatient Hospital	Home Health	Other Institutional	Primary Care	Pediatrics	OB-GYN	Therapists	Non-Emerg Transport	Medical Equipment	Other Professional	Mental/Behavioral - Rehab	Mental/Behavioral - Other	Adult Dental	Pediatric Dental
United Q1																
197	Precertification/authorization/notification absent.			X			X		X			X	X	X		
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised		X		X	X	X	X	X	X	X	X	X			
97	The benefit for this service is included in the payment/allowance for another service/proced		X			X	X	X		X		X				
252	An attachment/other documentation is required to adjudicate this claim/service. At least on		X	X		X	X	X		X	X	X		X		
18	Exact duplicate claim/service (Use only with Group Code OA except where state workers	X	X	X		X	X	X	X	X	X		X	X		
United Q2																
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised		X	X	X	X	X	X	X	X	X	X				
197	Precertification/authorization/notification absent.	X		X		X	X		X		X	X	X	X		
97	The benefit for this service is included in the payment/allowance for another service/proced		X			X	X	X				X				
252	An attachment/other documentation is required to adjudicate this claim/service. At least on		X		X	X	X	X		X	X	X		X		
18	Exact duplicate claim/service (Use only with Group Code OA except where state workers	X	X	X	X	X	X	X	X		X	X	X	X		
United Q3																
197	Precertification/authorization/notification absent.	X		X					X			X	X	X		
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised		X		X	X	X	X	X	X	X	X		X		
97	The benefit for this service is included in the payment/allowance for another service/proced		X			X	X	X			X	X				
252	An attachment/other documentation is required to adjudicate this claim/service. At least on	X	X			X	X	X		X	X	X		X		
18	Exact duplicate claim/service (Use only with Group Code OA except where state workers	X	X		X	X	X	X	X		X	X	X	X		

Exhibit III.11F
Details on Reasons for Denied Medical Claims
By Provider Category for Q1, Q2 and Q3 2018 Adjudicated Claims
Top 5 Denial Codes for MCNA

CARC	Description	Adult Dental	Pediatric Dental
MCNA Q1			
1	Deductible Amount	X	X
18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)		X
14	The date of birth follows the date of service.	X	
35	Lifetime benefit maximum has been reached.		X
31	Patient cannot be identified as our insured.		X
MCNA Q2			
1	Deductible Amount	X	X
18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)		X
14	The date of birth follows the date of service.	X	
35	Lifetime benefit maximum has been reached.		X
31	Patient cannot be identified as our insured.		X
MCNA Q3			
1	Deductible Amount	X	X
18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)		X
14	The date of birth follows the date of service.	X	
35	Lifetime benefit maximum has been reached.		X
31	Patient cannot be identified as our insured.		X

Provider Education Related to Claims Adjudication

The LDH initiated specific reporting for MCO provider education with the release of the new reporting requirements pertaining to Act 710 in February 2019. As such, the data collection on provider education has recently begun. LDH is requesting information on education for providers at the individual national provider identifier (NPI) level. On a quarterly basis starting with information pertaining to Q1 2019, each MCO will provide information on individual providers to state if the provider who was outreached to accepted the education on claims processing from the MCO and, if yes, the date the education occurred and the mode of education (e.g., by phone or in person).

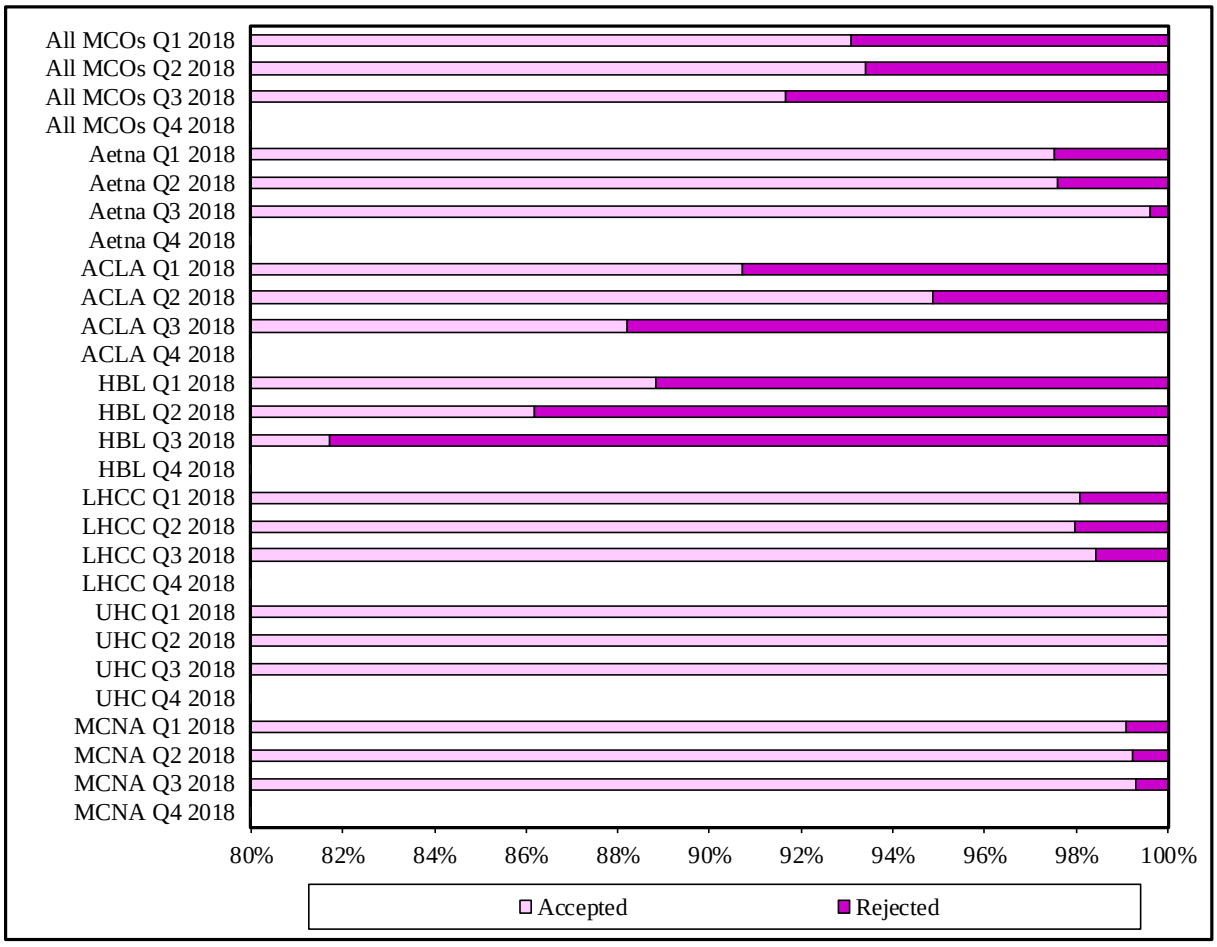
SECTION IV: FINDINGS RELATED TO MCO ENCOUNTER SUBMISSIONS TO LDH

The MCOs are required to send all claims that they have adjudicated—both paid and denied—to LDH in order for LDH to capture all information pertaining to MCO medical expenditures and to track utilization related to outcome measures. Act 710 requested specific information pertaining to encounter submissions, including the number that were accepted by LDH and the number rejected. LDH is also tracking the timeliness in which encounters are being submitted by the MCOs.

MCO Encounters Accepted and Rejected by LDH

In the first three quarters of Calendar Year (CY) 2018, 94.4% to 96.2% of the encounters submitted by all MCOs combined were accepted by LDH. There were differences at the MCO level. All of UHC's encounters were accepted and most of Aetna's, LHCC's and MCNA's were accepted. Only 91.3% of ACLA's encounters (average over three quarters) were accepted and only 85.6% of Healthy Blue's encounters (average over three quarters) were accepted.

Exhibit IV.1
Encounter Submissions Accepted and Rejected by LDH
All Claim Types
By MCO and By Quarter



There are differences in the encounter acceptance rate when reviewed by claim type. The MCOs are required to submit encounters in a pre-determined format based on the claim type. Encounters are submitted separately for each of the following claim type:

- Institutional encounters (837I)
- Professional encounters (837P)
- Dental encounters (837D)
- Pharmacy encounters

Exhibits IV.2 and IV.3 on the next two pages delineate the acceptance and rejection rates of encounters for each MCO by claim type and by quarter. The key findings from these exhibits show that:

- Healthy Blue's lower overall encounter acceptance rate was due to both institutional and professional encounters as well as pharmacy encounters in Q2 and Q3.

- ACLA's lower encounter acceptance rate overall was due to institutional and pharmacy encounters but not professional encounters.

- Although Aetna and LHCC had high acceptance rates overall, Aetna had some challenges with institutional encounters (Q2 only) and pharmacy encounters (Q1 only). LHCC has some challenges with professional encounters in each quarter.

Exhibit IV.2
Encounter Submissions Accepted and Rejected by LDH
Institutional and Professional Claim Types
By MCO and By Quarter

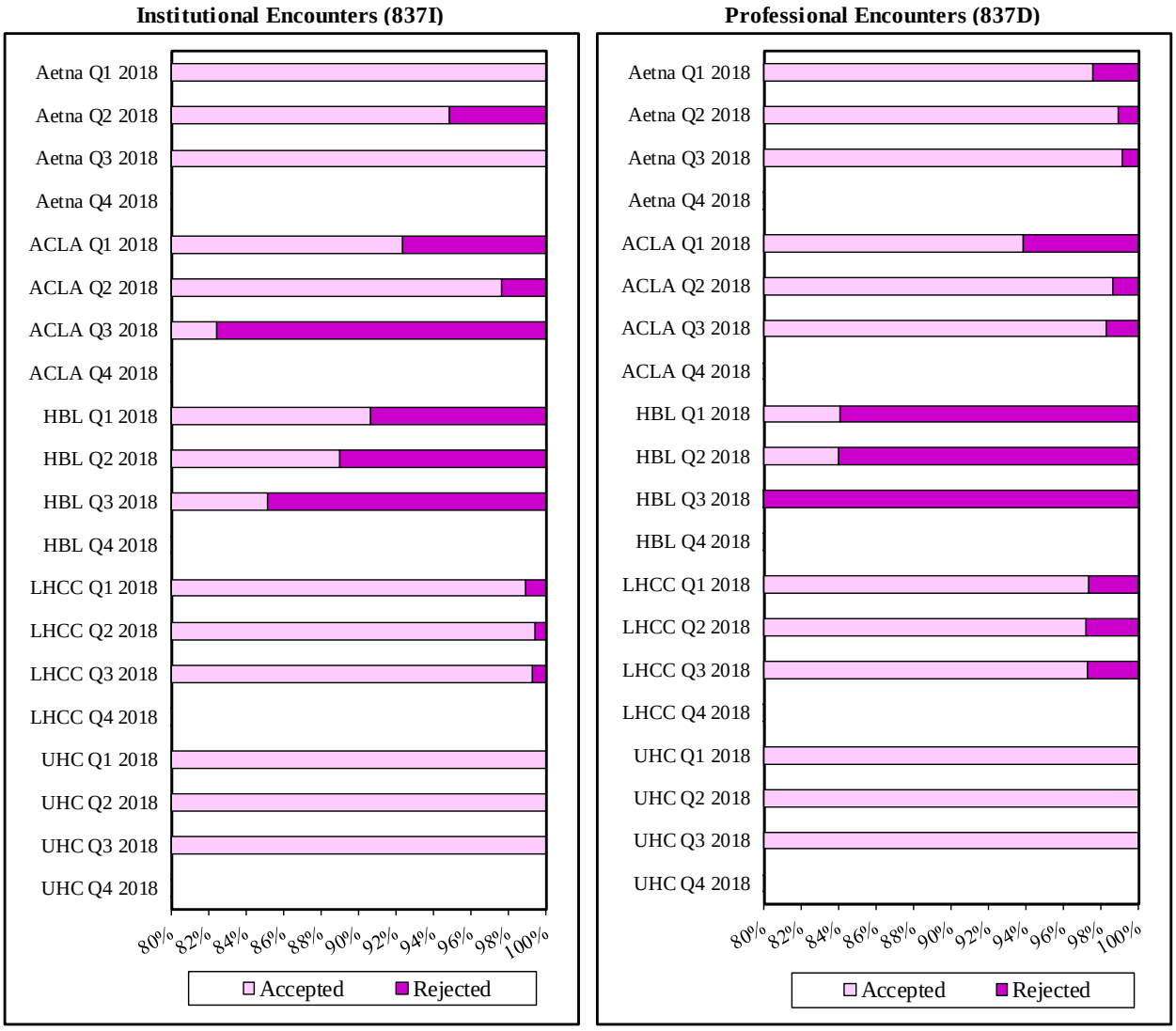
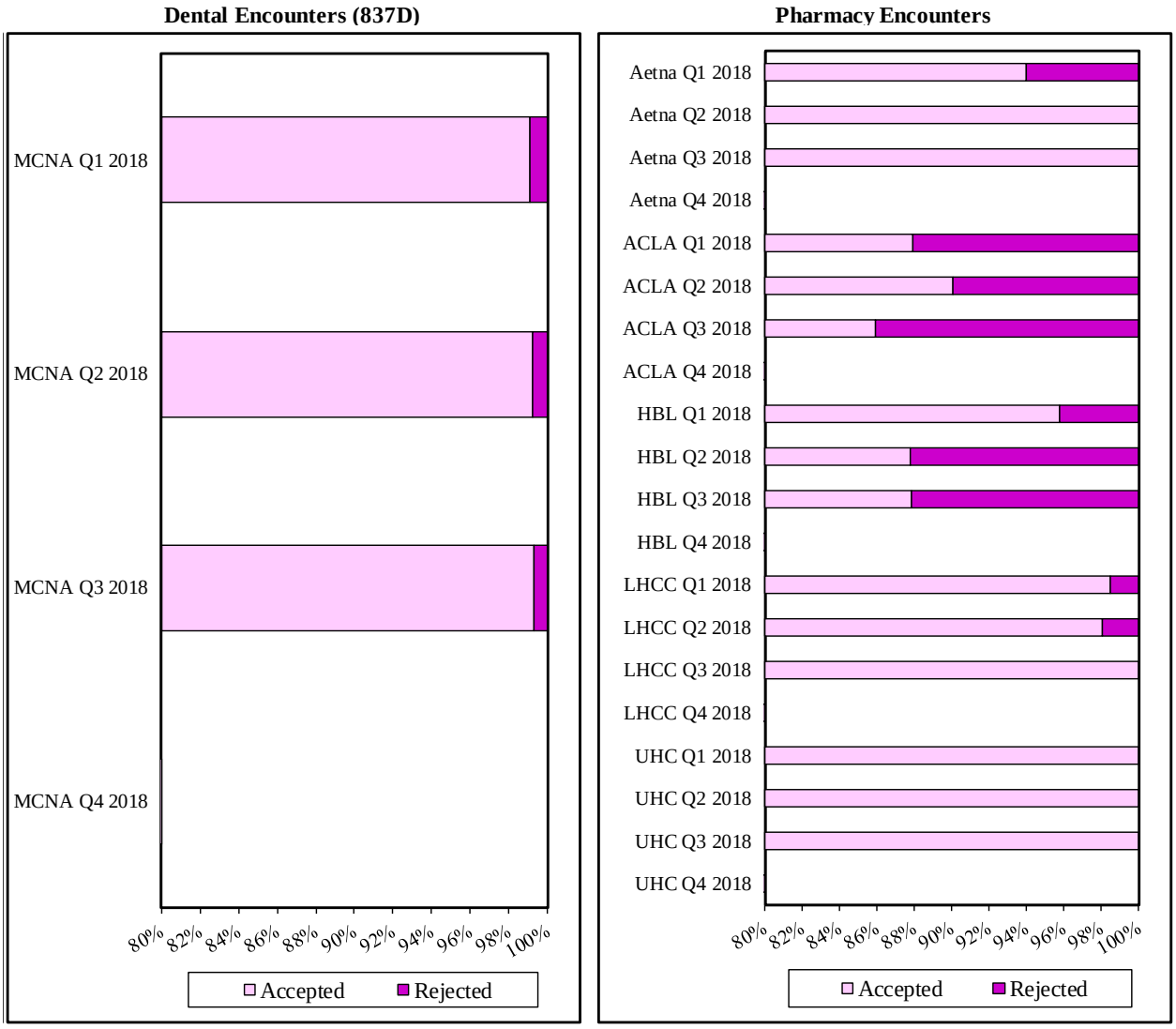


Exhibit IV.3
Encounter Submissions Accepted and Rejected by LDH
Dental and Pharmacy Claim Types
By MCO and By Quarter



Timeliness of Encounter Submissions Accepted by LDH

A common benchmark to track the timeliness of encounter submissions is the average turnaround time (TAT). In the previous section of this report, the average TAT that was measured was the date from which the MCO received the claim from the provider to the date that payment was made to the provider or notice of denial was given. In this section, the average TAT measures the date from which the MCO gave notice to the provider to the date that the encounter was submitted to LDH.

Because of the manner in which the encounters are submitted, the average TAT is computed for each claim type separately. The data in Exhibits IV.4 and IV.5 on the next two pages track the average TAT by MCO, by quarter and by claim type. A common benchmark used is that MCOs should submit encounters within 30 days of adjudication. The results shown in the exhibits show the percentage of encounters accepted by LDH that were submitted within 30 days of adjudication.

Key findings from both exhibits appear below:

- When the encounters are accepted by LDH, Healthy Blue has the highest percentage submitted within 30 days. Almost 100% were submitted within 30 days for institutional, professional and pharmacy encounters.

- LHCC has the second highest TAT among the MCOs. There was slightly lower compliance in Q1, but in Q2 and Q3 more than 98% of institutional, 92% of professional, and 97% of pharmacy encounters were submitted within 30 days.

- UHC has had some challenges with meeting an average 30-day TAT for institutional and professional encounters in Q1 and pharmacy encounters in Q2.

- ACLA has had some challenges with meeting an average 30-day TAT for institutional encounters in Q3 and pharmacy encounters in Q1 and Q2.

- Aetna has not had specific issues with any specific claim type per se, but they do have a lower percentage of encounters submitted within 30 days for each claim type than many of their peers.

- MCNA has few issues meeting an average 30-day TAT for its dental encounters.

Exhibit IV.4
Turnaround Time for Encounter Submissions Accepted by LDH
(within 30 days or more than 30 days from MCO adjudication)
Institutional and Professional Claim Types
By MCO and By Quarter

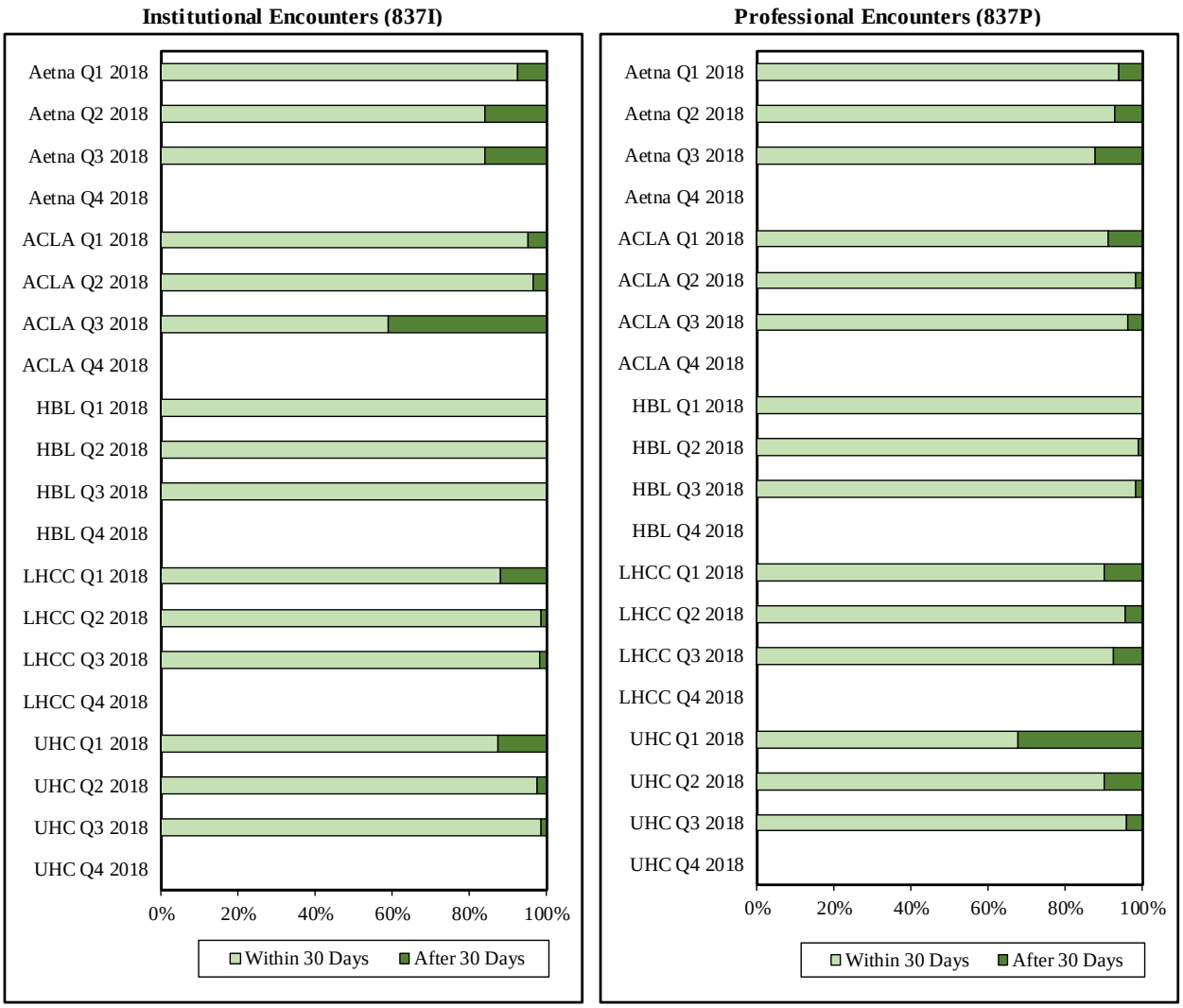
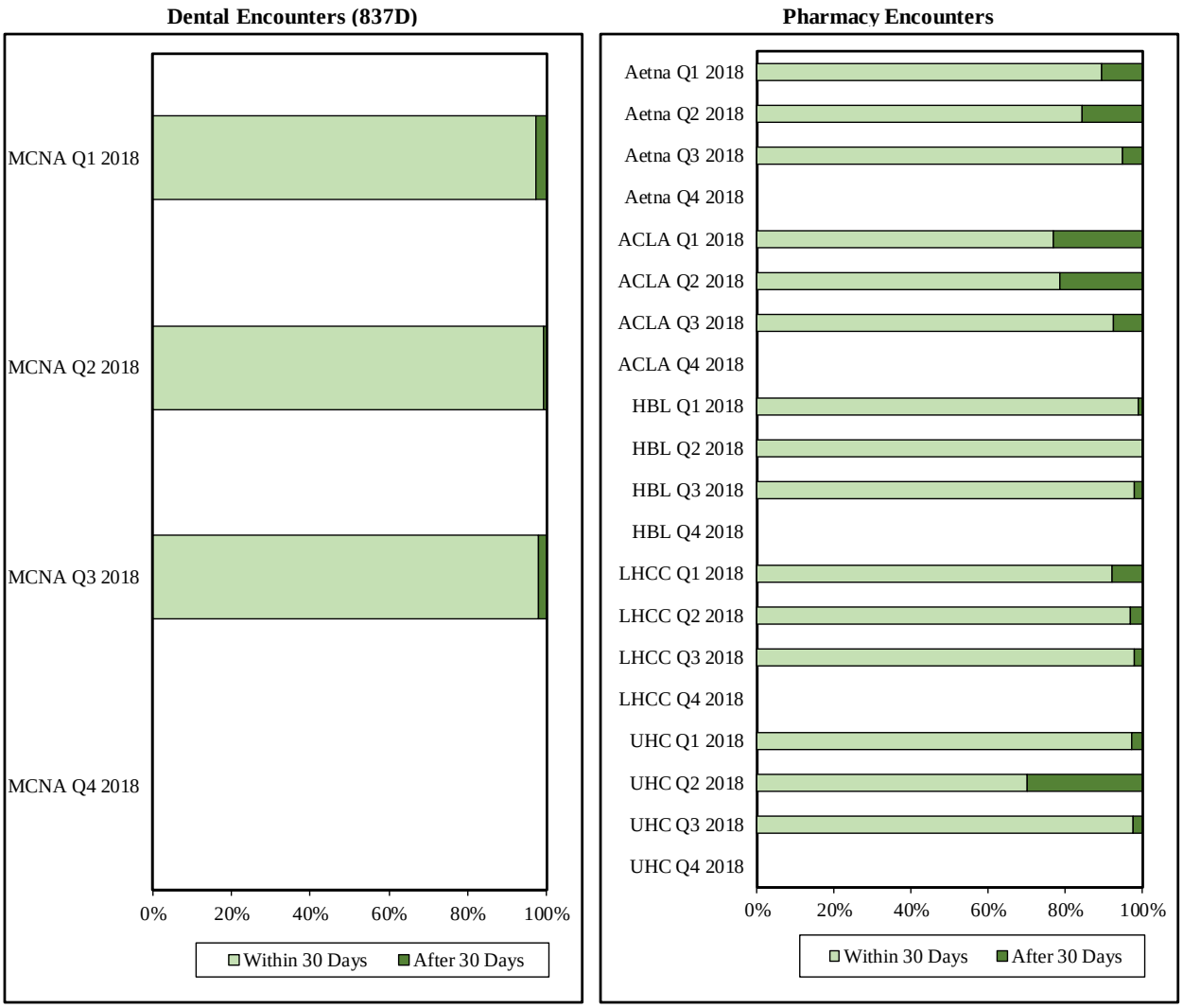


Exhibit IV.5
Turnaround Time for Encounter Submissions Accepted by LDH
(within 30 days or more than 30 days from MCO adjudication)
Dental and Pharmacy Claim Types
By MCO and By Quarter



APPENDIX A
Map of LDH Provider Types/Specialties to the Provider Categories in this Report

Provider Type Categories	Claim Form	Claim Type	Billing Provider Type/Specialty PT=Provider Type PS=Provider Specialty	Reporting Level	Notes
Inpatient Hospital	UB-04/837-I	01		Header	Include Distinct Part Psych, Freestanding Psych, and Freestanding Rehab hospitals here.
Outpatient Hospital	UB-04/837-I	03		Detail	
Home Health	UB-04/837-I	06		Detail	
All Other - UB-04/837-I	UB-04/837-I	Any Other		Detail	Only include claims billed on claim form UB-04/837-I and has any other CT, PT and/or PS **not already listed in the above UB-04/837-I categories**. This category should not include any claims with CT 01, 03 or 06.
MHR/BHR	CMS-1500/837-P	04	MHR- PT= 77 AND PS= 78 BHR- PT= AG AND PS= 8E	Detail	
All Other Specialized Behavioral Health - Not MHR/BHR	CMS-1500/837-P	04	**See Appendix AD of MCO SCG for PT/PS**	Detail	Do not include MHR/BHR claims in this category.
Primary Care Services - Excluding Pediatricians (Primary Care)	CMS-1500/837-P	04	PS= 01, 08, 41, 42, 79, 94	Detail	Do not include Pediatricians (Primary Care) claims in this category
Pediatricians (Primary Care)	CMS-1500/837-P	04	PS= 37	Detail	
OB-GYN & MFM	CMS-1500/837-P	04	PS= 09, 15, 16, 3C	Detail	
Therapies (PT/OT/ST)	CMS-1500/837-P	04	PS= 65, 71, 74	Detail	
NEMT & NEAT	CMS-1500/837-P	08		Detail	
Medical Equipment / Supplies	CMS-1500/837-P	09		Detail	
All Other CMS-1500	CMS-1500/837-P	Any Other	Any other claim type 04, or other claim type/PT/PS combinations NOT already listed for claim form CMS-1500/837-P	Detail	
Pharmacy[1]	NCPDP	12		Detail	
Dental - EPSDT	ADA/837-D	10		Detail	
Dental - Adult	ADA/837-D	11		Detail	

[1]Pharmacy provider type category should be based off of the prescribing provider's NPI, not the pharmacy's NPI.

APPENDIX B

List of All Claim Adjustment Reason Codes (CARCs)

Active Codes January 1, 2017 - Present (11/1/18)

Rows in yellow indicate CARCs that have been deactivated in CY2017 or CY2018 but kept in this list to account for claims processing lag.

CARC	CARC Description
1	Deductible Amount
2	Coinsurance Amount
3	Co-payment Amount
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.
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.
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.
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.
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	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.
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.
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.
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.
13	The date of death precedes the date of service.
14	The date of birth follows the date of service.
15	The authorization number is missing, invalid, or does not apply to the billed services or provider.
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.
18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)
19	This is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.
20	This injury/illness is covered by the liability carrier.
21	This injury/illness is the liability of the no-fault carrier.
22	This care may be covered by another payer per coordination of benefits.
23	The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)
24	Charges are covered under a capitation agreement/managed care plan.
26	Expenses incurred prior to coverage.
27	Expenses incurred after coverage terminated.
29	The time limit for filing has expired.
31	Patient cannot be identified as our insured.
32	Our records indicate that this dependent is not an eligible dependent as defined.
33	Insured has no dependent coverage.
34	Insured has no coverage for newborns.
35	Lifetime benefit maximum has been reached.
39	Services denied at the time authorization/pre-certification was requested.
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.
44	Prompt-pay discount.
45	**NOT COUNTING ON THE DISTRIBUTION OF CARCS REPORT**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)
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.
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.
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.
53	Services by an immediate relative or a member of the same household are not covered.
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.
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.
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.
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.
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.

APPENDIX B

List of All Claim Adjustment Reason Codes (CARCs)

Active Codes January 1, 2017 - Present (11/1/18)

Rows in yellow indicate CARCs that have been deactivated in CY2017 or CY2018 but kept in this list to account for claims processing lag.

CARC	CARC Description
60	Charges for outpatient services are not covered when performed within a period of time prior to or after inpatient services.
61	Penalty for failure to obtain second surgical opinion. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. This change effective 1/1/2017: Adjusted for failure to obtain second surgical opinion
66	Blood Deductible.
69	Day outlier amount.
70	Cost outlier - Adjustment to compensate for additional costs.
74	Indirect Medical Education Adjustment.
75	Direct Medical Education Adjustment.
76	Disproportionate Share Adjustment.
78	Non-Covered days/Room charge adjustment.
85	Patient Interest Adjustment (Use Only Group code PR)
89	Professional fees removed from charges.
90	Ingredient cost adjustment. Note: To be used for pharmaceuticals only.
91	Dispensing fee adjustment.
94	Processed in Excess of charges.
95	Plan procedures not followed.
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.
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.
100	Payment made to patient/insured/responsible party/employer.
101	Predetermination: anticipated payment upon completion of services or claim adjudication.
102	Major Medical Adjustment.
103	Provider promotional discount (e.g., Senior citizen discount).
104	Managed care withholding.
105	Tax withholding.
106	Patient payment option/election not in effect.
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.
108	Rent/purchase guidelines were not met. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.
110	Billing date predates service date.
111	Not covered unless the provider accepts assignment.
112	Service not furnished directly to the patient and/or not documented.
114	Procedure/product not approved by the Food and Drug Administration.
115	Procedure postponed, canceled, or delayed.
116	The advance indemnification notice signed by the patient did not comply with requirements.
117	Transportation is only covered to the closest facility that can provide the necessary care.
118	ESRD network support adjustment.
119	Benefit maximum for this time period or occurrence has been reached.
121	Indemnification adjustment - compensation for outstanding member responsibility.
122	Psychiatric reduction.
128	Newborn's services are covered in the mother's Allowance.
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.)
130	Claim submission fee.
131	Claim specific negotiated discount.
132	Prearranged demonstration project adjustment.
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).
134	Technical fees removed from charges.
135	Interim bills cannot be processed.
136	Failure to follow prior payer's coverage rules. (Use only with Group Code OA)
137	Regulatory Surcharges, Assessments, Allowances or Health Related Taxes.
138	Appeal procedures not followed or time limits not met.
139	Contracted funding agreement - Subscriber is employed by the provider of services.
140	Patient/Insured health identification number and name do not match.
142	Monthly Medicaid patient liability amount.
143	Portion of payment deferred.
144	Incentive adjustment, e.g. preferred product/service.
146	Diagnosis was invalid for the date(s) of service reported.
147	Provider contracted/negotiated rate expired or not on file.
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.)

APPENDIX B

List of All Claim Adjustment Reason Codes (CARCs)

Active Codes January 1, 2017 - Present (11/1/18)

Rows in yellow indicate CARCs that have been deactivated in CY2017 or CY2018 but kept in this list to account for claims processing lag.

CARC	CARC Description
149	Lifetime benefit maximum has been reached for this service/benefit category.
150	Payer deems the information submitted does not support this level of service.
151	Payment adjusted because the payer deems the information submitted does not support this many/frequency of services.
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.
153	Payer deems the information submitted does not support this dosage.
154	Payer deems the information submitted does not support this day's supply.
155	Patient refused the service/procedure.
157	Service/procedure was provided as a result of an act of war.
158	Service/procedure was provided outside of the United States.
159	Service/procedure was provided as a result of terrorism.
160	Injury/illness was the result of an activity that is a benefit exclusion.
161	Provider performance bonus
163	Attachment/other documentation referenced on the claim was not received.
164	Attachment/other documentation referenced on the claim was not received in a timely fashion.
165	Referral absent or exceeded.
166	These services were submitted after this payers responsibility for processing claims under this plan ended.
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.
168	Service(s) have been considered under the patient's medical plan. Benefits are not available under this dental plan.
169	Alternate benefit has been provided.
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.
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.
172	Payment is adjusted when performed/billed by a provider of this specialty. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
173	Service/equipment was not prescribed by a physician.
174	Service was not prescribed prior to delivery.
175	Prescription is incomplete.
176	Prescription is not current.
177	Patient has not met the required eligibility requirements.
178	Patient has not met the required spend down requirements.
179	Patient has not met the required waiting requirements. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
180	Patient has not met the required residency requirements.
181	Procedure code was invalid on the date of service.
182	Procedure modifier was invalid on the date of service.
183	The referring provider is not eligible to refer the service billed. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
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.
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.
186	Level of care change adjustment.
187	Consumer Spending Account payments (includes but is not limited to Flexible Spending Account, Health Savings Account, Health Reimbursement Account, etc.)
188	This product/procedure is only covered when used according to FDA recommendations.
189	'Not otherwise classified' or 'unlisted' procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service
190	Payment is included in the allowance for a Skilled Nursing Facility (SNF) qualified stay.
192	Non standard adjustment code from paper remittance. Note: This code is to be used by providers/payers providing Coordination of Benefits information to another payer in the 837 transaction only. This code is only used when the non-standard code cannot be reasonably mapped to an existing Claims Adjustment Reason Code, specifically Deductible, Coinsurance and Co-payment.
193	Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
194	Anesthesia performed by the operating physician, the assistant surgeon or the attending physician.
195	Refund issued to an erroneous priority payer for this claim/service.
197	Precertification/authorization/notification absent.
198	Precertification/authorization exceeded.
199	Revenue code and Procedure code do not match.
200	Expenses incurred during lapse in coverage
201	Patient is responsible for amount of this claim/service through 'set aside arrangement' or other agreement. (Use only with Group Code PR) At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
202	Non-covered personal comfort or convenience services.
203	Discontinued or reduced service.
204	This service/equipment/drug is not covered under the patient’s current benefit plan
205	Pharmacy discount card processing fee

APPENDIX B

List of All Claim Adjustment Reason Codes (CARCs)

Active Codes January 1, 2017 - Present (11/1/18)

Rows in yellow indicate CARCs that have been deactivated in CY2017 or CY2018 but kept in this list to account for claims processing lag.

CARC	CARC Description
206	National Provider Identifier - missing.
207	National Provider identifier - Invalid format
208	National Provider Identifier - Not matched.
209	Per regulatory or other agreement. The provider cannot collect this amount from the patient. However, this amount may be billed to subsequent payer. Refund to patient if collected. (Use only with Group code OA)
210	Payment adjusted because pre-certification/authorization not received in a timely fashion
211	National Drug Codes (NDC) not eligible for rebate, are not covered.
212	Administrative surcharges are not covered
213	Non-compliance with the physician self referral prohibition legislation or payer policy.
215	Based on subrogation of a third party settlement
216	Based on the findings of a review organization
219	Based on extent of injury. 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).
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.
223	Adjustment code for mandated federal, state or local law/regulation that is not already covered by another code and is mandated before a new code can be created.
224	Patient identification compromised by identity theft. Identity verification required for processing this and future claims.
225	Penalty or Interest Payment by Payer (Only used for plan to plan encounter reporting within the 837)
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.)
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.)
228	Denied for failure of this provider, another provider or the subscriber to supply requested information to a previous payer for their adjudication
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)
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.
232	Institutional Transfer Amount. Note - Applies to institutional claims only and explains the DRG amount difference when the patient care crosses multiple institutions.
233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.
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.)
235	Sales Tax
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.
237	Legislated/Regulatory Penalty. 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.)
238	Claim spans eligible and ineligible periods of coverage, this is the reduction for the ineligible period. (Use only with Group Code PR)
239	Claim spans eligible and ineligible periods of coverage. Rebill separate claims.
240	The diagnosis is inconsistent with the patient's birth weight. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
241	Low Income Subsidy (LIS) Co-payment Amount
242	Services not provided by network/primary care providers.
243	Services not authorized by network/primary care providers.
245	Provider performance program withhold.
246	This non-payable code is for required reporting only.
247	Deductible for Professional service rendered in an Institutional setting and billed on an Institutional claim.
248	Coinsurance for Professional service rendered in an Institutional setting and billed on an Institutional claim.
249	This claim has been identified as a readmission. (Use only with Group Code CO)
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).
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).
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).
253	Sequestration - reduction in federal payment
254	Claim received by the dental plan, but benefits not available under this plan. Submit these services to the patient's medical plan for further consideration.
256	Service not payable per managed care contract.

APPENDIX B

List of All Claim Adjustment Reason Codes (CARCs)

Active Codes January 1, 2017 - Present (11/1/18)

Rows in yellow indicate CARCs that have been deactivated in CY2017 or CY2018 but kept in this list to account for claims processing lag.

CARC	CARC Description
257	The disposition of the claim/service is undetermined during the premium payment grace period, per Health Insurance Exchange requirements. This claim/service will be reversed and corrected when the grace period ends (due to premium payment or lack of premium payment). (Use only with Group Code OA)
258	Claim/service not covered when patient is in custody/incarcerated. Applicable federal, state or local authority may cover the claim/service.
259	Additional payment for Dental/Vision service utilization.
260	Processed under Medicaid ACA Enhanced Fee Schedule
261	The procedure or service is inconsistent with the patient's history.
262	Adjustment for delivery cost. Note: To be used for pharmaceuticals only.
263	Adjustment for shipping cost. Note: To be used for pharmaceuticals only.
264	Adjustment for postage cost. Note: To be used for pharmaceuticals only.
265	Adjustment for administrative cost. Note: To be used for pharmaceuticals only.
266	Adjustment for compound preparation cost. Note: To be used for pharmaceuticals only.
267	Claim/service spans multiple months. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)
268	The Claim spans two calendar years. Please resubmit one claim per calendar year.
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.
270	Claim received by the medical plan, but benefits not available under this plan. Submit these services to the patient's dental plan for further consideration.
271	Prior contractual reductions related to a current periodic payment as part of a contractual payment schedule when deferred amounts have been previously reported. (Use only with group code OA)
272	Coverage/program guidelines were not met.
273	Coverage/program guidelines were exceeded.
274	Fee/Service not payable per patient Care Coordination arrangement.
275	Prior payer's (or payers') patient responsibility (deductible, coinsurance, co-payment) not covered. (Use only with Group Code PR)
276	Services denied by the prior payer(s) are not covered by this payer.
277	The disposition of the claim/service is undetermined during the premium payment grace period, per Health Insurance SHOP Exchange requirements. This claim/service will be reversed and corrected when the grace period ends (due to premium payment or lack of premium payment). (Use only with Group Code OA)
278	Performance program proficiency requirements not met. (Use only with Group Codes CO or PI) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
279	Services not provided by Preferred network providers. Usage: Use this code when there are member network limitations. For example, using contracted providers not in the member's 'narrow' network.
280	Claim received by the medical plan, but benefits not available under this plan. Submit these services to the patient's Pharmacy plan for further consideration.
281	Deductible waived per contractual agreement. Use only with Group Code CO.
282	The procedure/revenue code is inconsistent with the type of bill. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
283	Attending provider is not eligible to provide direction of care.
284	Precertification/authorization/notification/pre-treatment number may be valid but does not apply to the billed services.
285	Appeal procedures not followed
286	Appeal time limits not met
287	Referral exceeded
288	Referral absent
289	Services considered under the dental and medical plans, benefits not available.
290	Claim received by the dental plan, but benefits not available under this plan. Claim has been forwarded to the patient's medical plan for further consideration.
291	Claim received by the medical plan, but benefits not available under this plan. Claim has been forwarded to the patient's dental plan for further consideration.
292	Claim received by the medical plan, but benefits not available under this plan. Claim has been forwarded to the patient's pharmacy plan for further consideration.
293	Payment made to employer.
294	Payment made to attorney.
295	Pharmacy Direct/Indirect Remuneration (DIR)
296	Precertification/authorization/notification/pre-treatment number may be valid but does not apply to the provider.
A0	Patient refund amount.
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.)
A5	Medicare Claim PPS Capital Cost Outlier Amount.
A6	Prior hospitalization or 30 day transfer requirement not met.
A8	Ungroupable DRG.
B1	Non-covered visits.
B4	Late filing penalty.
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.
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.
B9	Patient is enrolled in a Hospice.
B10	Allowed amount has been reduced because a component of the basic procedure/test was paid. The beneficiary is not liable for more than the charge limit for the basic procedure/test.

APPENDIX B

List of All Claim Adjustment Reason Codes (CARCs)

Active Codes January 1, 2017 - Present (11/1/18)

Rows in yellow indicate CARCs that have been deactivated in CY2017 or CY2018 but kept in this list to account for claims processing lag.

CARC	CARC Description
B11	The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.
B12	Services not documented in patients' medical records.
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.
B14	Only one visit or consultation per physician per day is covered.
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.
B16	'New Patient' qualifications were not met.
B20	Procedure/service was partially or fully furnished by another provider.
B22	This payment is adjusted based on the diagnosis.
B23	Procedure billed is not authorized per your Clinical Laboratory Improvement Amendment (CLIA) proficiency test.
P1	State-mandated Requirement for Property and Casualty, see Claim Payment Remarks Code for specific explanation. To be used for Property and Casualty only.
P2	Not a work related injury/illness and thus not the liability of the workers' compensation carrier 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.
P3	Workers' Compensation case settled. Patient is responsible for amount of this claim/service through WC 'Medicare set aside arrangement' or other agreement. To be used for Workers' Compensation only. (Use only with Group Code PR)
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
P5	Based on payer reasonable and customary fees. No maximum allowable defined by legislated fee arrangement. To be used for Property and Casualty only.
P6	Based on entitlement to benefits. 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 Property and Casualty only.
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.
P8	Claim is under investigation. 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 Property and Casualty only.
P9	No available or correlating CPT/HCPCS code to describe this service. To be used for Property and Casualty only.
P10	Payment reduced to zero due to litigation. Additional information will be sent following the conclusion of litigation. To be used for Property and Casualty only.
P11	The disposition of the related Property & Casualty claim (injury or illness) is pending due to litigation. To be used for Property and Casualty only. (Use only with Group Code OA)
P12	Workers' compensation jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). 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 Workers' Compensation only.
P13	Payment reduced or denied based on workers' compensation 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 Workers' Compensation only.
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.
P15	Workers' Compensation Medical Treatment Guideline Adjustment. To be used for Workers' Compensation only.
P16	Medical provider not authorized/certified to provide treatment to injured workers in this jurisdiction. To be used for Workers' Compensation only. (Use with Group Code CO or OA)
P17	Referral not authorized by attending physician per regulatory requirement. To be used for Property and Casualty only.
P18	Procedure is not listed in the jurisdiction fee schedule. An allowance has been made for a comparable service. To be used for Property and Casualty only.
P19	Procedure has a relative value of zero in the jurisdiction fee schedule, therefore no payment is due. To be used for Property and Casualty only.
P20	Service not paid under jurisdiction allowed outpatient facility fee schedule. To be used for Property and Casualty only.
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.
P22	Payment adjusted 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.

APPENDIX B

List of All Claim Adjustment Reason Codes (CARCs)

Active Codes January 1, 2017 - Present (11/1/18)

Rows in yellow indicate CARCs that have been deactivated in CY2017 or CY2018 but kept in this list to account for claims processing lag.

CARC	CARC Description
P23	Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional fee schedule adjustment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). 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.
P24	Payment adjusted based on Preferred Provider Organization (PPO). Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). 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 only. Use only with Group Code CO.
P25	Payment adjusted based on Medical Provider Network (MPN). Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). 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 only. (Use only with Group Code CO).
P26	Payment adjusted based on Voluntary Provider network (VPN). Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). 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 only. (Use only with Group Code CO).
P27	Payment denied based on the Liability Coverage Benefits jurisdictional regulations and/or payment policies. Usage: 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.
P28	Payment adjusted based on the Liability Coverage Benefits jurisdictional regulations and/or payment policies. Usage: 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.
P29	Liability Benefits jurisdictional fee schedule adjustment. Usage: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Class of Contract Code Identification Segment (Loop 2100 Other Claim Related Information REF). 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.

APPENDIX C

List of All National Council for Prescription Drug Programs (NCPDP) Reject Codes

NCPDP Code	Description
Ø1	M/I Bin Number
Ø2	M/I Version/Release Number
Ø3	M/I Transaction Code
Ø4	M/I Processor Control Number
Ø5	M/I Service Provider Number
Ø6	M/I Group ID
Ø7	M/I Cardholder ID
Ø8	M/I Person Code
Ø9	M/I Date Of Birth
1Ø	M/I Patient Gender Code
11	M/I Patient Relationship Code
12	M/I Place of Service
13	M/I Other Coverage Code
14	M/I Eligibility Clarification Code
15	M/I Date of Service
16	M/I Prescription/Service Reference Number
17	M/I Fill Number
19	M/I Days Supply
1W	Multi-Ingredient Compound Must Be A Single Transaction
1Y	Claim Segment Required For Adjudication
1Z	Clinical Segment Required For Adjudication
2C	M/I Pregnancy Indicator
2D	M/I Provider Accept Assignment Indicator
2E	M/I Primary Care Provider ID Qualifier
2G	M/I Compound Ingredient Modifier Code Count
2H	M/I Compound Ingredient Modifier Code
2J	M/I Prescriber First Name
2K	M/I Prescriber Street Address
2M	M/I Prescriber City Address
2N	M/I Prescriber State/Province Address
2P	M/I Prescriber Zip/Postal Zone
2Ø	M/I Compound Code
21	M/I Product/Service ID
22	M/I Dispense As Written (DAW)/Product Selection Code
23	M/I Ingredient Cost Submitted
25	M/I Prescriber ID
26	M/I Unit Of Measure
27	Product Identifier not FDA/NSDE Listed
28	M/I Date Prescription Written
29	M/I Number Of Refills Authorized
31	No matching paid claim found for reversal request.
32	M/I Level Of Service
33	M/I Prescription Origin Code
34	M/I Submission Clarification Code
35	M/I Primary Care Provider ID
39	M/I Diagnosis Code
4S	Compound Product ID Requires a Modifier Code
4X	M/I Patient Residence
4Y	Patient Residence Value Not Supported
4Z	Place of Service Not Supported By Plan
4Ø	Pharmacy Not Contracted With Plan On Date Of Service
41	Submit Bill To Other Processor Or Primary Payer
42	Plan's Prescriber data base indicates the Prescriber ID Submitted is inactive or expired
43	Plan's Prescriber data base indicates the associated DEA to submitted Prescriber ID is inactive
44	Plan's Prescriber data base indicates the associated DEA to submitted Prescriber ID Is not found
46	Plan's Prescriber data base indicates associated DEA to submitted Prescriber ID does not allow this drug DEA Schedule
5C	M/I Other Payer Coverage Type
5E	M/I Other Payer Reject Count
5J	M/I Facility City Address

APPENDIX C
List of All National Council for Prescription Drug Programs (NCPDP) Reject Codes

NCPDP Code	Description
5Ø	Non-Matched Pharmacy Number
51	Non-Matched Group ID
52	Non-Matched Cardholder ID
53	Non-Matched Person Code
54	Non-Matched Product/Service ID Number
55	Non-Matched Product Package Size
56	Non-Matched Prescriber ID
58	Non-Matched Primary Prescriber
6C	M/I Other Payer ID Qualifier
6D	M/I Facility Zip/Postal Zone
6E	M/I Other Payer Reject Code
6G	Coordination Of Benefits/Other Payments Segment Required For Adjudication
6J	Insurance Segment Required For Adjudication
6K	Patient Segment Required For Adjudication
6M	Pharmacy Provider Segment Required For Adjudication
6N	Prescriber Segment Required For Adjudication
6P	Pricing Segment Required For Adjudication
6Q	Prior Authorization Segment Required For Adjudication
6S	Transaction Segment Required For Adjudication
6T	Compound Segment Required For Adjudication
6U	Compound Segment Incorrectly Formatted
6V	Multi-ingredient Compounds Not Supported,
6W	DUR/PPS Segment Required For Adjudication
6X	DUR/PPS Segment Incorrectly Formatted
6Z	Provider Not Eligible To Perform Service/Dispense Product
6Ø	Product/Service Not Covered For Patient Age
61	Product/Service Not Covered For Patient Gender
62	Patient/Card Holder ID Name Mismatch
63	Product/Service ID Not Covered For Institutionalized Patient
64	Claim Submitted Does Not Match Prior Authorization
65	Patient Is Not Covered
66	Patient Age Exceeds Maximum Age
67	Filled Before Coverage Effective
68	Filled After Coverage Expired
69	Filled After Coverage Terminated
7A	Provider Does Not Match Authorization On File
7B	Service Provider ID Qualifier Value Not Supported For Processor/Payer
7C	M/I Other Payer ID
7D	Non-Matched DOB
7G	Future Date Not Allowed For DOB
7H	Non-Matched Gender Code
7J	Patient Relationship Code Value Not Supported
7K	Discrepancy Between Other Coverage Code And Other Payer Amount
7M	Discrepancy Between Other Coverage Code And Other Coverage Information On File
7N	Patient ID Qualifier Value Not Supported
7P	Coordination Of Benefits/Other Payments Count Exceeds Number of Supported Payers
7Q	Other Payer ID Qualifier Value Not Supported
7R	Other Payer Amount Paid Count Exceeds Number of Supported Groupings
7V	Duplicate Refills,
7W	Refills Exceed allowable Refills
7X	Days Supply Exceeds Plan Limitation
7Y	Compounds Not Covered,
7Z	Compound Requires Two Or More Ingredients,
7Ø	Product/Service Not Covered – Plan/Benefit Exclusion
71	Prescriber ID Is Not Covered
72	Primary Prescriber Is Not Covered
73	Refills Are Not Covered
74	Other Carrier Payment Meets Or Exceeds Payable
75	Prior Authorization Required

APPENDIX C
List of All National Council for Prescription Drug Programs (NCPDP) Reject Codes

NCPDP Code	Description
76	Plan Limitations Exceeded
77	Discontinued Product/Service ID Number
78	Cost Exceeds Maximum
79	Refill Too Soon
8A	Compound Requires At Least One Covered Ingredient
8B	Compound Segment Missing On A Compound Claim
8C	M/I Facility ID
8D	Compound Segment Present On A Non- Compound Claim
8E	M/I DUR/PPS Level Of Effort
8G	Product/Service ID (4Ø7-D7) Must Be A Single Zero "Ø" For Compounds
8H	Product/Service Only Covered On Compound Claim
8J	Incorrect Product/Service ID For Processor/Payer
8K	DAW Code Value Not Supported
8M	Sum Of Compound Ingredient Costs Does Not Equal Ingredient Cost Submitted
8N	Future Date Prescription Written Not Allowed,
8P	Date Written Different On Previous Filling
8Q	Excessive Refills Authorized
8R	Submission Clarification Code Value Not Supported
8S	Basis Of Cost Determination Value Not Supported
8T	U&C Must Be Greater Than Zero
8U	GAD Must Be Greater Than Zero
8W	Discrepancy Between Other Coverage Code and Other Payer Amount Paid
8X	Collection From Cardholder Not Allowed
8Y	Excessive Amount Collected
8Z	Product/Service ID Qualifier Value Not Supported
8Ø	Drug-Diagnosis Mismatch
81	Claim Too Old
82	Claim Is Post-Dated
83	Duplicate Paid/Captured Claim
84	Claim Has Not Been Paid/Captured
85	Claim Not Processed
86	Submit Manual Reversal
87	Reversal Not Processed
88	DUR Reject Error
89	Rejected Claim Fees Paid
9B	Reason For Service Code Value Not Supported
9C	Professional Service Code Value Not Supported
9D	Result Of Service Code Value Not Supported
9E	Quantity Does Not Match Dispensing Unit
9G	Quantity Dispensed Exceeds Maximum Allowed
9H	Quantity Not Valid For Product/Service ID Submitted
9J	Future Other Payer Date Not Allowed
9K	Compound Ingredient Component Count Exceeds Number Of Ingredients Supported
9M	Minimum Of Two Ingredients Required
9N	Compound Ingredient Quantity Exceeds Maximum Allowed
9Q	Route Of Administration Submitted Not Covered
9R	Prescription/Service Reference Number Qualifier Submitted Not Covered
9T	Prior Authorization Type Code Submitted Not Covered
9U	Provider ID Qualifier Submitted Not Covered
9V	Prescriber ID Qualifier Submitted Not Covered
9W	DUR/PPS Code Counter Exceeds Number Of Occurrences Supported
9Y	Compound Product ID Qualifier Submitted Not Covered
9Z	Duplicate Product ID In Compound
AB	Date Written Is After Date Filled
AC	Product Not Covered Non-Participating Manufacturer
AD	Billing Provider Not Eligible To Bill This Claim Type
AE	QMB (Qualified Medicare Beneficiary)- Bill Medicare
AF	Patient Enrolled Under Managed Care
AG	Days Supply Limitation For Product/Service

APPENDIX C
List of All National Council for Prescription Drug Programs (NCPDP) Reject Codes

NCPDP Code	Description
AH	Unit Dose Packaging Only Payable For Nursing Home Recipients
AJ	Generic Drug Required
AK	M/I Software Vendor/Certification ID
AM	M/I Segment Identification
AQ	M/I Facility Segment
A1	ID Submitted is associated with a Sanctioned Prescriber
A2	ID Submitted is associated to a Deceased Prescriber
A3	This Product May Be Covered Under Hospice – Medicare A
A4	This Product May Be Covered Under The Medicare- B Bundled Payment To An ESRD Dialysis Facility
A5	Not Covered Under Part D Law
A6	This Product/Service May Be Covered Under Medicare Part B
A7	M/I Internal Control Number
A9	M/I Transaction Count
BA	Compound Basis of Cost Determination Submitted Not Covered
BB	Diagnosis Code Qualifier Submitted Not Covered
BC	Future Measurement Date Not Allowed
BE	M/I Professional Service Fee Submitted
B2	M/I Service Provider ID Qualifier
CA	M/I Patient First Name
CB	M/I Patient Last Name
CC	M/I Cardholder First Name
CD	M/I Cardholder Last Name
CM	M/I Patient Street Address
CN	M/I Patient City Address
CO	M/I Patient State/Province Address
CP	M/I Patient Zip/Postal Zone
CQ	M/I Patient Phone Number
CR	M/I Carrier ID
CW	M/I Alternate ID
CX	M/I Patient ID Qualifier
CY	M/I Patient ID
CZ	M/I Employer ID
DC	M/I Dispensing Fee Submitted
DN	M/I Basis Of Cost Determination
DQ	M/I Usual And Customary Charge
DR	M/I Prescriber Last Name
DT	M/I Special Packaging Indicator
DU	M/I Gross Amount Due
DV	M/I Other Payer Amount Paid
DX	M/I Patient Paid Amount Submitted
DY	M/I Date Of Injury
DZ	M/I Claim/Reference ID
EA	M/I Originally Prescribed Product/Service Code
EB	M/I Originally Prescribed Quantity
EC	M/I Compound Ingredient Component Count
ED	M/I Compound Ingredient Quantity
EE	M/I Compound Ingredient Drug Cost
EF	M/I Compound Dosage Form Description Code
EG	M/I Compound Dispensing Unit Form Indicator
EJ	M/I Originally Prescribed Product/Service ID Qualifier
EK	M/I Scheduled Prescription ID Number
EM	M/I Prescription/Service Reference Number Qualifier
EN	M/I Associated Prescription/Service Reference Number
EP	M/I Associated Prescription/Service Date
ER	M/I Procedure Modifier Code
ET	M/I Quantity Prescribed
EU	M/I Prior Authorization Type Code
EV	M/I Prior Authorization Number Submitted
EY	M/I Provider ID Qualifier

APPENDIX C
List of All National Council for Prescription Drug Programs (NCPDP) Reject Codes

NCPDP Code	Description
EZ	M/I Prescriber ID Qualifier
E1	M/I Product/Service ID Qualifier
E2	M/I Route of Administration
E3	M/I Incentive Amount Submitted
E4	M/I Reason For Service Code
E5	M/I Professional Service Code
E6	M/I Result Of Service Code
E7	M/I Quantity Dispensed
E8	M/I Other Payer Date
E9	M/I Provider ID
FO	M/I Plan ID
GE	M/I Percentage Sales Tax Amount Submitted
G1	M/I Compound Type
G4	Physician must contact plan
G5	Pharmacist must contact plan
G6	Pharmacy Not Contracted in Specialty Network
G7	Pharmacy Not Contracted in Home Infusion Network
G8	Pharmacy Not Contracted in Long Term Care Network
G9	Pharmacy Not Contracted in 9Ø Day Retail Network (this message would be used when the pharmacy is not contracted to provide a 9Ø days supply of drugs)
HA	M/I Flat Sales Tax Amount Submitted
HB	M/I Other Payer Amount Paid Count
HC	M/I Other Payer Amount Paid Qualifier
HD	M/I Dispensing Status
HE	M/I Percentage Sales Tax Rate Submitted
H6	M/I DUR Co-Agent ID
H7	M/I Other Amount Claimed Submitted Count
H8	M/I Other Amount Claimed Submitted Qualifier
H9	M/I Other Amount Claimed Submitted
JE	M/I Percentage Sales Tax Basis Submitted
M1	Patient Not Covered In This Aid Category
M2	Recipient Locked In
M4	Prescription/Service Reference Number/Time Limit Exceeded
MG	M/I Other Payer BIN Number
MH	M/I Other Payer Processor Control Number
MJ	M/I Other Payer Group ID
MK	Non-Matched Other Payer BIN Number
MM	Non-Matched Other Payer Processor Control Number
MN	Non-Matched Other Payer Group ID
MP	Other Payer Cardholder ID Not Covered
MR	Product Not On Formulary
MT	M/I Patient Assignment Indicator (Direct Member Reimbursement Indicator)
NN	Transaction Rejected At Switch Or Intermediary
NP	M/I Other Payer- Patient Responsibility Amount Qualifier
NQ	M/I Other Payer- Patient Responsibility Amount
NR	M/I Other Payer- Patient Responsibility Amount Count
NU	M/I Other Payer Cardholder ID
NV	M/I Delay Reason Code
NX	M/I Submission Clarification Code Count
N1	No patient match found.
N3	M/I Medicaid Paid Amount
N4	M/I Medicaid Subrogation Internal Control Number/Transaction Control Number (ICN/TCN)
N5	M/I Medicaid ID Number
N7	Use Prior Authorization Code Provided During Transition Period
N8	Use Prior Authorization Code Provided For Emergency Fill
N9	Use Prior Authorization Code Provided For Level of Care Change
PA	PA Exhausted/Not Renewable
PY	Non-Matched Unit Form/Route of Administration
PZ	Non-Matched Unit Of Measure To Product/Service ID

APPENDIX C
List of All National Council for Prescription Drug Programs (NCPDP) Reject Codes

NCPDP Code	Description
PØ	Non-zero Value Required for Vaccine Administration
P3	Compound Ingredient Component Count Does Not Match Number Of Repetitions
P4	Coordination Of Benefits/Other Payments Count Does Not Match Number Of Repetitions
P6	Date Of Service Prior To Date Of Birth
RE	M/I Compound Product ID Qualifier
RK	Partial Fill Transaction Not Supported
RV	Multiple Reversals Per Transmission Not Supported
RØ	Professional Service Code of "MA" required for Vaccine Incentive Fee Submitted
SF	Other Payer Amount Paid Count Does Not Match Number Of Repetitions
SG	Submission Clarification Code Count Does Not Match Number of Repetitions
SH	Other Payer-Patient Responsibility Amount Count Does Not Match Number of Repetitions
TE	Missing/Invalid Compound Product ID
TN	Emergency Fill/Resubmit Claim
TP	Level of Care Change/Resubmit Claim
TQ	Dosage Exceeds Product Labeling Limit
TR	M/I Billing Entity Type Indicator
TS	M/I Pay To Qualifier
TT	M/I Pay To ID
TU	M/I Pay To Name
TV	M/I Pay To Street Address
TW	M/I Pay To City Address
TX	M/I Pay to State/ Province Address
TY	M/I Pay To Zip/Postal Zone
TZ	M/I Generic Equivalent Product ID Qualifier
UA	M/I Generic Equivalent Product ID
UE	M/I Compound Ingredient Basis Of Cost Determination
UU	DAW Ø cannot be submitted on a multi- source drug with available generics.
U7	M/I Pharmacy Service Type
VA	Pay To Qualifier Value Not Supported
VB	Generic Equivalent Product ID Qualifier Value Not Supported
VC	Pharmacy Service Type Value Not Supported
VE	M/I Diagnosis Code Count
WE	M/I Diagnosis Code Qualifier
X8	Procedure Modifier Code Count Exceeds Number Of Occurrences Supported
X9	Diagnosis Code Count Exceeds Number Of Occurrences Supported
YA	Compound Ingredient Modifier Code Count Exceeds Number Of Occurrences Supported
YB	Other Amount Claimed Submitted Count Exceeds Number Of Occurrences Supported
YC	Other Payer Reject Count Exceeds Number Of Occurrences Supported
YD	Other Payer-Patient Responsibility Amount Count Exceeds Number Of Occurrences Supported
YE	Submission Clarification Code Count Exceeds Number of Occurrences Supported
YJ	Medicaid Agency Number Not Supported
YK	M/I Service Provider Name
YM	M/I Service Provider Street Address
YN	M/I Service Provider City Address
YP	M/I Service Provider State/Province Code Address
YQ	M/I Service Provider Zip/Postal Code
Z1	Prescriber Alternate ID Qualifier Value Not Supported
Z5	M/I Service Provider Segment
Z9	Prescriber Alternate ID Not Covered
ZA	The Coordination of Benefits/Other Payments Segment is mandatory to a downstream payer.
ZK	M/I Prescriber ID Associated State/Province Address
ZW	M/I Compound Preparation Time
ZZ	Cardholder ID submitted is inactive. New Cardholder ID on file.

APPENDIX D

Detailed Information for Exhibits Shown in Sections III and IV of the Report

Exhibit III.1
Claim Accepted and Rejected Rate
All Claim Types
By MCO and By Quarter

	Number Accepted	Number Rejected	Accepted	Rejected
All MCOs Q1 2018	23,234,037	104,951	99.6%	0.4%
All MCOs Q2 2018	22,498,079	102,126	99.5%	0.5%
All MCOs Q3 2018	21,939,614	131,617	99.4%	0.6%
All MCOs Q4 2018	0	0	0.0%	0.0%
Aetna Q1 2018	1,195,835	3,161	99.7%	0.3%
Aetna Q2 2018	1,235,697	4,149	99.7%	0.3%
Aetna Q3 2018	1,241,785	2,586	99.8%	0.2%
Aetna Q4 2018	0	0	0.0%	0.0%
ACLA Q1 2018	3,092,323	11,720	99.6%	0.4%
ACLA Q2 2018	3,017,999	6,766	99.8%	0.2%
ACLA Q3 2018	2,998,710	40,019	98.7%	1.3%
ACLA Q4 2018	0	0	0.0%	0.0%
Healthy Blue Q1 2018	5,145,488	1,311	100.0%	0.0%
Healthy Blue Q2 2018	3,960,342	2,848	99.9%	0.1%
Healthy Blue Q3 2018	4,068,357	1,622	100.0%	0.0%
Healthy Blue Q4 2018	0	0	0.0%	0.0%
LHCC Q1 2018	6,779,964	69,813	99.0%	1.0%
LHCC Q2 2018	6,669,222	59,956	99.1%	0.9%
LHCC Q3 2018	6,719,466	69,097	99.0%	1.0%
LHCC Q4 2018	0	0	0.0%	0.0%
UHC Q1 2018	7,020,427	18,946	99.7%	0.3%
UHC Q2 2018	7,614,819	28,407	99.6%	0.4%
UHC Q3 2018	6,911,296	18,293	99.7%	0.3%
UHC Q4 2018	0	0	0.0%	0.0%

Exhibit III.2
Claim Status for Adjudicated Claims
All Claim Types
By MCO and By Quarter

	Number Paid	Number Denied	Paid	Denied
All MCOs Q1 2018	19,211,164	4,015,902	82.7%	17.3%
All MCOs Q2 2018	18,761,883	3,848,213	83.0%	17.0%
All MCOs Q3 2018	17,735,342	3,998,349	81.6%	18.4%
All MCOs Q4 2018	0	0	0.0%	0.0%
Aetna Q1 2018	1,010,025	184,990	84.5%	15.5%
Aetna Q2 2018	1,057,434	178,476	85.6%	14.4%
Aetna Q3 2018	1,061,443	178,944	85.6%	14.4%
Aetna Q4 2018	0	0	0.0%	0.0%
ACLA Q1 2018	2,473,581	603,484	80.4%	19.6%
ACLA Q2 2018	2,532,447	518,838	83.0%	17.0%
ACLA Q3 2018	2,442,398	524,053	82.3%	17.7%
ACLA Q4 2018	0	0	0.0%	0.0%
Healthy Blue Q1 2018	4,336,499	821,447	84.1%	15.9%
Healthy Blue Q2 2018	3,206,084	768,422	80.7%	19.3%
Healthy Blue Q3 2018	3,208,955	834,543	79.4%	20.6%
Healthy Blue Q4 2018	0	0	0.0%	0.0%
LHCC Q1 2018	5,594,373	1,240,586	81.8%	18.2%
LHCC Q2 2018	5,498,368	1,251,681	81.5%	18.5%
LHCC Q3 2018	5,313,035	1,287,935	80.5%	19.5%
LHCC Q4 2018	0	0	0.0%	0.0%
UHC Q1 2018	5,796,686	1,165,395	83.3%	16.7%
UHC Q2 2018	6,467,550	1,130,796	85.1%	14.9%
UHC Q3 2018	5,709,511	1,172,874	83.0%	17.0%
UHC Q4 2018	0	0	0.0%	0.0%

Exhibit III.3A
Claim Status for Adjudicated Claims
Institutional Providers
For All MCOs Combined By Quarter

	Number Paid	Number Denied	Paid	Denied
Inpatient Hospital Q1 2018	46,418	14,145	76.6%	23.4%
Inpatient Hospital Q2 2018	45,421	13,480	77.1%	22.9%
Inpatient Hospital Q3 2018	44,222	13,017	77.3%	22.7%
Inpatient Hospital Q4 2018	0	0	0.0%	0.0%
Outpatient Hospital Q1 2018	4,358,067	463,655	90.4%	9.6%
Outpatient Hospital Q2 2018	4,310,748	452,716	90.5%	9.5%
Outpatient Hospital Q3 2018	4,152,508	436,877	90.5%	9.5%
Outpatient Hospital Q4 2018	0	0	0.0%	0.0%
Home Health Q1 2018	30,276	9,360	76.4%	23.6%
Home Health Q2 2018	30,896	7,378	80.7%	19.3%
Home Health Q3 2018	32,933	6,539	83.4%	16.6%
Home Health Q4 2018	0	0	0.0%	0.0%
Other Institutional Q1 2018	192,020	29,700	86.6%	13.4%
Other Institutional Q2 2018	195,362	26,169	88.2%	11.8%
Other Institutional Q3 2018	205,274	25,424	89.0%	11.0%
Other Institutional Q4 2018	0	0	0.0%	0.0%

Exhibit III.3B
Claim Status for Adjudicated Claims
Professional Service Providers
For All MCOs Combined By Quarter

	Number Paid	Number Denied	Paid	Denied
Primary Care Q1 2018	1,457,734	169,392	89.6%	10.4%
Primary Care Q2 2018	1,471,101	162,817	90.0%	10.0%
Primary Care Q3 2018	1,500,880	168,080	89.9%	10.1%
Primary Care Q4 2018	0	0	0.0%	0.0%
Pediatrics Q1 2018	638,496	65,847	90.7%	9.3%
Pediatrics Q2 2018	599,716	62,812	90.5%	9.5%
Pediatrics Q3 2018	665,908	77,814	89.5%	10.5%
Pediatrics Q4 2018	0	0	0.0%	0.0%
OB-GYN Q1 2018	194,770	27,521	87.6%	12.4%
OB-GYN Q2 2018	201,004	25,158	88.9%	11.1%
OB-GYN Q3 2018	206,443	27,261	88.3%	11.7%
OB-GYN Q4 2018	0	0	0.0%	0.0%
Therapists (PT/OT/ST) Q1 2018	31,405	3,890	89.0%	11.0%
Therapists (PT/OT/ST) Q2 2018	41,416	5,695	87.9%	12.1%
Therapists (PT/OT/ST) Q3 2018	44,671	7,106	86.3%	13.7%
Therapists (PT/OT/ST) Q4 2018	0	0	0.0%	0.0%
Non-Emerg Transport Q1 2018	201,557	8,795	95.8%	4.2%
Non-Emerg Transport Q2 2018	259,271	14,155	94.8%	5.2%
Non-Emerg Transport Q3 2018	274,775	14,247	95.1%	4.9%
Non-Emerg Transport Q4 2018	0	0	0.0%	0.0%
Medical Equipment/Supplies Q1 2018	123,225	24,236	83.6%	16.4%
Medical Equipment/Supplies Q2 2018	122,195	22,579	84.4%	15.6%
Medical Equipment/Supplies Q3 2018	114,092	22,383	83.6%	16.4%
Medical Equipment/Supplies Q4 2018	0	0	0.0%	0.0%
All Other Professional Q1 2018	4,449,661	1,014,079	81.4%	18.6%
All Other Professional Q2 2018	4,386,492	900,634	83.0%	17.0%
All Other Professional Q3 2018	4,177,732	978,490	81.0%	19.0%
All Other Professional Q4 2018	0	0	0.0%	0.0%

Exhibit III.3C
Claim Status for Adjudicated Claims
Behavioral Health, Dental and Pharmacy
For All MCOs Combined By Quarter

	Number Paid	Number Denied	Paid	Denied
Mental/Behavioral Rehab Q1 2018	537,511	81,196	86.9%	13.1%
Mental/Behavioral Rehab Q2 2018	566,187	65,548	89.6%	10.4%
Mental/Behavioral Rehab Q3 2018	503,971	71,654	87.6%	12.4%
Mental/Behavioral Rehab Q4 2018	0	0	0.0%	0.0%
Mental/Behavioral Other Q1 2018	285,831	49,521	85.2%	14.8%
Mental/Behavioral Other Q2 2018	312,270	54,017	85.3%	14.7%
Mental/Behavioral Other Q3 2018	334,663	56,943	85.5%	14.5%
Mental/Behavioral Other Q4 2018	0	0	0.0%	0.0%
Dental - Children Q1 2018	789,348	70,171	92.5%	8.2%
Dental - Children Q2 2018	758,779	71,444	91.8%	8.6%
Dental - Children Q3 2018	834,027	71,364	91.7%	7.9%
Dental - Children Q4 2018	0	0	0.0%	0.0%
Dental - Adults Q1 2018	137,542	28,320	73.5%	17.1%
Dental - Adults Q2 2018	138,719	30,295	72.0%	17.9%
Dental - Adults Q3 2018	126,958	28,846	69.0%	18.5%
Dental - Adults Q4 2018	0	0	0.0%	0.0%
Pharmacy Q1 2018	6,534,444	2,030,033	76.3%	23.7%
Pharmacy Q2 2018	6,089,605	2,008,226	75.2%	24.8%
Pharmacy Q3 2018	5,357,820	2,066,791	72.2%	27.8%
Pharmacy Q4 2018	0	0	0.0%	0.0%

Exhibit III.4A - Q1
Claim Status for Adjudicated Claims
By Provider Specialty - Institutional Providers
For All MCOs by Quarter, for Adjudicated Claims

Inpatient	Q1			
	Number Paid	Number Denied	Paid	Denied
All MCOs	46,418	14,145	76.6%	23.4%
Aetna	5,753	1,680	77.4%	22.6%
ACLA	7,276	2,526	74.2%	25.8%
Healthy Blue	8,345	3,090	73.0%	27.0%
LHCC	16,625	3,856	81.2%	18.8%
UHC	8,419	2,993	73.8%	26.2%

Outpatient	Q1			
	Number Paid	Number Denied	Paid	Denied
All MCOs	4,358,067	463,655	90.4%	9.6%
Aetna	261,367	21,788	92.3%	7.7%
ACLA	627,114	81,812	88.5%	11.5%
Healthy Blue	788,527	75,704	91.2%	8.8%
LHCC	1,312,083	165,246	88.8%	11.2%
UHC	1,368,976	119,105	92.0%	8.0%

Home Health	Q1			
	Number Paid	Number Denied	Paid	Denied
All MCOs	30,276	9,360	76.4%	23.6%
Aetna	2,384	786	75.2%	24.8%
ACLA	4,400	2,983	59.6%	40.4%
Healthy Blue	5,850	630	90.3%	9.7%
LHCC	17,147	4,772	78.2%	21.8%
UHC	495	189	72.4%	27.6%

Other Institutional Providers	Q1			
	Number Paid	Number Denied	Paid	Denied
All MCOs	192,020	29,700	86.6%	13.4%
Aetna	160,231	15,590	91.1%	8.9%
ACLA	114	6,811	1.6%	98.4%
Healthy Blue	22,762	4,087	84.8%	15.2%
LHCC	2,551	2,110	54.7%	45.3%
UHC	6,362	1,102	85.2%	14.8%

Exhibit III.4A - Q2
Claim Status for Adjudicated Claims
By Provider Specialty - Institutional Providers
For All MCOs by Quarter, for Adjudicated Claims

Inpatient	**Q2**			
	Number Paid	**Number Denied**	**Paid**	**Denied**
All MCOs	45,421	13,480	77.1%	22.9%
Aetna	5,381	1,466	78.6%	21.4%
ACLA	7,233	2,097	77.5%	22.5%
Healthy Blue	8,570	3,172	73.0%	27.0%
LHCC	15,737	4,036	79.6%	20.4%
UHC	8,500	2,709	75.8%	24.2%

Outpatient	**Q2**			
	Number Paid	**Number Denied**	**Paid**	**Denied**
All MCOs	4,310,748	452,716	90.5%	9.5%
Aetna	255,783	17,361	93.6%	6.4%
ACLA	624,377	70,148	89.9%	10.1%
Healthy Blue	772,955	68,826	91.8%	8.2%
LHCC	1,281,473	181,685	87.6%	12.4%
UHC	1,376,160	114,696	92.3%	7.7%

Home Health	**Q2**			
	Number Paid	**Number Denied**	**Paid**	**Denied**
All MCOs	30,896	7,378	80.7%	19.3%
Aetna	2,225	425	84.0%	16.0%
ACLA	4,702	2,168	68.4%	31.6%
Healthy Blue	6,318	567	91.8%	8.2%
LHCC	17,170	3,998	81.1%	18.9%
UHC	481	220	68.6%	31.4%

Other Institutional Providers	**Q2**			
	Number Paid	**Number Denied**	**Paid**	**Denied**
All MCOs	195,362	26,169	88.2%	11.8%
Aetna	158,306	15,200	91.2%	8.8%
ACLA	140	1,535	8.4%	91.6%
Healthy Blue	27,503	4,713	85.4%	14.6%
LHCC	2,766	3,002	48.0%	52.0%
UHC	6,647	1,719	79.5%	20.5%

Exhibit III.4A - Q3
Claim Status for Adjudicated Claims
By Provider Specialty - Institutional Providers
For All MCOs by Quarter, for Adjudicated Claims

Inpatient	**Q3**			
	Number Paid	**Number Denied**	**Paid**	**Denied**
All MCOs	44,222	13,017	77.1%	22.9%
Aetna	5,344	1,323	78.6%	21.4%
ACLA	6,785	1,923	77.5%	22.5%
Healthy Blue	8,604	3,373	73.0%	27.0%
LHCC	15,628	4,170	79.6%	20.4%
UHC	7,861	2,228	75.8%	24.2%

Outpatient	**Q3**			
	Number Paid	**Number Denied**	**Paid**	**Denied**
All MCOs	4,152,508	436,877	90.5%	9.5%
Aetna	250,427	16,092	93.6%	6.4%
ACLA	613,643	69,765	89.9%	10.1%
Healthy Blue	772,238	64,687	91.8%	8.2%
LHCC	1,209,725	177,440	87.6%	12.4%
UHC	1,306,475	108,893	92.3%	7.7%

Home Health	**Q3**			
	Number Paid	**Number Denied**	**Paid**	**Denied**
All MCOs	32,933	6,539	80.7%	19.3%
Aetna	2,136	641	84.0%	16.0%
ACLA	5,393	1,657	68.4%	31.6%
Healthy Blue	5,097	630	91.8%	8.2%
LHCC	19,873	3,534	81.1%	18.9%
UHC	434	77	68.6%	31.4%

Other Institutional Providers	**Q3**			
	Number Paid	**Number Denied**	**Paid**	**Denied**
All MCOs	205,274	25,424	88.2%	11.8%
Aetna	162,523	17,295	91.2%	8.8%
ACLA	140	847	8.4%	91.6%
Healthy Blue	34,354	4,152	85.4%	14.6%
LHCC	2,186	2,034	48.0%	52.0%
UHC	6,071	1,096	79.5%	20.5%

Exhibit III.4B - Q1
Claim Status for Adjudicated Claims
By Provider Specialty - Professional Service Providers
For All MCOs by Quarter, for Adjudicated Claims

Primary Care	**Q1**			
	Number Paid	**Number Denied**	**Paid**	**Denied**
All MCOs	1,456,289	169,392	89.6%	10.4%
Aetna	102	155	90.9%	9.1%
ACLA	132,084	21,721	85.9%	14.1%
Healthy Blue	312,806	39,043	88.9%	11.1%
LHCC	294,931	42,171	87.5%	12.5%
UHC	716,366	66,302	91.5%	8.5%

Pediatrics	**Q1**			
	Number Paid	**Number Denied**	**Paid**	**Denied**
All MCOs	638,496	65,847	90.7%	9.3%
Aetna	766	32	96.0%	4.0%
ACLA	139,681	15,027	90.3%	9.7%
Healthy Blue	194,333	18,593	91.3%	8.7%
LHCC	140,639	16,037	89.8%	10.2%
UHC	163,077	16,158	91.0%	9.0%

OB-GYN	**Q1**			
	Number Paid	**Number Denied**	**Paid**	**Denied**
All MCOs	194,770	27,521	87.6%	12.4%
Aetna	102	12	89.5%	10.5%
ACLA	42,139	7,901	84.2%	15.8%
Healthy Blue	61,280	10,512	85.4%	14.6%
LHCC	57,433	6,384	90.0%	10.0%
UHC	33,816	2,712	92.6%	7.4%

Therapists (Physical, Occupational, Speech)	**Q1**			
	Number Paid	**Number Denied**	**Paid**	**Denied**
All MCOs	31,405	3,890	89.0%	11.0%
Aetna	8	108	6.9%	93.1%
ACLA	4,555	885	83.7%	16.3%
Healthy Blue	8,472	1,193	87.7%	12.3%
LHCC	6,916	591	92.1%	7.9%
UHC	11,454	1,113	91.1%	8.9%

Exhibit III.4B - Q1
Claim Status for Adjudicated Claims
By Provider Specialty - Professional Service Providers
For All MCOs by Quarter, for Adjudicated Claims

Non-Emergency Medical Transportation	Q1			
	Number Paid	Number Denied	Paid	Denied
All MCOs	201,557	8,795	95.8%	4.2%
Aetna	737	41	94.7%	5.3%
ACLA	37,226	592	98.4%	1.6%
Healthy Blue	46,190	5,868	88.7%	11.3%
LHCC	108,487	771	99.3%	0.7%
UHC	8,917	1,523	85.4%	14.6%

Medical Equipment & Supplies	Q1			
	Number Paid	Number Denied	Paid	Denied
All MCOs	123,225	24,236	83.6%	16.4%
Aetna	28,791	6,084	82.6%	17.4%
ACLA	17,261	5,238	76.7%	23.3%
Healthy Blue	777	298	72.3%	27.7%
LHCC	31,947	5,653	85.0%	15.0%
UHC	44,449	6,963	86.5%	13.5%

All Other Professional Services exc. BH and Dental	Q1			
	Number Paid	Number Denied	Paid	Denied
All MCOs	4,449,661	1,014,079	81.4%	18.6%
Aetna	72,666	16,892	81.1%	18.9%
ACLA	611,703	182,110	77.1%	22.9%
Healthy Blue	530,376	123,828	81.1%	18.9%
LHCC	2,067,826	420,369	83.1%	16.9%
UHC	1,167,090	270,880	81.2%	18.8%

Exhibit III.4B - Q2
Claim Status for Adjudicated Claims
By Provider Specialty - Professional Service Providers
For All MCOs by Quarter, for Adjudicated Claims

Primary Care	**Q2**			
	Number Paid	**Number Denied**	**Paid**	**Denied**
All MCOs	1,471,101	162,817	90.0%	10.0%
Aetna	1,150	79	93.6%	6.4%
ACLA	125,646	17,096	88.0%	12.0%
Healthy Blue	305,873	35,962	89.5%	10.5%
LHCC	359,089	51,583	87.4%	12.6%
UHC	679,343	58,097	92.1%	7.9%

Pediatrics	**Q2**			
	Number Paid	**Number Denied**	**Paid**	**Denied**
All MCOs	599,716	62,812	90.5%	9.5%
Aetna	585	65	90.0%	10.0%
ACLA	118,473	10,832	91.6%	8.4%
Healthy Blue	162,294	16,890	90.6%	9.4%
LHCC	180,698	20,730	89.7%	10.3%
UHC	137,666	14,295	90.6%	9.4%

OB-GYN	**Q2**			
	Number Paid	**Number Denied**	**Paid**	**Denied**
All MCOs	201,004	25,158	88.9%	11.1%
Aetna	86	6	93.5%	6.5%
ACLA	43,309	6,231	87.4%	12.6%
Healthy Blue	62,416	8,933	87.5%	12.5%
LHCC	61,439	7,253	89.4%	10.6%
UHC	33,754	2,735	92.5%	7.5%

Therapists (Physical, Occupational, Speech)	**Q2**			
	Number Paid	**Number Denied**	**Paid**	**Denied**
All MCOs	41,416	5,695	87.9%	12.1%
Aetna	318	301	51.4%	48.6%
ACLA	5,494	1,144	82.8%	17.2%
Healthy Blue	10,217	1,945	84.0%	16.0%
LHCC	8,847	767	92.0%	8.0%
UHC	16,540	1,538	91.5%	8.5%

Exhibit III.4B - Q2
Claim Status for Adjudicated Claims
By Provider Specialty - Professional Service Providers
For All MCOs by Quarter, for Adjudicated Claims

Non-Emergency Medical Transportation	Q2			
	Number Paid	Number Denied	Paid	Denied
All MCOs	259,271	14,155	94.8%	5.2%
Aetna	46,933	508	98.9%	1.1%
ACLA	52,364	5,269	90.9%	9.1%
Healthy Blue	48,386	5,808	89.3%	10.7%
LHCC	101,889	1,075	99.0%	1.0%
UHC	9,699	1,495	86.6%	13.4%

Medical Equipment & Supplies	Q2			
	Number Paid	Number Denied	Paid	Denied
All MCOs	122,195	22,579	84.4%	15.6%
Aetna	27,747	5,070	84.6%	15.4%
ACLA	17,060	4,099	80.6%	19.4%
Healthy Blue	1,016	433	70.1%	29.9%
LHCC	33,326	6,418	83.9%	16.1%
UHC	43,046	6,559	86.8%	13.2%

All Other Professional Services exc. BH and Dental	Q2			
	Number Paid	Number Denied	Paid	Denied
All MCOs	4,386,492	900,634	83.0%	17.0%
Aetna	71,790	15,007	82.7%	17.3%
ACLA	682,149	143,261	82.6%	17.4%
Healthy Blue	578,666	93,309	86.1%	13.9%
LHCC	1,819,434	407,399	81.7%	18.3%
UHC	1,234,453	241,658	83.6%	16.4%

Exhibit III.4B - Q3
Claim Status for Adjudicated Claims
By Provider Specialty - Professional Service Providers
For All MCOs by Quarter, for Adjudicated Claims

Primary Care	**Q3**			
	Number Paid	**Number Denied**	**Paid**	**Denied**
All MCOs	1,500,880	168,080	89.9%	10.1%
Aetna	1,311	59	95.7%	4.3%
ACLA	122,440	18,863	86.7%	13.3%
Healthy Blue	308,945	38,312	89.0%	11.0%
LHCC	408,760	50,051	89.1%	10.9%
UHC	659,424	60,795	91.6%	8.4%

Pediatrics	**Q3**			
	Number Paid	**Number Denied**	**Paid**	**Denied**
All MCOs	665,908	77,814	89.5%	10.5%
Aetna	376	21	94.7%	5.3%
ACLA	119,598	8,828	93.1%	6.9%
Healthy Blue	174,877	21,716	89.0%	11.0%
LHCC	220,612	23,047	90.5%	9.5%
UHC	150,445	24,202	86.1%	13.9%

OB-GYN	**Q3**			
	Number Paid	**Number Denied**	**Paid**	**Denied**
All MCOs	206,443	27,261	88.3%	11.7%
Aetna	115	3	97.5%	2.5%
ACLA	40,082	7,725	83.8%	16.2%
Healthy Blue	64,867	8,665	88.2%	11.8%
LHCC	67,386	8,244	89.1%	10.9%
UHC	33,993	2,624	92.8%	7.2%

Therapists (Physical, Occupational, Speech)	**Q3**			
	Number Paid	**Number Denied**	**Paid**	**Denied**
All MCOs	44,671	7,106	86.3%	13.7%
Aetna	715	338	67.9%	32.1%
ACLA	6,147	1,391	81.5%	18.5%
Healthy Blue	10,411	2,685	79.5%	20.5%
LHCC	11,023	1,547	87.7%	12.3%
UHC	16,375	1,145	93.5%	6.5%

Exhibit III.4B - Q3
Claim Status for Adjudicated Claims
By Provider Specialty - Professional Service Providers
For All MCOs by Quarter, for Adjudicated Claims

Non-Emergency Medical Transportation	Q3			
	Number Paid	Number Denied	Paid	Denied
All MCOs	274,775	14,247	95.1%	4.9%
Aetna	47,210	785	98.4%	1.6%
ACLA	54,784	5,084	91.5%	8.5%
Healthy Blue	57,553	4,654	92.5%	7.5%
LHCC	104,580	1,278	98.8%	1.2%
UHC	10,648	2,446	81.3%	18.7%

Medical Equipment & Supplies	Q3			
	Number Paid	Number Denied	Paid	Denied
All MCOs	114,092	22,383	83.6%	16.4%
Aetna	27,389	6,181	81.6%	18.4%
ACLA	15,756	3,679	81.1%	18.9%
Healthy Blue	1,077	387	73.6%	26.4%
LHCC	30,252	6,236	82.9%	17.1%
UHC	39,618	5,900	87.0%	13.0%

All Other Professional Services exc. BH and Dental	Q3			
	Number Paid	Number Denied	Paid	Denied
All MCOs	4,177,732	978,490	81.0%	19.0%
Aetna	70,368	12,498	84.9%	15.1%
ACLA	631,631	138,720	82.0%	18.0%
Healthy Blue	586,375	124,478	82.5%	17.5%
LHCC	1,611,000	447,906	78.2%	21.8%
UHC	1,278,358	254,888	83.4%	16.6%

Exhibit III.4C - Q1
Claim Status for Adjudicated Claims
By Provider Specialty - Behavioral Health, Dental and Pharmacy
For All MCOs by Quarter, for Adjudicated Claims

Mental/Behavioral Health - Rehab	Q1			
	Number Paid	Number Denied	Paid	Denied
All MCOs	537,511	81,216	86.9%	13.1%
Aetna	360	166	71.1%	28.9%
ACLA	137,729	23,928	85.2%	14.8%
Healthy Blue	137,319	15,127	90.1%	9.9%
LHCC	72,991	8,577	89.5%	10.5%
UHC	189,112	33,418	85.0%	15.0%

Mental/Behavioral Health - Other	Q1			
	Number Paid	Number Denied	Paid	Denied
All MCOs	285,831	49,521	85.2%	14.8%
Aetna	6	2	75.0%	25.0%
ACLA	31,083	4,584	87.1%	12.9%
Healthy Blue	105,061	19,724	84.2%	15.8%
LHCC	78,407	14,293	84.6%	15.4%
UHC	71,274	10,918	86.7%	13.3%

Pharmacy	Q1			
	Number Paid	Number Denied	Paid	Denied
All MCOs	5,858,441	2,030,033	76.3%	23.7%
Aetna	463,299	117,528	79.8%	20.2%
ACLA	0	246,558	73.3%	26.7%
Healthy Blue	2,093,544	493,690	80.9%	19.1%
LHCC	1,358,265	540,238	71.5%	28.5%
UHC	1,943,333	632,019	75.5%	24.5%

Dental (MCNA is the only MCO)	Q1			
	Number Paid	Number Denied	Paid	Denied
Dental - Children	789,273	70,171	91.8%	8.2%
Dental - Adults	7,868	3,788	82.9%	17.1%

Exhibit III.4C - Q2
Claim Status for Adjudicated Claims
By Provider Specialty - Behavioral Health, Dental and Pharmacy
For All MCOs by Quarter, for Adjudicated Claims

Mental/Behavioral Health - Rehab	Q2			
	Number Paid	Number Denied	Paid	Denied
All MCOs	566,187	65,548	89.6%	10.4%
Aetna	472	182	72.2%	27.8%
ACLA	146,418	12,824	91.9%	8.1%
Healthy Blue	135,964	19,172	87.6%	12.4%
LHCC	88,226	9,410	90.4%	9.6%
UHC	195,107	23,960	89.1%	10.9%

Mental/Behavioral Health - Other	Q2			
	Number Paid	Number Denied	Paid	Denied
All MCOs	312,270	54,017	85.3%	14.7%
Aetna	3	5	37.5%	62.5%
ACLA	29,542	3,460	89.5%	10.5%
Healthy Blue	123,320	21,467	85.2%	14.8%
LHCC	86,603	13,394	86.6%	13.4%
UHC	72,802	15,691	82.3%	17.7%

Pharmacy	Q2			
	Number Paid	Number Denied	Paid	Denied
All MCOs	5,420,990	2,008,226	75.2%	24.8%
Aetna	475,356	117,430	80.2%	19.8%
ACLA	0	236,286	73.9%	26.1%
Healthy Blue	941,673	476,696	66.4%	33.6%
LHCC	1,415,771	532,390	72.7%	27.3%
UHC	2,588,190	645,424	80.0%	20.0%

Dental (MCNA is the only MCO)	Q2			
	Number Paid	Number Denied	Paid	Denied
Dental - Children	758,709	71,444	91.4%	8.6%
Dental - Adults	8,590	3,466	82.1%	17.9%

Exhibit III.4C - Q3
Claim Status for Adjudicated Claims
By Provider Specialty - Behavioral Health, Dental and Pharmacy
For All MCOs by Quarter, for Adjudicated Claims

Mental/Behavioral Health - Rehab	Q3			
	Number Paid	Number Denied	Paid	Denied
All MCOs	503,971	71,654	87.6%	12.4%
Aetna	360	148	70.9%	29.1%
ACLA	120,079	12,056	90.9%	9.1%
Healthy Blue	128,632	24,423	84.0%	16.0%
LHCC	74,985	8,726	89.6%	10.4%
UHC	179,915	26,301	87.2%	12.8%

Mental/Behavioral Health - Other	Q3			
	Number Paid	Number Denied	Paid	Denied
All MCOs	334,663	56,943	85.5%	14.5%
Aetna	1	4	20.0%	80.0%
ACLA	31,364	3,310	90.5%	9.5%
Healthy Blue	120,225	23,534	83.6%	16.4%
LHCC	98,912	18,940	83.9%	16.1%
UHC	84,161	11,155	88.3%	11.7%

Pharmacy	Q3			
	Number Paid	Number Denied	Paid	Denied
All MCOs	5,357,820	2,066,791	72.2%	27.8%
Aetna	482,718	118,304	80.3%	19.7%
ACLA	668,087	247,802	72.9%	27.1%
Healthy Blue	915,105	501,999	64.6%	35.4%
LHCC	1,415,531	527,562	72.8%	27.2%
UHC	1,876,379	671,124	73.7%	26.3%

Dental (MCNA is the only MCO)	Q3			
	Number Paid	Number Denied	Paid	Denied
Dental - Children	833,937	71,364	92.1%	7.9%
Dental - Adults	7,598	3,123	81.5%	18.5%

Exhibit III.5
Value of Paid and Denied Claims
By MCO for Q1, Q2 and Q3 2018 Adjudicated Claims

	Number Paid	Number Denied	Value of Paid Claims	Value of Denied Claims
All MCOs Q1	20,310,348	4,090,301	$1,470,530,317	$339,105,898
All MCOs Q2	19,529,182	3,923,123	$1,531,538,834	$335,726,160
All MCOs Q3	18,576,877	4,072,836	$1,492,999,951	$357,167,179
All MCOs Q4				

Quarter 1

	Number Paid	Number Denied	Value of Paid Claims	Value of Denied Claims
Aetna	1,312,068	185,430	$193,044,485	$34,125,935
ACLA	2,473,581	603,484	$186,770,125	$59,017,080
Healthy Blue	4,336,499	821,447	$229,246,499	$50,327,569
LHCC	5,594,373	1,240,586	$393,304,629	$92,522,839
UHC	5,796,686	1,165,395	$431,074,068	$98,829,018

Quarter 2

	Number Paid	Number Denied	Value of Paid Claims	Value of Denied Claims
Aetna	1,057,434	178,476	$204,462,244	$32,490,639
ACLA	2,532,447	518,838	$191,088,168	$46,083,691
Healthy Blue	3,206,084	768,422	$236,935,869	$67,766,521
LHCC	5,498,368	1,251,681	$395,473,392	$95,875,053
UHC	6,467,550	1,130,796	$467,627,243	$89,192,841

Quarter 3

	Number Paid	Number Denied	Value of Paid Claims	Value of Denied Claims
Aetna	1,061,443	178,944	$197,485,203	$30,846,035
ACLA	2,442,398	524,053	$186,145,471	$44,975,254
Healthy Blue	3,208,955	834,543	$240,372,625	$74,843,216
LHCC	5,313,035	1,287,935	$383,882,060	$98,646,740
UHC	5,709,511	1,172,874	$446,813,875	$103,905,779

MCNA is the MCO that provides dental coverage only.
Their total expenditures are approx. $37M per quarter. They have been excluded from this exhibit.

Exhibit III.6

Examination of Individual Providers Who Billed an MCO that Had More Than 10% of their Claims Denied

Legend

Y means that more than 50% of the providers in this group had 10% or more of their claims denied by the MCO

N means that less than 50% of the providers in this group had 10% or more of their claims denied by the MCO

-- means that the number of providers in the category is too small (5 or less) to make a finding

Provider Category	Group Based on Volume	Aetna			ACLA			HBL			LHCC			UHC			MCNA		
		Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3	Q1	Q2	Q3
Inpatient Hospital	Low	76%	70%	70%	65%	62%	62%	68%	74%	71%	65%	49%	61%	63%	63%	63%			
	Medium	73%	76%	80%	--	--	--	94%	91%	86%	83%	73%	75%	88%	80%	81%			
	High	81%	66%	81%	--	--	--	--	--	--	--	--	--	--	--	--			
Outpatient Hospital	Low	63%	49%	48%	49%	47%	44%	37%	30%	37%	56%	55%	53%	57%	58%	57%			
	Medium	100%	59%	62%	58%	56%	57%	73%	77%	67%	90%	82%	91%	60%	69%	66%			
	High	88%	45%	41%	57%	40%	34%	37%	30%	28%	65%	88%	75%	28%	29%	30%			
Home Health	Low	56%	62%	65%	57%	46%	46%	41%	36%	51%	57%	55%	47%	54%	72%	36%			
	Medium	90%	50%	50%	--	--	--	33%	35%	40%	52%	57%	44%	--	--	--			
	High	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--			
Other Institutional Providers	Low	75%	61%	66%	64%	62%	55%	44%	44%	44%	65%	82%	80%	36%	15%	24%			
	Medium	98%	77%	78%	--	--	--	47%	31%	29%	--	--	--	56%	67%	50%			
	High	88%	65%	61%	--	--	--	27%	36%	31%	--	--	--	--	--	--			
Primary Care	Low	62%	41%	32%	46%	41%	42%	37%	38%	36%	36%	35%	36%	59%	58%	55%			
	Medium	--	--	--	86%	82%	91%	31%	29%	29%	34%	28%	32%	45%	42%	38%			
	High	--	--	--	--	--	--	26%	27%	30%	42%	50%	49%	28%	27%	28%			
Pediatrics	Low	71%	67%	50%	26%	22%	29%	35%	35%	35%	39%	38%	31%	60%	61%	51%			
	Medium	--	--	--	74%	67%	72%	24%	28%	43%	26%	29%	14%	31%	47%	38%			
	High	--	--	--	--	--	--	24%	34%	22%	36%	8%	21%	32%	30%	34%			
OB-GYN	Low	--	--	--	49%	46%	49%	50%	47%	41%	32%	38%	48%	63%	54%	54%			
	Medium	--	--	--	92%	60%	86%	40%	40%	36%	29%	38%	41%	46%	33%	38%			
	High	--	--	--	--	--	--	64%	13%	39%	30%	50%	--	20%	5%	26%			
Therapists	Low	--	--	--	48%	48%	64%	43%	49%	67%	43%	26%	15%	41%	58%	45%			
	Medium	--	--	--	--	--	--	56%	66%	82%	50%	50%	0%	37%	50%	38%			
	High	--	--	--	--	--	--	--	--	--	--	--	--	33%	38%	14%			
Non-Emergency Transportation	Low	0%	8%	17%	10%	20%	49%	48%	44%	42%	4%	4%	19%	50%	43%	55%			
	Medium	0%	4%	7%	6%	40%	38%	44%	50%	33%	0%	4%	7%	67%	55%	60%			
	High	0%	0%	13%	0%	39%	24%	34%	42%	22%	0%	2%	0%	--	--	--			
Medical Equipment/ Supplies	Low	59%	58%	61%	50%	56%	58%	54%	51%	40%	46%	36%	45%	67%	64%	67%			
	Medium	69%	72%	84%	89%	89%	100%	--	--	--	288%	62%	65%	43%	44%	37%			
	High	100%	--	100%	--	--	--	--	--	--	4%	64%	67%	50%	40%	32%			
All Other Professional Provid.	Low	--	42%	43%	45%	42%	44%	36%	37%	35%	34%	36%	32%	56%	49%	54%			
	Medium	--	45%	37%	87%	80%	78%	44%	37%	31%	43%	42%	45%	52%	49%	51%			
	High	--	39%	30%	94%	81%	87%	50%	37%	46%	47%	46%	50%	43%	52%	41%			
Behavioral Health Rehab	Low	63%	51%	73%	27%	25%	30%	38%	43%	34%	53%	52%	45%	54%	52%	56%			
	Medium	64%	--	--	88%	82%	61%	35%	36%	38%	7%	20%	33%	43%	46%	35%			
	High	29%	--	--	--	--	--	36%	39%	42%	21%	41%	19%	42%	34%	36%			
Behavioral Health All Other	Low	--	--	--	35%	33%	27%	42%	46%	45%	40%	41%	40%	55%	49%	54%			
	Medium	--	--	--	100%	--	88%	45%	37%	44%	43%	33%	38%	56%	49%	58%			
	High	--	--	--	--	--	--	41%	46%	47%	13%	57%	50%	39%	52%	42%			
Dental - Children	Low																45%	48%	47%
	Medium																48%	55%	49%
	High																84%	95%	85%
Dental - Adults	Low																91%	88%	90%
	Medium																100%	100%	100%
	High																--	--	--
Pharmacy	Low	60%	59%	58%	94%	92%	93%	84%	48%	88%	97%	96%	96%	69%	64%	73%			
	Medium	93%	91%	92%	98%	98%	99%	86%	84%	100%	99%	99%	99%	97%	89%	98%			
	High	96%	99%	98%	100%	100%	100%	89%	98%	100%	100%	100%	100%	99%	94%	100%			

Exhibit III.7B
Turnaround Time for Claims Processing of Adjudicated Claims (using average days)
All Claim Types
By All MCOs and By Quarter

	Paid	Denied
All MCOs Q1 2018	7.4	4.7
All MCOs Q2 2018	7.2	4.6
All MCOs Q3 2018	6.9	4.5
All MCOs Q4 2018	0.0	0.0
Aetna Q1 2018	4.4	4.1
Aetna Q2 2018	4.1	4.1
Aetna Q3 2018	4.4	4.1
Aetna Q4 2018	0.0	0.0
ACLA Q1 2018	3.2	3.2
ACLA Q2 2018	3.5	3.6
ACLA Q3 2018	3.2	3.0
ACLA Q4 2018	0.0	0.0
Healthy Blue Q1 2018	9.2	4.8
Healthy Blue Q2 2018	7.6	4.0
Healthy Blue Q3 2018	7.8	4.2
Healthy Blue Q4 2018	0.0	0.0
LHCC Q1 2018	7.1	6.1
LHCC Q2 2018	6.6	6.0
LHCC Q3 2018	6.2	5.6
LHCC Q4 2018	0.0	0.0
UHC Q1 2018	8.6	3.9
UHC Q2 2018	9.2	3.5
UHC Q3 2018	9.0	4.0
UHC Q4 2018	0.0	0.0
MCNA Q1 2018	7.9	8.8
MCNA Q2 2018	9.0	10.2
MCNA Q3 2018	7.3	8.1
MCNA Q4 2018	0.0	0.0

Exhibit III.8A
Turnaround Time for Claims Processing of Adjudicated Claims (using average days)
Institutional Providers
By All MCOs Combined By Quarter

	Paid	Denied
Inpatient Hosp Q1 2018	10.8	10.6
Inpatient Hosp Q2 2018	10.8	11.8
Inpatient Hosp Q3 2018	10.9	12.1
Inpatient Hosp Q4 2018	0.0	0.0
Outpatient Hosp Q1 2018	7.3	10.0
Outpatient Hosp Q2 2018	7.1	9.5
Outpatient Hosp Q3 2018	7.1	9.7
Outpatient Hosp Q4 2018	0.0	0.0
Home Health Q1 2018	8.5	8.5
Home Health Q2 2018	8.6	9.3
Home Health Q3 2018	8.5	8.2
Home Health Q4 2018	0.0	0.0
Other Institut Q1 2018	7.4	10.2
Other Institut Q2 2018	7.3	11.5
Other Institut Q3 2018	8.2	11.8
Other Institut Q4 2018	0.0	0.0

Exhibit III.8B
Turnaround Time for Claims Processing of Adjudicated Claims (using average days)
Professional Service Providers
By All MCOs Combined By Quarter

	Paid	Denied
Primary Care Q1 2018	7.4	8.3
Primary Care Q2 2018	7.2	7.8
Primary Care Q3 2018	7.2	7.9
Primary Care Q4 2018	0.0	0.0
Pediatrics Q1 2018	6.0	9.0
Pediatrics Q2 2018	6.1	8.1
Pediatrics Q3 2018	6.1	8.0
Pediatrics Q4 2018	0.0	0.0
OB-GYN Q1 2018	6.6	8.6
OB-GYN Q2 2018	6.3	7.8
OB-GYN Q3 2018	6.4	8.3
OB-GYN Q4 2018	0.0	0.0
Therapists (PT/OT/ST) Q1 2018	8.2	8.5
Therapists (PT/OT/ST) Q2 2018	9.4	8.1
Therapists (PT/OT/ST) Q3 2018	8.9	9.0
Therapists (PT/OT/ST) Q4 2018	0.0	0.0
Non-Emerg Transport Q1 2018	10.1	9.2
Non-Emerg Transport Q2 2018	8.4	9.0
Non-Emerg Transport Q3 2018	8.7	9.5
Non-Emerg Transport Q4 2018	0.0	0.0
Medical Equip/Supplies Q1 2018	8.3	10.1
Medical Equip/Supplies Q2 2018	8.1	9.8
Medical Equip/Supplies Q3 2018	8.3	9.7
Medical Equip/Supplies Q4 2018	0.0	0.0
All Other Professional Q1 2018	7.5	8.1
All Other Professional Q2 2018	7.2	8.1
All Other Professional Q3 2018	7.1	7.8
All Other Professional Q4 2018	0.0	0.0

Exhibit III.8C
Turnaround Time for Claims Processing of Adjudicated Claims (using average days)
Behavioral Health, Dental and Pharmacy
By All MCOs Combined By Quarter

	Paid	Denied
Mental/Behavioral Rehab Q1 2018	7.1	9.3
Mental/Behavioral Rehab Q2 2018	6.9	10.4
Mental/Behavioral Rehab Q3 2018	7.4	9.7
Mental/Behavioral Rehab Q4 2018	0.0	0.0
Mental/Behavioral Other Q1 2018	8.5	10.0
Mental/Behavioral Other Q2 2018	8.1	9.6
Mental/Behavioral Other Q3 2018	8.2	8.4
Mental/Behavioral Other Q4 2018	0.0	0.0
Dental - Children Q1 2018	7.9	8.9
Dental - Children Q2 2018	9.0	10.2
Dental - Children Q3 2018	7.3	8.1
Dental - Children Q4 2018	0.0	0.0
Dental - Adults Q1 2018	7.1	7.0
Dental - Adults Q2 2018	6.9	7.1
Dental - Adults Q3 2018	6.8	7.3
Dental - Adults Q4 2018	0.0	0.0
Pharmacy Q1 2018	7.4	0.7
Pharmacy Q2 2018	7.0	0.7
Pharmacy Q3 2018	6.1	0.7
Pharmacy Q4 2018	0.0	0.0

Exhibit III.9A
Turnaround Time for Claims Processing of Adjudicated Claims (using average days)
By Provider Specialty - Institutional Providers
By MCO for Q1 - Q3 2018 Adjudicated Claims

Inpatient Hospital	Quarter 1		Quarter 2		Quarter 3	
	Paid	Denied	Paid	Denied	Paid	Denied
All MCOs	10.8	10.6	10.8	11.8	10.9	12.1
Aetna	19.8	13.4	16.4	14.0	23.0	13.7
ACLA	7.6	7.2	8.7	8.7	6.7	7.1
Healthy Blue	9.8	12.2	11.1	14.9	8.6	11.7
LHCC	10.4	11.9	10.1	12.2	9.3	11.9
UHC	9.2	8.4	9.9	9.1	11.8	16.4

Outpatient Hospital	Quarter 1		Quarter 2		Quarter 3	
	Paid	Denied	Paid	Denied	Paid	Denied
All MCOs	6.8	9.4	6.6	8.9	6.7	9.2
Aetna	7.0	9.9	6.8	11.6	6.8	10.6
ACLA	3.9	4.5	4.2	5.2	3.7	4.3
Healthy Blue	5.4	14.3	4.8	11.4	5.0	11.0
LHCC	9.2	10.8	8.7	10.4	8.3	10.0
UHC	8.2	9.9	8.4	9.1	8.9	11.6

Home Health	Quarter 1		Quarter 2		Quarter 3	
	Paid	Denied	Paid	Denied	Paid	Denied
All MCOs	8.1	7.2	8.0	7.8	8.0	7.2
Aetna	8.9	9.2	8.9	10.2	8.6	10.1
ACLA	4.5	5.2	4.9	6.2	4.1	5.0
Healthy Blue	7.2	10.2	7.1	6.5	6.7	8.9
LHCC	10.0	10.3	10.1	11.4	10.1	9.2
UHC	8.9	8.3	8.4	6.5	8.1	8.7

Other Institutional	Quarter 1		Quarter 2		Quarter 3	
	Paid	Denied	Paid	Denied	Paid	Denied
All MCOs	7.4	9.1	7.3	11.2	8.2	11.7
Aetna	7.7	11.2	7.6	11.6	8.8	12.2
ACLA	7.8	5.7	6.0	6.6	4.7	5.6
Healthy Blue	4.5	12.9	5.2	10.6	5.6	10.9
LHCC	9.9	12.0	9.0	13.2	8.5	11.1
UHC	8.7	9.6	8.4	14.3	8.5	15.6

Exhibit III.9B
Turnaround Time for Claims Processing of Adjudicated Claims (using average days)
By Provider Specialty - Professional Providers, Part 1
By MCO for Q1 - Q3 2018 Adjudicated Claims

Primary Care	Quarter 1		Quarter 2		Quarter 3	
	Paid	Denied	Paid	Denied	Paid	Denied
All MCOs	7.2	8.1	7.1	7.6	7.1	7.7
Aetna	6.4	9.1	6.5	8.9	6.1	7.0
ACLA	3.5	4.1	3.5	4.8	3.2	3.9
Healthy Blue	5.7	10.0	5.5	7.6	6.0	8.4
LHCC	8.6	9.1	8.0	9.0	7.3	8.5
UHC	8.3	8.2	8.3	7.7	8.5	8.2

Pediatrics	Quarter 1		Quarter 2		Quarter 3	
	Paid	Denied	Paid	Denied	Paid	Denied
All MCOs	5.6	8.6	5.7	7.7	5.8	7.8
Aetna	7.7	7.8	6.9	11.7	5.6	10.2
ACLA	3.5	4.4	3.5	5.1	3.2	4.1
Healthy Blue	4.7	11.3	4.4	9.4	5.0	10.3
LHCC	8.5	11.9	8.0	9.0	7.3	7.9
UHC	7.6	7.6	7.7	7.3	8.1	7.5

OB-GYN	Quarter 1		Quarter 2		Quarter 3	
	Paid	Denied	Paid	Denied	Paid	Denied
All MCOs	6.3	8.2	5.9	7.4	6.2	7.8
Aetna	6.4	6.8	6.4	5.3	6.1	7.7
ACLA	3.7	4.4	4.2	5.8	3.8	4.6
Healthy Blue	6.0	10.5	4.9	7.3	6.0	10.0
LHCC	8.6	10.6	8.2	10.1	7.5	8.9
UHC	7.9	8.3	8.0	7.9	8.2	11.3

Therapists (Physical, Occupational, Speech)	Quarter 1		Quarter 2		Quarter 3	
	Paid	Denied	Paid	Denied	Paid	Denied
All MCOs	8.0	7.9	9.1	7.5	8.6	8.5
Aetna	9.9	7.0	8.6	14.7	12.5	10.5
ACLA	5.3	6.2	5.8	7.4	5.2	6.3
Healthy Blue	8.1	10.1	6.5	7.6	6.5	10.0
LHCC	10.6	9.2	14.5	7.4	11.6	9.1
UHC	8.0	8.3	9.7	8.3	9.8	9.1

Exhibit III.9C
Turnaround Time for Claims Processing of Adjudicated Claims (using average days)
By Provider Specialty - Professional Providers, Part 2
By MCO for Q1 - Q3 2018 Adjudicated Claims

Non-Emergency Medical Transportation	Quarter 1		Quarter 2		Quarter 3	
	Paid	Denied	Paid	Denied	Paid	Denied
All MCOs	8.4	8.6	7.8	8.8	8.7	9.4
Aetna	9.3	12.4	1.1	1.8	1.0	1.8
ACLA	10.5	10.1	9.7	9.1	9.2	8.9
Healthy Blue	9.0	9.1	9.0	9.4	9.2	9.1
LHCC	10.6	10.6	10.9	11.2	11.5	12.5
UHC	8.6	8.2	8.5	8.3	10.0	12.3

Medical Equipment and Supplies	Quarter 1		Quarter 2		Quarter 3	
	Paid	Denied	Paid	Denied	Paid	Denied
All MCOs	8.0	9.6	7.8	9.3	8.0	9.3
Aetna	7.8	9.1	7.9	11.4	9.6	10.2
ACLA	4.9	5.8	4.6	6.7	4.0	5.4
Healthy Blue	7.8	13.9	7.6	10.1	6.6	9.0
LHCC	10.6	15.9	9.7	11.7	8.4	11.8
UHC	8.5	9.3	8.5	8.5	9.1	9.5

All Other Professional Services exc. BH and Dental	Quarter 1		Quarter 2		Quarter 3	
	Paid	Denied	Paid	Denied	Paid	Denied
All MCOs	7.2	7.5	6.8	7.5	6.7	7.5
Aetna	6.2	8.8	6.3	8.2	7.0	9.1
ACLA	4.0	4.5	4.1	5.8	3.9	4.4
Healthy Blue	5.3	8.6	4.5	7.1	4.9	8.4
LHCC	8.9	9.5	8.5	9.5	7.9	8.3
UHC	8.1	7.8	8.2	7.3	8.6	8.6

Exhibit III.9D
Turnaround Time for Claims Processing of Adjudicated Claims (using average days)
By Provider Specialty - Behavioral Health, Dental and Pharmacy
By MCO for Q1 - Q3 2018 Adjudicated Claims

Mental/Behavioral Health - Rehab	Quarter 1		Quarter 2		Quarter 3	
	Paid	Denied	Paid	Denied	Paid	Denied
All MCOs	6.8	9.0	6.6	10.1	7.1	9.4
Aetna	6.4	10.3	6.2	8.7	6.5	8.1
ACLA	4.4	6.8	4.4	6.8	4.7	10.2
Healthy Blue	6.1	9.1	5.1	11.0	6.3	8.2
LHCC	8.8	10.2	7.9	9.3	7.7	9.3
UHC	9.2	10.9	9.4	11.6	9.8	11.0

Mental/Behavioral Health - Other	Quarter 1		Quarter 2		Quarter 3	
	Paid	Denied	Paid	Denied	Paid	Denied
All MCOs	8.3	10.0	7.9	9.5	8.0	8.4
Aetna	9.0	8.0	8.0	18.0	8.0	10.5
ACLA	3.7	4.4	3.7	4.4	3.5	4.4
Healthy Blue	7.2	10.7	7.1	8.9	6.2	7.1
LHCC	8.9	9.6	8.1	9.9	7.8	8.5
UHC	12.0	11.8	11.4	11.3	13.1	12.3

Pharmacy	Quarter 1		Quarter 2		Quarter 3	
	Paid	Denied	Paid	Denied	Paid	Denied
All MCOs	7.4	0.7	7.0	0.7	6.1	0.7
Aetna	1.0	1.0	1.0	1.0	1.0	1.0
ACLA	1.0	1.0	1.0	1.0	1.0	1.0
Healthy Blue	13.0	1.0	13.8	1.0	13.7	1.0
LHCC	1.0	1.0	1.0	1.0	1.0	1.0
UHC	9.4	0.0	10.6	0.0	9.4	0.0

Dental (MCNA is the only MCO)	Quarter 1		Quarter 2		Quarter 3	
	Paid	Denied	Paid	Denied	Paid	Denied
Dental - Children	7.9	8.9	9.0	10.2	7.3	8.1
Dental - Adults	7.7	7.3	10.3	9.8	8.2	7.9

Exhibit III.10- Q1
Details on Reasons for Denied Claims
By MCO for Q1 2018 Adjudicated Claims

For Medical Claims		Rank Among	Ranking					
CARC	Description	All MCOs	Aetna	ACLA	Healthy Blue	LHCC	UHC	MCNA
197	Precertification/authorization/notification absent.	1	5	4	1	1	1	
16	Claim/service lacks information or has submission/billing error(s)	2	1	2		5		
96	Non-covered charge(s).	3		1		3	2	
252	An attachment/other documentation is required to adjudicate this claim/service.	4		3	3		4	
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	5	4	5			3	
18	Exact duplicate claim/service	6	3			2	5	2
256	Service not payable per managed care contract.	7			2			
29	The time limit for filing has expired.	8						
234	This procedure is not paid separately.	9	2					
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	10						

For Pharmacy Claims		Rank Among	Ranking				
NCPDP	Description	All MCOs	Aetna	ACLA	Healthy Blue	LHCC	UHC
88	DUR Reject Error	1					1
7J	Patient Relationship Code Value Not Supported	2				1	
79	Refill Too Soon	3	1	1			4
76	Plan Limitations Exceeded	4	4	3			2
7A	Provider Does Not Match Authorization On File	5				2	
7Ø	Product/Service Not Covered – Plan/Benefit Exclusion	6	2	2			3
7N	Patient ID Qualifier Value Not Supported	7				3	
4X	M/I Patient Residence	8				4	
19	M/I Days Supply	9				5	5
75	Prior Authorization Required	10	5				

Exhibit III.10- Q2
Details on Reasons for Denied Claims
By MCO for Q2 2018 Adjudicated Claims

For Medical Claims		Rank Among	Ranking					
CARC	Description	All MCOs	Aetna	ACLA	Healthy Blue	LHCC	UHC	MCNA
197	Precertification/authorization/notification absent.	1		3	1	1	2	
96	Non-covered charge(s).	2	5	1		3	1	
252	An attachment/other documentation is required to adjudicate this claim/service.	3		2	3		4	
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	4	3	4			3	
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	5	1	5				
18	Exact duplicate claim/service.	6	2			2	5	2
29	The time limit for filing has expired.	7						
256	Service not payable per managed care contract.	8			2			
27	Expenses incurred after coverage terminated.	9						
109	Claim/service not covered by this payer/contractor.	10			4			

For Pharmacy Claims		Rank Among	Ranking				
NCPDP	Description	All MCOs	Aetna	ACLA	Healthy Blue	LHCC	UHC
88	DUR Reject Error	1					1
79	Refill Too Soon	2	1				4
7J	Patient Relationship Code Value Not Supported	3				1	
7N	Patient ID Qualifier Value Not Supported	4				2	
76	Plan Limitations Exceeded	5	4				2
39	M/I Diagnosis Code	6		4		4	
7Ø	Product/Service Not Covered – Plan/Benefit Exclusion	7	2				3
7A	Provider Does Not Match Authorization On File	8				3	
19	M/I Days Supply	9					
75	Prior Authorization Required	10	5				5

Exhibit III.10- Q3
Details on Reasons for Denied Claims
By MCO for Q2 2018 Adjudicated Claims

For Medical Claims		Rank Among	Ranking					
CARC	Description	All MCOs	Aetna	ACLA	Healthy Blue	LHCC	UHC	MCNA
197	Precertification/authorization/notification absent.	1		3	1	1	1	
96	Non-covered charge(s).	2	5	1		4	2	
16	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	3	1	2				
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	4	2	5			3	
252	An attachment/other documentation is required to adjudicate this claim/service.	5		4	3		4	
18	Exact duplicate claim/service.	6	3			2	5	2
256	Service not payable per managed care contract.	7			2			
27	Expenses incurred after coverage terminated.	8						
29	The time limit for filing has expired.	9						
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	10						

For Pharmacy Claims		Rank Among	Ranking				
NCPDP	Description	All MCOs	Aetna	ACLA	Healthy Blue	LHCC	UHC
88	DUR Reject Error	1					1
79	Refill Too Soon	2	1	1			4
7J	Patient Relationship Code Value Not Supported	3				1	
76	Plan Limitations Exceeded	4	4	2			3
7N	Patient ID Qualifier Value Not Supported	5				2	
7Ø	Product/Service Not Covered – Plan/Benefit Exclusion	6	2	3			2
39	M/I Diagnosis Code	7		4		4	
7A	Provider Does Not Match Authorization On File	8				3	
19	M/I Days Supply	9				5	
75	Prior Authorization Required	10	5				5

Exhibit III.11- Q1
Details on Reasons for Denied Medical Claims
By MCO and By Provider Category for Q1 2018 Adjudicated Claims
Top 5 Denial Codes for Each MCO

			Ranking														
	CARC	Description	Inpatient Hospital	Outpatient Hospital	Home Health	Other Institutional	Primary Care	Pediatrics	OB-GYN	Therapists	Non-Emerg Transport	Medical Equipment	Other Professional	Mental/Behavioral - Rehab	Mental/Behavioral - Other	Adult Dental	Pediatric Dental
	Aetna																
1	16	Claim/service lacks information or has submission/billing error(s) which is r	1	1	1	1	3	1	1	1	1	1	1	1	1		
2	234	This procedure is not paid separately. At least one Remark Code must be pr		2		2									4		
3	18	Exact duplicate claim/service (Use only with Group Code OA except where	2	5	2	5	1		5	3	2	4	3	4	4		
4	97	The benefit for this service is included in the payment/allowance for another	3	4	3	4	2	4	5	4	3	3	4		4		
5	197	Precertification/authorization/notification absent.	4							2	4	5	2		4		
	ACLA																
1	96	Non-covered charge(s). At least one Remark Code must be provided (may b	1	1	2	1	1	1	1	1	3	2	2		1		
2	16	Claim/service lacks information or has submission/billing error(s) which is r		4			2	3	2	3	1	4	1				
3	252	An attachment/other documentation is required to adjudicate this claim/serv		3			5		3			5	3	1			
4	197	Precertification/authorization/notification absent.	4		5				4	2		1	4	3			
5	97	The benefit for this service is included in the payment/allowance for another		2			4	4					5		3		
	Healthy Blue																
1	197	Precertification/authorization/notification absent.	4	5	1	1	2	3	3	2	2	2	1	1	1		
2	256	Service not payable per managed care contract.		2	2	2	1	1	2	1	2	1	2		4		
3	252	An attachment/other documentation is required to adjudicate this claim/serv	2	3	3	4	3	4	4	4	2	3	3	5	2		
4	109	Claim/service not covered by this payer/contractor. You must send the claim	5	1		3	4				2		4		3		
5	119	Benefit maximum for this time period or occurrence has been reached.					5		5		2				5		

Exhibit III.11- Q1
Details on Reasons for Denied Medical Claims
By MCO and By Provider Category for Q1 2018 Adjudicated Claims
Top 5 Denial Codes for Each MCO

			Ranking														
	CARC	Description	Inpatient Hospital	Outpatient Hospital	Home Health	Other Institutional	Primary Care	Pediatrics	OB-GYN	Therapists	Non-Emerg Transport	Medical Equipment	Other Professional	Mental/Behavioral - Rehab	Mental/Behavioral - Other	Adult Dental	Pediatric Dental
	LHCC																
1	197	Precertification/authorization/notification absent.	1		1	3				3		2	1	1	1		
2	18	Exact duplicate claim/service (Use only with Group Code OA except where	4	1	2		3	3		2			3	3	2		
3	96	Non-covered charge(s). At least one Remark Code must be provided (may b		2	4	2	2	4	3				4				
4	49	This is a non-covered service because it is a routine/preventive exam or a di											2				
5	16	Claim/service lacks information or has submission/billing error(s) which is r	3	3	3	1					1	4		4	5		
	United																
1	197	Precertification/authorization/notification absent.			5			3		5			1	1	1		
2	96	Non-covered charge(s). At least one Remark Code must be provided (may b		2		1	1	2	2	1	2	1	2	3			
3	97	The benefit for this service is included in the payment/allowance for another		5			2	1	1		4		3				
4	252	An attachment/other documentation is required to adjudicate this claim/serv		1	5		4	5	3		3	2	4		4		
5	18	Exact duplicate claim/service (Use only with Group Code OA except where	3	4	4		3	4	4	3	5	5		2	2		
	MCNA																
1	1	Deductible Amount														2	1
2	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)															1
3	14	The date of birth follows the date of service.														1	
4	35	Lifetime benefit maximum has been reached.															3
5	31	Patient cannot be identified as our insured.															4

Exhibit III.11- Q2
Details on Reasons for Denied Medical Claims
By MCO and By Provider Category for Q2 2018 Adjudicated Claims
Top 5 Denial Codes for Each MCO

			Ranking														
	CARC	Description	*Inpatient Hospital*	*Outpatient Hospital*	*Home Health*	*Other Institutional*	*Primary Care*	*Pediatrics*	*OB-GYN*	*Therapists*	*Non-Emerg Transport*	*Medical Equipment*	*Other Professional*	*Mental/Behavioral - Rehab*	*Mental/Behavioral - Other*	*Adult Dental*	*Pediatric Dental*
	Aetna																
1	16	Claim/service lacks information or has submission/billing error(s) which is r	1	1	1	2	1	2	3	1	1	1	1	1	3		
2	18	Exact duplicate claim/service (Use only with Group Code OA except where	2	3	2	4	1	4	1	3	2	4	2	3	5		
3	97	The benefit for this service is included in the payment/allowance for another	3	2	3	3	3	5	2	4	3	3	4		5		
4	147	Provider contracted/negotiated rate expired or not on file.	5		4	1	5	3	4			5			5		
5	96	Non-covered charge(s). At least one Remark Code must be provided (may b			5	5	3	1	4			2	5		5		
	ACLA																
1	96	Non-covered charge(s). At least one Remark Code must be provided (may b	2	1	2	1	1	2	1	2		2	2	4	1		
2	252	An attachment/other documentation is required to adjudicate this claim/serv		4			4	5	2		5	5	1		2		
3	197	Precertification/authorization/notification absent.	4				2		3	1		1	3	1	5		
4	97	The benefit for this service is included in the payment/allowance for another servic		2			3	3					5				
5	16	Claim/service lacks information or has submission/billing error(s) which is r		3		5			4	5	1	4		5			
	Healthy Blue																
1	197	Precertification/authorization/notification absent.	4	4	1	4	2	4	2	2	2	2	1	1	1		
2	256	Service not payable per managed care contract.		2	2	2	1	1	3	1	2	1	2		5		
3	252	An attachment/other documentation is required to adjudicate this claim/serv	2	1	4	1	3	5	4	4	2	3	3	5	2		
4	109	Claim/service not covered by this payer/contractor. You must send the claim	5	3	5	3	4			5	2		4		4		
5	119	Benefit maximum for this time period or occurrence has been reached.			5				5		2						

Exhibit III.11- Q2
Details on Reasons for Denied Medical Claims
By MCO and By Provider Category for Q2 2018 Adjudicated Claims
Top 5 Denial Codes for Each MCO

			Ranking														
	CARC	Description	*Inpatient Hospital*	*Outpatient Hospital*	*Home Health*	*Other Institutional*	*Primary Care*	*Pediatrics*	*OB-GYN*	*Therapists*	*Non-Emerg Transport*	*Medical Equipment*	*Other Professional*	*Mental/Behavioral - Rehab*	*Mental/Behavioral - Other*	*Adult Dental*	*Pediatric Dental*
	LHCC																
1	197	Precertification/authorization/notification absent.	1		1						2	2	1	2	1		
2	18	Exact duplicate claim/service (Use only with Group Code OA except where	4	1	2		3	2		2	2	5	2	1	3		
3	96	Non-covered charge(s). At least one Remark Code must be provided (may b		2	3	4	2	5	4		2		4				
4	B7	This provider was not certified/eligible to be paid for this procedure/service					5	4	5		2		5	3			
5	246	This non-payable code is for required reporting only.					1		2		2						
	United																
1	96	Non-covered charge(s). At least one Remark Code must be provided (may b		1	5	1	1	2	2	1	2	1	2				
2	197	Precertification/authorization/notification absent.	5		2		5	3		5		5	1	2	1		
3	97	The benefit for this service is included in the payment/allowance for another		4			2	1	1				3				
4	252	An attachment/other documentation is required to adjudicate this claim/serv		2		4	3	4	3		3	2	4		5		
5	18	Exact duplicate claim/service (Use only with Group Code OA except where	4	3	4	5	4	5	4	3		4	5	1	3		
	MCNA																
1	1	Deductible Amount														2	1
2	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)															1
3	14	The date of birth follows the date of service.														1	
4	35	Lifetime benefit maximum has been reached.															3
5	31	Patient cannot be identified as our insured.															4

Exhibit III.11- Q3
Details on Reasons for Denied Medical Claims
By MCO and By Provider Category for Q3 2018 Adjudicated Claims
Top 5 Denial Codes for Each MCO

			Ranking														
	CARC	Description	Inpatient Hospital	Outpatient Hospital	Home Health	Other Institutional	Primary Care	Pediatrics	OB-GYN	Therapists	Non-Emerg Transport	Medical Equipment	Other Professional	Mental/Behavioral - Rehab	Mental/Behavioral - Other	Adult Dental	Pediatric Dental
	Aetna																
1	16	Claim/service lacks information or has submission/billing error(s) which is r	1	1	1	2	2	3	3	1	1	1	1	2	3		
2	97	The benefit for this service is included in the payment/allowance for another	3	2	4	3	4	5	1	3	3	4	3		3		
3	18	Exact duplicate claim/service (Use only with Group Code OA except where	2	3	2	4	3	4	1	2	2	5	2	5	3		
4	147	Provider contracted/negotiated rate expired or not on file.			5	1	5	1				2			3		
5	96	Non-covered charge(s). At least one Remark Code must be provided (may b			3	5	1	2				3	5		3		
	ACLA																
1	96	Non-covered charge(s). At least one Remark Code must be provided (may b	2	1	1	1	1	1	3	2	4	2	1	4	1		
2	16	Claim/service lacks information or has submission/billing error(s) which is r		3			3	3	2	5	1	4	4	5			
3	197	Precertification/authorization/notification absent.	4		3		2	4	4	1		1	2	1			
4	252	An attachment/other documentation is required to adjudicate this claim/serv		4	5		5		5	4			3		3		
5	97	The benefit for this service is included in the payment/allowance for another		2		3	4	2					5		2		
	Healthy Blue																
1	197	Precertification/authorization/notification absent.	4	3	1	2	2	5	3	1	2	2	1	2	1		
2	256	Service not payable per managed care contract.		2	3	4	1	1	2	2	2	1	2		5		
3	252	An attachment/other documentation is required to adjudicate this claim/serv	3	1	4	1	4	4	4	4	2	5	4		2		
4	119	Benefit maximum for this time period or occurrence has been reached.							5		2			5			
5	109	Claim/service not covered by this payer/contractor. You must send the claim	5	4		3	3			5	2		5		4		

Exhibit III.11- Q3
Details on Reasons for Denied Medical Claims
By MCO and By Provider Category for Q3 2018 Adjudicated Claims
Top 5 Denial Codes for Each MCO

			Ranking														
	CARC	Description	*Inpatient Hospital*	*Outpatient Hospital*	*Home Health*	*Other Institutional*	*Primary Care*	*Pediatrics*	*OB-GYN*	*Therapists*	*Non-Emerg Transport*	*Medical Equipment*	*Other Professional*	*Mental/Behavioral - Rehab*	*Mental/Behavioral - Other*	*Adult Dental*	*Pediatric Dental*
	LHCC																
1	197	Precertification/authorization/notification absent.	1		2	3					2	2	1	1	1		
2	18	Exact duplicate claim/service (Use only with Group Code OA except where	2	3	1	5		5		1	2	5	3	3	2		
3	222	Exceeds the contracted maximum number of hours/days/units by this provid									2	1	2				
4	96	Non-covered charge(s). At least one Remark Code must be provided (may b		2		2	3		5		2						
5	204	This service/equipment/drug is not covered under the patient's current benef		5	4	4			4		2		5				
	United																
1	197	Precertification/authorization/notification absent.	4		5					5			1	2	1		
2	96	Non-covered charge(s). At least one Remark Code must be provided (may b		2		1	1	3	2	1	1	1	2		4		
3	97	The benefit for this service is included in the payment/allowance for another		5			2	1	1			5	3				
4	252	An attachment/other documentation is required to adjudicate this claim/serv	5	1			3	5	3		4	4	4		2		
5	18	Exact duplicate claim/service (Use only with Group Code OA except where	3	3		2	4	4	4	3		3	5	1	5		
	MCNA																
1	1	Deductible Amount														2	1
2	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)															1
3	14	The date of birth follows the date of service.														1	
4	35	Lifetime benefit maximum has been reached.															3
5	31	Patient cannot be identified as our insured.															4

Exhibit IV.1
Encounter Submissions Accepted and Rejected by LDH
All Claim Types
By MCO and By Quarter

	Accepted	Rejected
All MCOs Q1 2018	95.8%	7.1%
All MCOs Q2 2018	96.2%	6.8%
All MCOs Q3 2018	94.4%	8.6%
All MCOs Q4 2018	0.0%	0.0%
Aetna Q1 2018	97.5%	2.5%
Aetna Q2 2018	97.6%	2.4%
Aetna Q3 2018	99.6%	0.4%
Aetna Q4 2018	0.0%	0.0%
ACLA Q1 2018	90.7%	9.3%
ACLA Q2 2018	94.9%	5.1%
ACLA Q3 2018	88.2%	11.8%
ACLA Q4 2018	0.0%	0.0%
HBL Q1 2018	88.8%	11.2%
HBL Q2 2018	86.2%	13.8%
HBL Q3 2018	81.7%	18.3%
HBL Q4 2018	0.0%	0.0%
LHCC Q1 2018	98.1%	1.9%
LHCC Q2 2018	98.0%	2.0%
LHCC Q3 2018	98.4%	1.6%
LHCC Q4 2018	0.0%	0.0%
UHC Q1 2018	100.0%	0.0%
UHC Q2 2018	100.0%	0.0%
UHC Q3 2018	100.0%	0.0%
UHC Q4 2018	0.0%	0.0%
MCNA Q1 2018	99.1%	0.9%
MCNA Q2 2018	99.2%	0.8%
MCNA Q3 2018	99.3%	0.7%
MCNA Q4 2018	0.0%	0.0%

Exhibit IV.2 and Exhibit IV.3
Encounter Submissions Accepted and Rejected by LDH
Institutional, Professional, Dental, and Pharmacy Claim Types
By MCO and By Quarter

	Institutional Encounters (837I)		Professional Encounters (837D)		Dental Encounters (837D)		Pharmacy Encounters	
	Accepted	Rejected	Accepted	Rejected	Accepted	Rejected	Accepted	Rejected
Aetna Q1 2018	100.0%	0.0%	97.6%	2.4%			94.0%	6.0%
Aetna Q2 2018	94.8%	5.2%	98.9%	1.1%			100.0%	0.0%
Aetna Q3 2018	100.0%	0.0%	99.1%	0.9%			100.0%	0.0%
Aetna Q4 2018	0.0%	0.0%	0.0%	0.0%			0.0%	0.0%
ACLA Q1 2018	92.4%	7.6%	93.8%	6.2%			87.9%	12.1%
ACLA Q2 2018	97.7%	2.3%	98.6%	1.4%			90.0%	10.0%
ACLA Q3 2018	82.4%	17.6%	98.3%	1.7%			85.9%	14.1%
ACLA Q4 2018	0.0%	0.0%	0.0%	0.0%			0.0%	0.0%
HBL Q1 2018	90.6%	9.4%	84.1%	15.9%			95.8%	4.2%
HBL Q2 2018	89.0%	11.0%	84.0%	16.0%			87.8%	12.2%
HBL Q3 2018	85.1%	14.9%	77.6%	22.4%			87.8%	12.2%
HBL Q4 2018	0.0%	0.0%	0.0%	0.0%			0.0%	0.0%
LHCC Q1 2018	99.0%	1.0%	97.4%	2.6%			98.5%	1.5%
LHCC Q2 2018	99.4%	0.6%	97.2%	2.8%			98.0%	2.0%
LHCC Q3 2018	99.3%	0.7%	97.3%	2.7%			100.0%	0.0%
LHCC Q4 2018	0.0%	0.0%	0.0%	0.0%			0.0%	0.0%
UHC Q1 2018	100.0%	0.0%	100.0%	0.0%			100.0%	0.0%
UHC Q2 2018	100.0%	0.0%	100.0%	0.0%			100.0%	0.0%
UHC Q3 2018	100.0%	0.0%	100.0%	0.0%			100.0%	0.0%
UHC Q4 2018	0.0%	0.0%	0.0%	0.0%			0.0%	0.0%
MCNA Q1 2018					99.1%	0.9%		
MCNA Q2 2018					99.2%	0.8%		
MCNA Q3 2018					99.3%	0.7%		
MCNA Q4 2018					0.0%	0.0%		

Exhibit IV.4 and Exhibit IV.5
Encounter Submissions Accepted and Rejected by LDH
Institutional, Professional, Dental, and Pharmacy Claim Types
By MCO and By Quarter

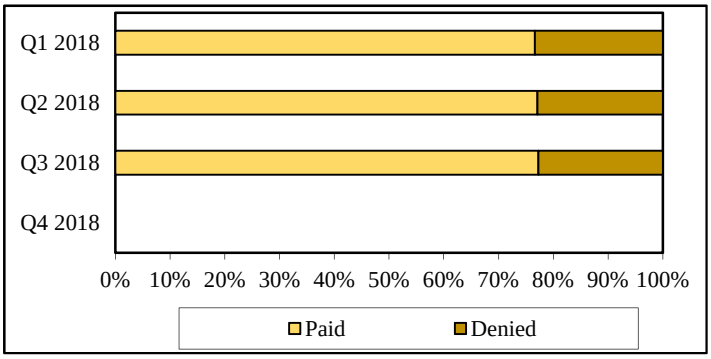
	Institutional Encounters (837I)		Professional Encounters (837D)		Dental Encounters (837D)		Pharmacy Encounters	
	Within 30 Days	After 30 Days	Within 30 Days	After 30 Days	Within 30 Days	Rejected	Within 30 Days	After 30 Days
Aetna Q1 2018	92.4%	7.6%	93.8%	6.2%			89.5%	10.5%
Aetna Q2 2018	84.1%	15.9%	93.0%	7.0%			84.5%	15.5%
Aetna Q3 2018	84.0%	16.0%	87.9%	12.1%			95.0%	5.0%
Aetna Q4 2018	0.0%	0.0%	0.0%	0.0%			0.0%	0.0%
ACLA Q1 2018	95.4%	4.6%	91.1%	8.9%			77.0%	23.0%
ACLA Q2 2018	96.4%	3.6%	98.5%	1.5%			78.6%	21.4%
ACLA Q3 2018	58.9%	41.1%	96.1%	3.9%			92.5%	7.5%
ACLA Q4 2018	0.0%	0.0%	0.0%	0.0%			0.0%	0.0%
HBL Q1 2018	100.0%	0.0%	99.9%	0.1%			99.0%	1.0%
HBL Q2 2018	100.0%	0.0%	98.9%	1.1%			100.0%	0.0%
HBL Q3 2018	100.0%	0.0%	98.1%	1.9%			97.9%	2.1%
HBL Q4 2018	0.0%	0.0%	0.0%	0.0%			0.0%	0.0%
LHCC Q1 2018	88.1%	11.9%	90.0%	10.0%			92.1%	7.9%
LHCC Q2 2018	98.7%	1.3%	95.7%	4.3%			96.9%	3.1%
LHCC Q3 2018	98.3%	1.7%	92.5%	7.5%			98.1%	1.9%
LHCC Q4 2018	0.0%	0.0%	0.0%	0.0%			0.0%	0.0%
UHC Q1 2018	87.5%	12.5%	67.6%	32.4%			97.3%	2.7%
UHC Q2 2018	97.6%	2.4%	90.1%	9.9%			70.0%	30.0%
UHC Q3 2018	98.7%	1.3%	95.8%	4.2%			97.7%	2.3%
UHC Q4 2018	0.0%	0.0%	0.0%	0.0%			0.0%	0.0%
MCNA Q1 2018					97.3%	2.7%		
MCNA Q2 2018					99.4%	0.6%		
MCNA Q3 2018					98.1%	1.9%		
MCNA Q4 2018					0.0%	0.0%		

APPENDIX E

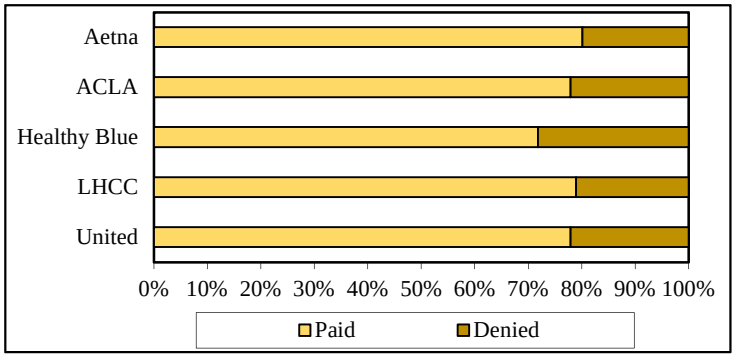
One-Page Summaries of Information on Claims for Each of the 16 Provider Types Shown in this Report

Summary of Information on Claims for Inpatient Hospital Services

Paid and Denied Trend in Most Recent Four Quarters Across All

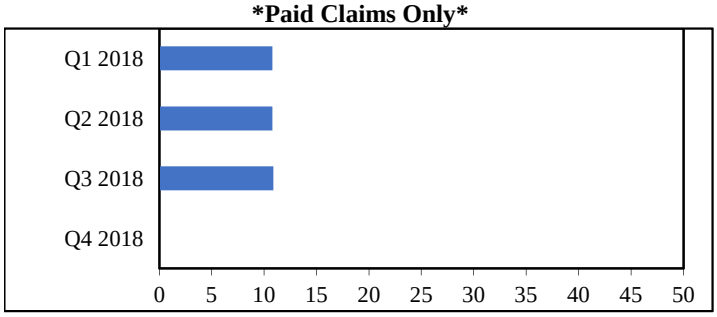


Paid and Denied Trend Quarter 3 2018 only For Each MCO



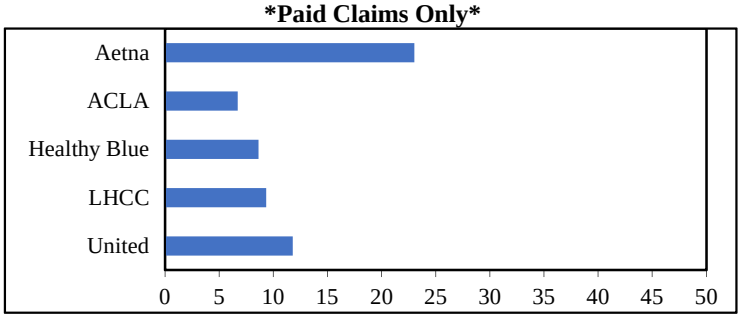
Claims Turnaround Time Most Recent 4 Qtrs All MCOs

Paid Claims Only

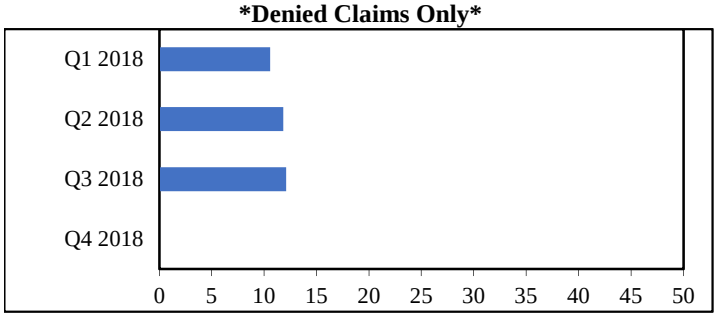


Claims Turnaround Time Quarter 3 2018 only Each MCOs

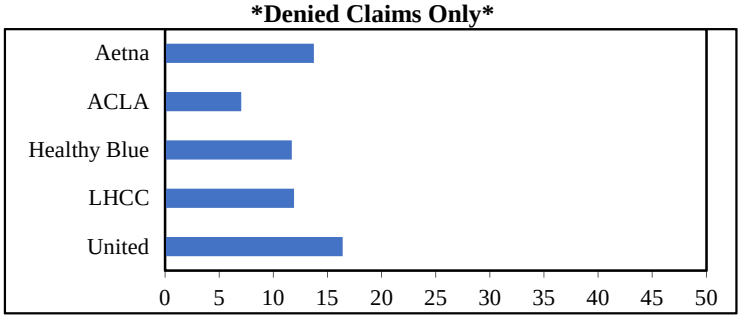
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCO within Three Provider Volume Ranges (# of claims submitted to the MCO in Quarter 3 2018 only)

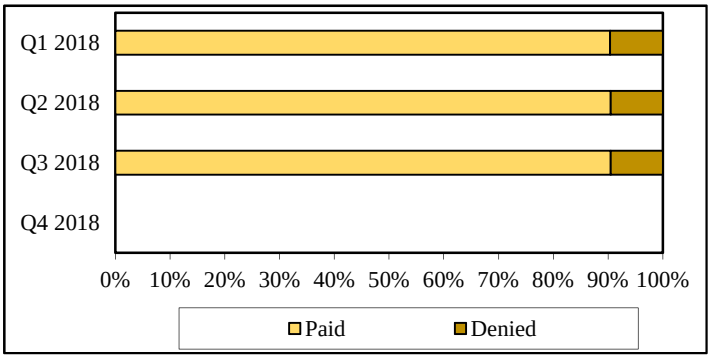
	Aetna		ACLA		Healthy Blue		LHCC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	194	136	296	184	269	190	76	46	213	134
101 - 250	49	39	0	0	36	31	12	9	32	26
> 250 claims	32	26	0	0	1	1	1	1	1	0

Top Denial Reasons this Quarter (An X means it was a top denial reason for the MCO.)

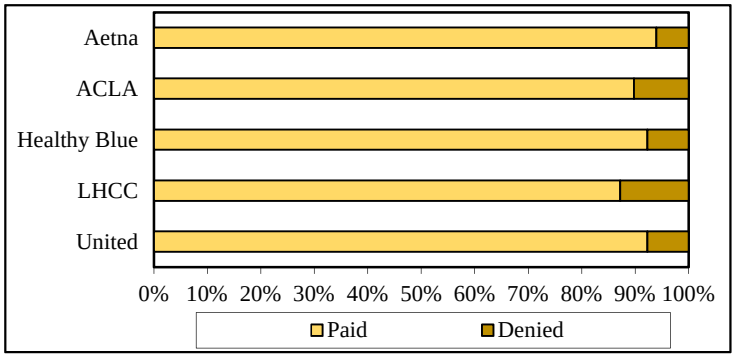
CARC Code	Description	Aetna	ACLA	HBL	LHCC	UHC
16	Claim/service lacks information or has submission/billing error(s	X				X
18	Exact duplicate claim/service (Use only with Group Code OA exc	X			X	X
97	The benefit for this service is included in the payment/allowance	X				
128	Newborn's services are covered in the mother's Allowance.		X	X		
197	Precertification/authorization/notification absent.	X	X	X	X	

Summary of Information on Claims for Outpatient Hospital Services

Paid and Denied Trend in Most Recent Four Quarters Across All

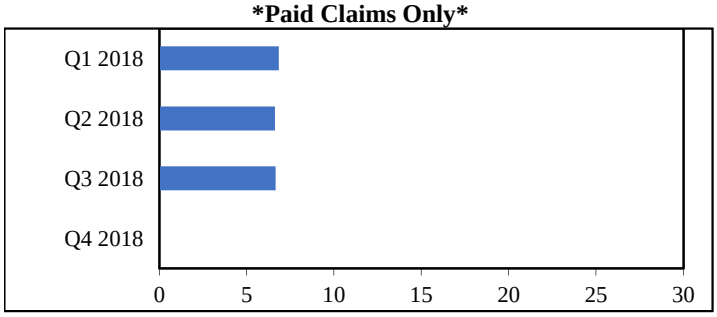


Paid and Denied Trend Quarter 3 2018 only For Each MCO



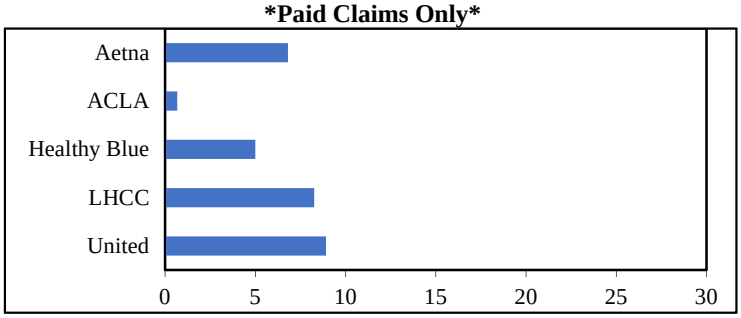
Claims Turnaround Time Most Recent 4 Qtrs All MCOs

Paid Claims Only

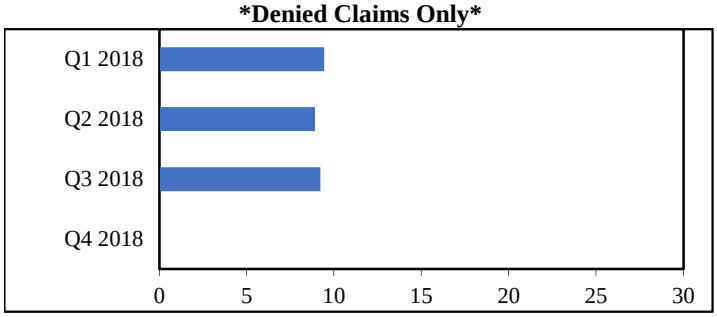


Claims Turnaround Time Quarter 3 2018 only Each MCOs

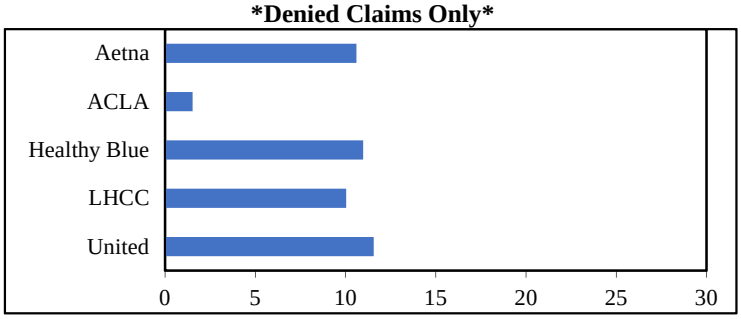
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCO within Three Provider Volume Ranges (# of claims submitted to the MCO in the Quarter 3 2018 only)

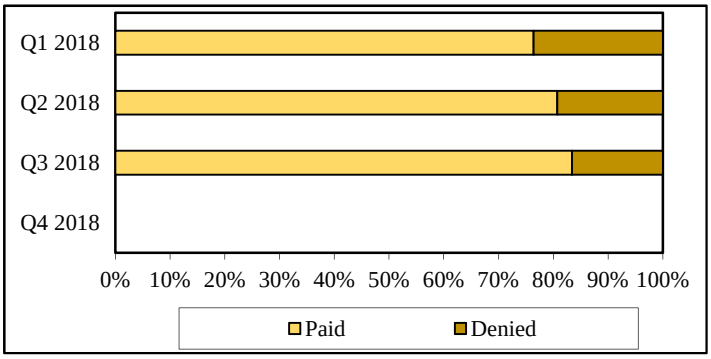
	Aetna		ACLA		Healthy Blue		LHCC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	305	147	560	249	379	141	260	137	1,038	587
101 - 250	39	24	74	42	21	14	11	10	113	75
> 250 claims	73	30	38	13	105	29	16	12	132	39

Top Denial Reasons this Quarter (An X means it was a top denial reason for the MCO.)

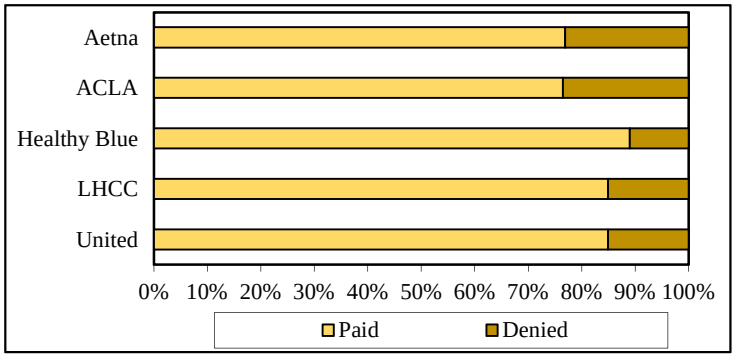
CARC Code	Description	Aetna	ACLA	HBL	LHCC	UHC
16	Claim/service lacks information or has submission/billing error(s	X	X		X	X
97	The benefit for this service is included in the payment/allowance	X	X			X
253	Sequestration - reduction in federal payment					X
18	Exact duplicate claim/service (Use only with Group Code OA ex	X			X	X
96	Non-covered charge(s). At least one Remark Code must be provi		X		X	

Summary of Information on Claims for Home Health Services

Paid and Denied Trend in Most Recent Four Quarters Across All

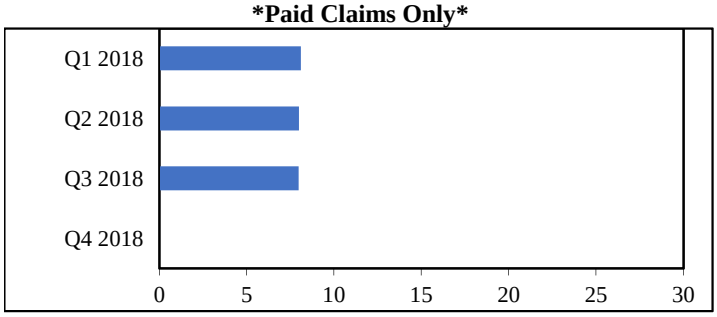


Paid and Denied Trend Quarter 3 2018 only For Each MCO



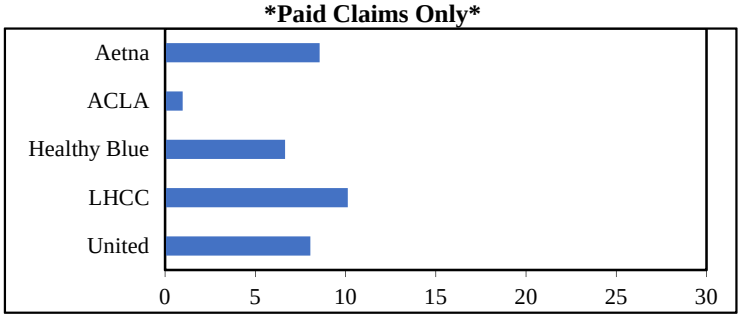
Claims Turnaround Time Most Recent 4 Qtrs All MCOs

Paid Claims Only

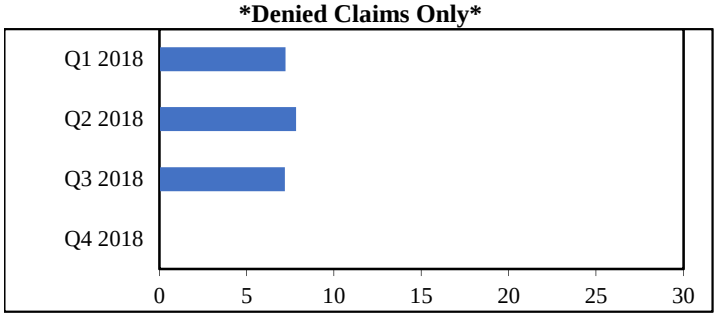


Claims Turnaround Time Quarter 3 2018 only Each MCOs

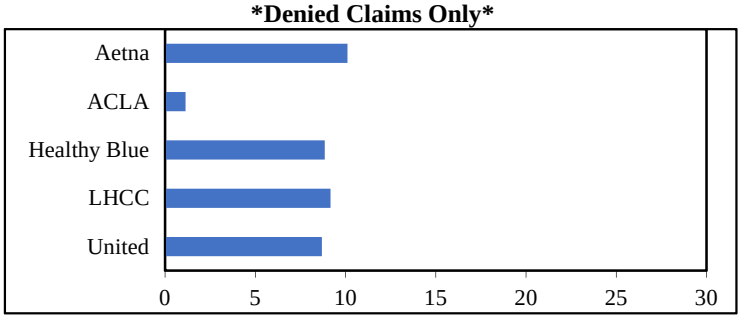
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCO within Three Provider Volume Ranges (# of claims submitted to the MCO in Quarter 3 2018 only)

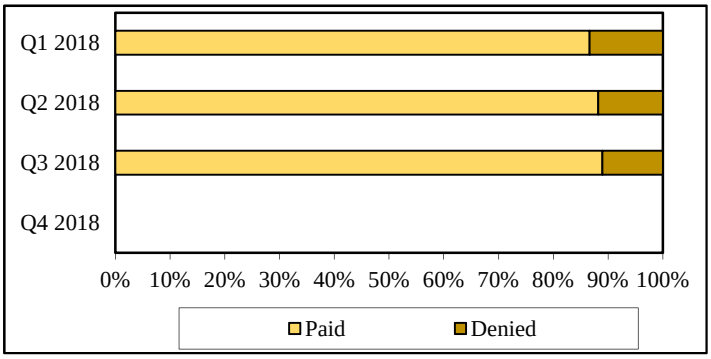
	Aetna		ACLA		Healthy Blue		LHCC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	40	26	68	31	53	27	68	32	22	8
101 - 250	8	4	4	4	10	4	27	12	1	1
> 250 claims	0	0	0	0	2	0	5	3	0	0

Top Denial Reasons this Quarter (An X means it was a top denial reason for the MCO.)

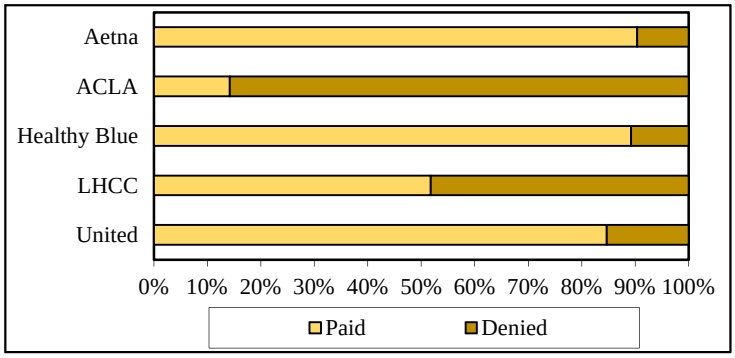
CARC Code	Description	Aetna	ACLA	HBL	LHCC	UHC
96	Non-covered charge(s). At least one Remark Code must be provi	X	X			
197	Precertification/authorization/notification absent.		X	X	X	
18	Exact duplicate claim/service (Use only with Group Code OA ex	X			X	
16	Claim/service lacks information or has submission/billing error(s	X				
22	This care may be covered by another payer per coordination of be				X	

Summary of Information on Claims for Other Institutional Services

Paid and Denied Trend in Most Recent Four Quarters Across All

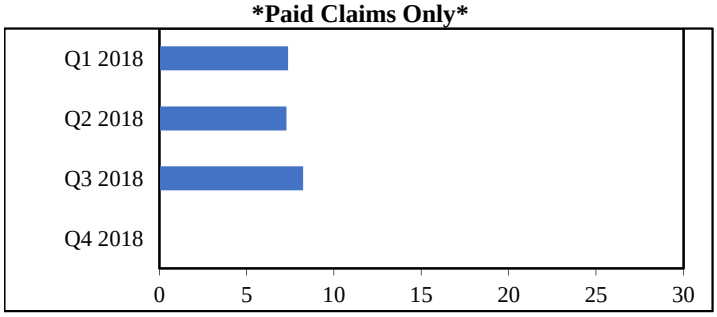


Paid and Denied Trend Quarter 3 2018 only For Each MCO



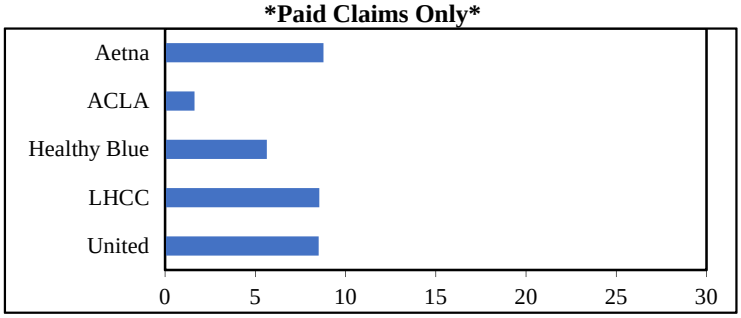
Claims Turnaround Time Most Recent 4 Qtrs All MCOs

Paid Claims Only

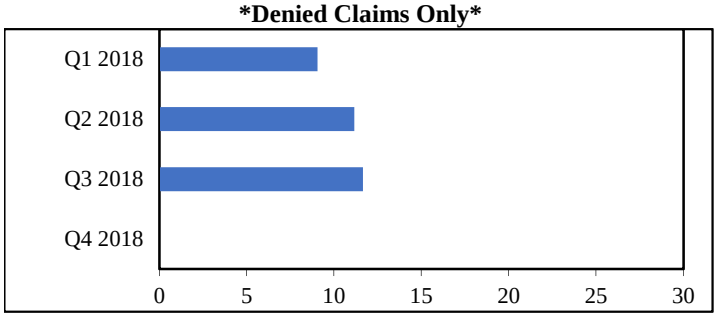


Claims Turnaround Time Quarter 3 2018 only Each MCOs

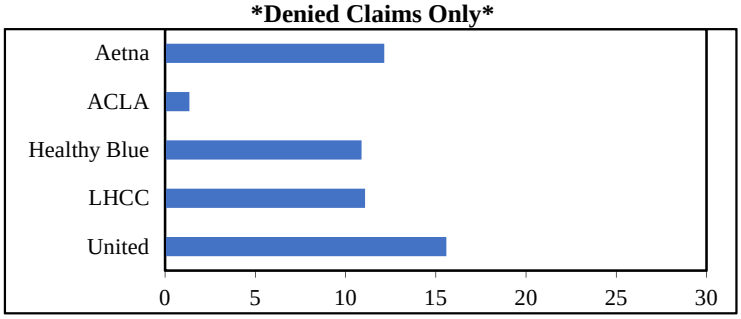
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCO within Three Provider Volume Ranges (# of claims submitted to the MCO in Quarter 3 2018 only)

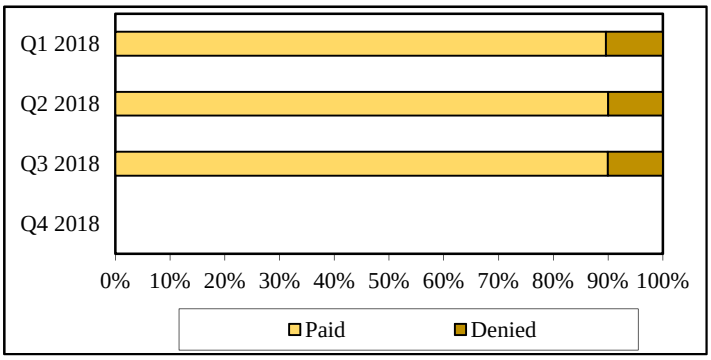
	Aetna		ACLA		Healthy Blue		LHCC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	179	119	11	6	111	49	25	20	17	4
101 - 250	72	56	1	1	48	14	2	2	14	7
> 250 claims	69	42	1	1	13	4	0	0	3	2

Top Denial Reasons this Quarter (An X means it was a top denial reason for the MCO.)

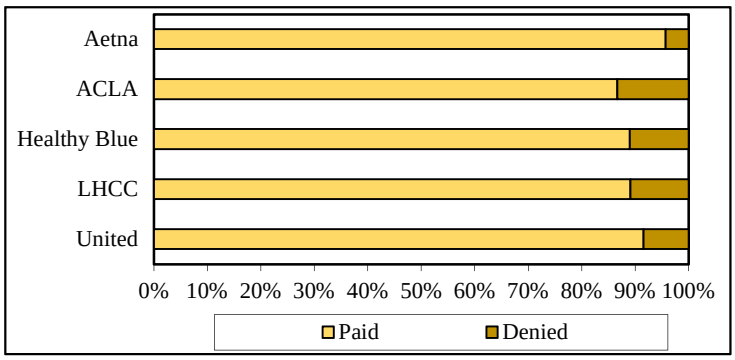
CARC Code	Description	Aetna	ACLA	HBL	LHCC	UHC
147	Provider contracted/negotiated rate expired or not on file.	X				
16	Claim/service lacks information or has submission/billing error(s	X			X	X
97	The benefit for this service is included in the payment/allowance	X	X			X
18	Exact duplicate claim/service (Use only with Group Code OA ex	X			X	X
96	Non-covered charge(s). At least one Remark Code must be provi	X	X		X	

Summary of Information on Claims for Primary Care Services

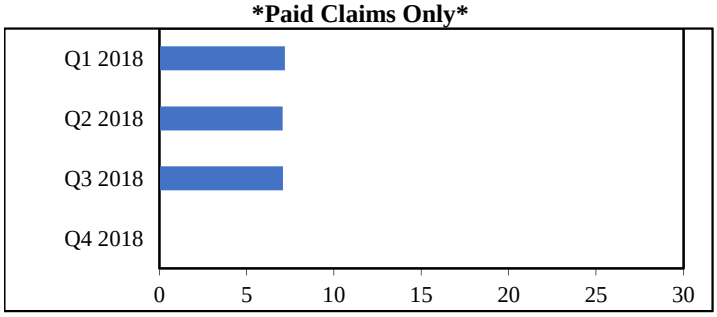
Paid and Denied Trend in Most Recent Four Quarters Across All



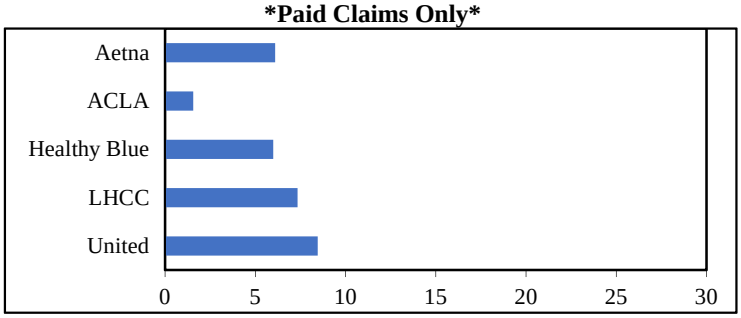
Paid and Denied Trend Quarter 3 2018 only For Each MCO



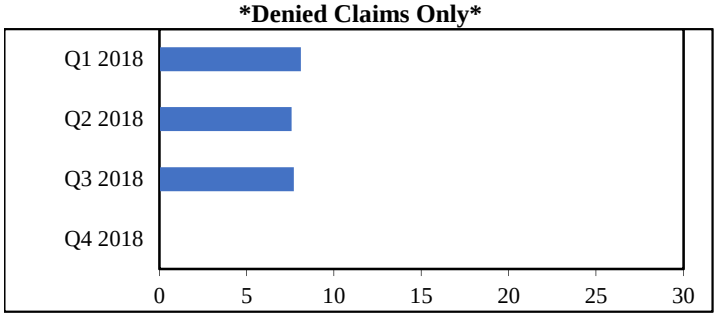
Claims Turnaround Time Most Recent 4 Qtrs All MCOs
Paid Claims Only



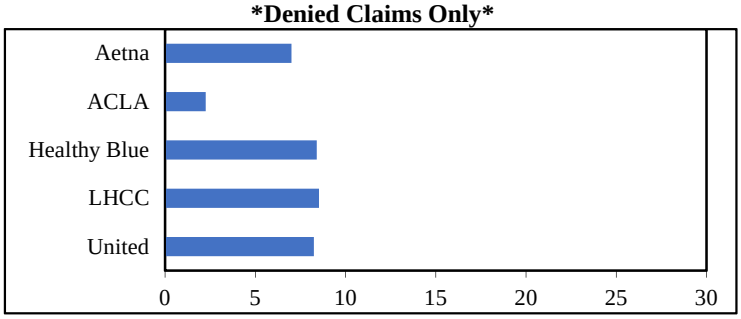
Claims Turnaround Time Quarter 3 2018 only Each MCOs
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCO within Three Provider Volume Ranges (# of claims submitted to the MCO in Quarter 3 2018 only)

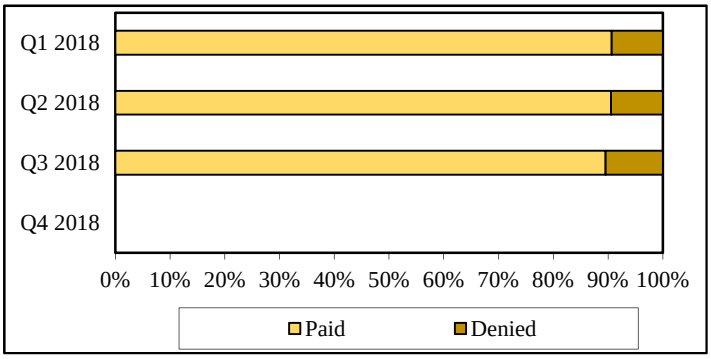
	Aetna		ACLA		Healthy Blue		LHCC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	25	8	843	356	3,373	1206	1,028	372	1,099	600
101 - 250	3	2	33	30	729	209	225	72	278	105
> 250 claims	0	0	3	3	125	37	41	20	271	77

Top Denial Reasons this Quarter (An X means it was a top denial reason for the MCO.)

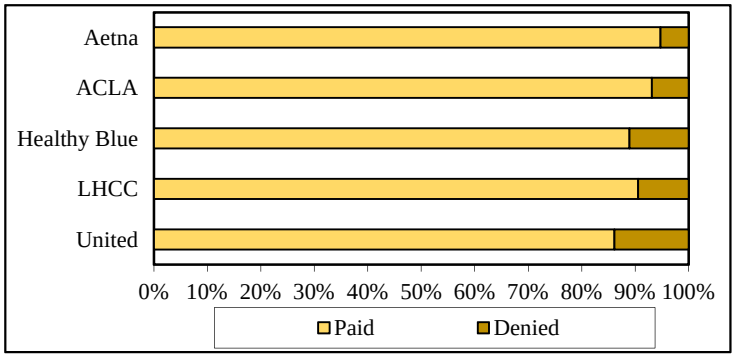
CARC Code	Description	Aetna	ACLA	HBL	LHCC	UHC
97	The benefit for this service is included in the payment/allowance	X	X			X
256	Service not payable per managed care contract.			X		
96	Non-covered charge(s). At least one Remark Code must be provi	X	X		X	
18	Exact duplicate claim/service (Use only with Group Code OA ex	X				X
100	Payment made to patient/insured/responsible party/employer.					X

Summary of Information on Claims for Pediatric Services

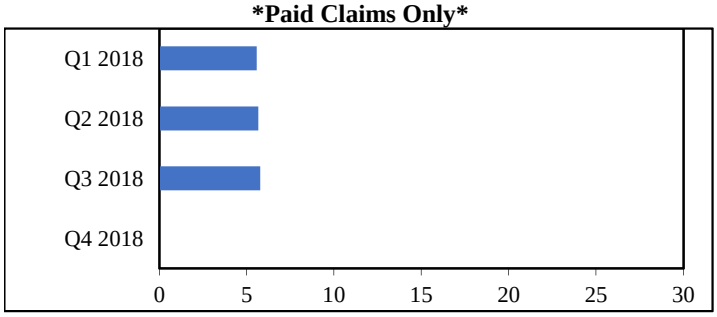
Paid and Denied Trend in Most Recent Four Quarters Across All



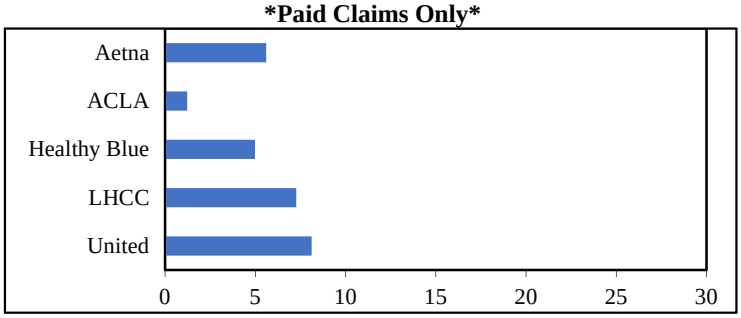
Paid and Denied Trend Quarter 3 2018 only For Each MCO



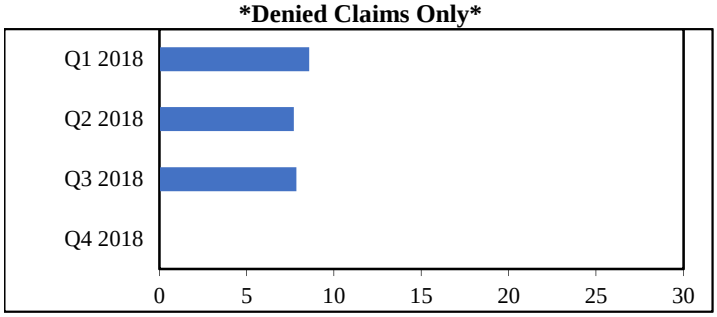
Claims Turnaround Time Most Recent 4 Qtrs All MCOs
Paid Claims Only



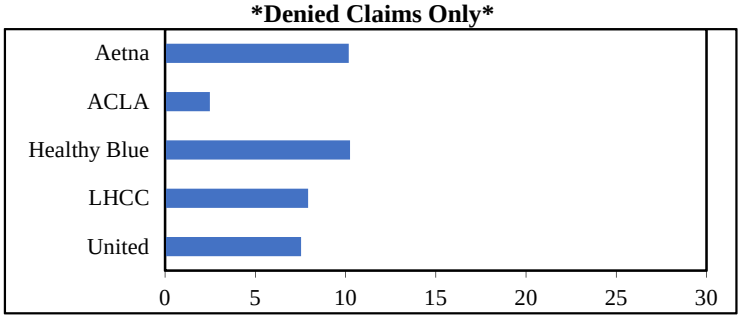
Claims Turnaround Time Quarter 3 2018 only Each MCOs
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCO within Three Provider Volume Ranges (# of claims submitted to the MCO in Quarter 3 2018 only)

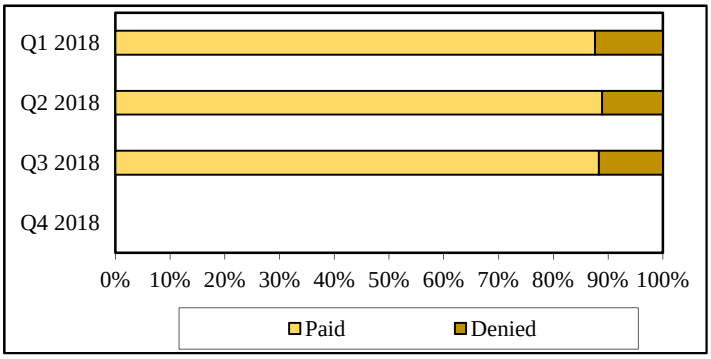
	Aetna		ACLA		Healthy Blue		LHCC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	6	3	260	75	434	154	96	30	41	21
101 - 250	1	0	25	18	257	111	43	6	13	5
> 250 claims	0	0	1	0	125	28	14	3	74	25

Top Denial Reasons this Quarter (An X means it was a top denial reason for the MCO.)

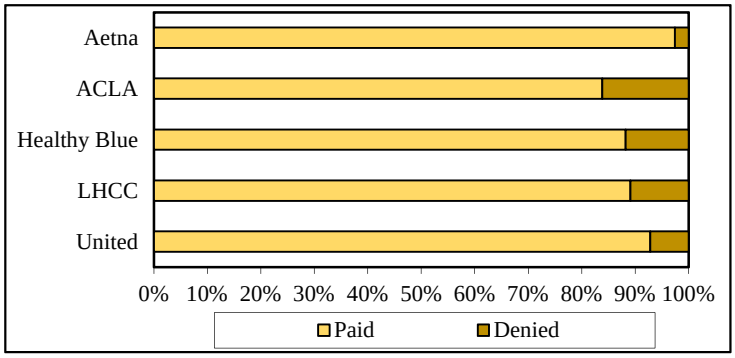
CARC Code	Description	Aetna	ACLA	HBL	LHCC	UHC
100	Payment made to patient/insured/responsible party/employer.					X
97	The benefit for this service is included in the payment/allowance	X	X			X
29	The time limit for filing has expired.					X
256	Service not payable per managed care contract.			X		
18	Exact duplicate claim/service (Use only with Group Code OA ex	X			X	X

Summary of Information on Claims for OBGYN Services

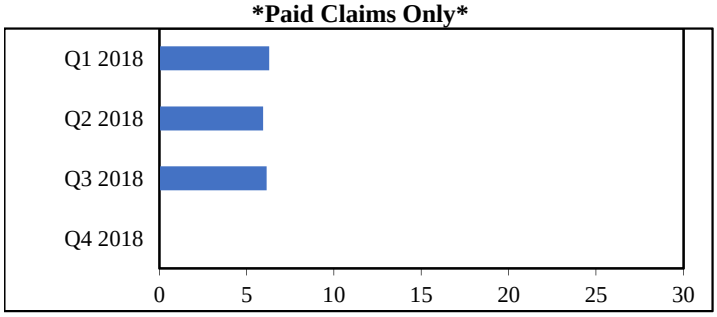
Paid and Denied Trend in Most Recent Four Quarters Across All



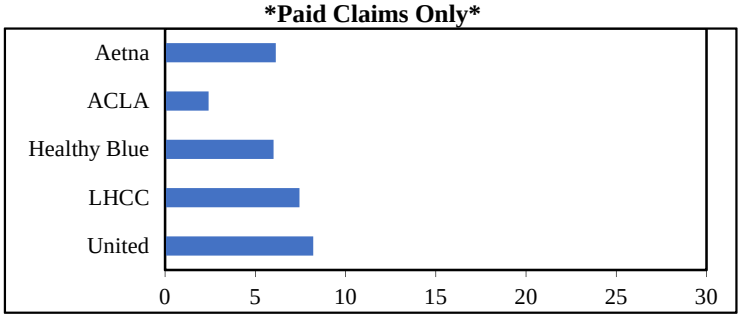
Paid and Denied Trend Most Recent Quarter For Each MCO



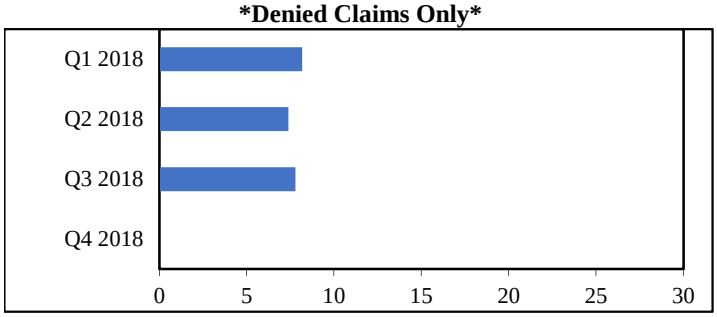
Claims Turnaround Time Most Recent 4 Qtrs All MCOs
Paid Claims Only



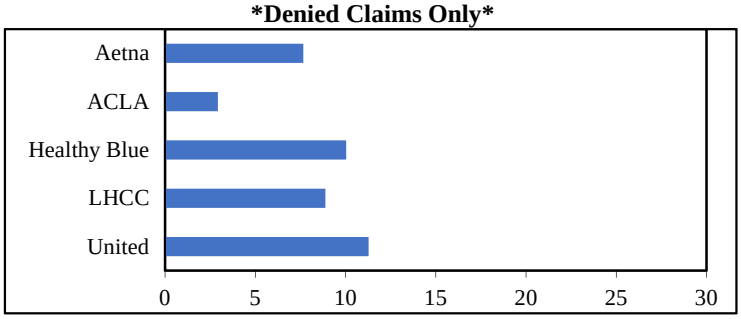
Claims Turnaround Time Quarter 3 2018 only Each MCOs
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCO within Three Provider Volume Ranges (# of claims submitted to the MCO in the most recent quarter)

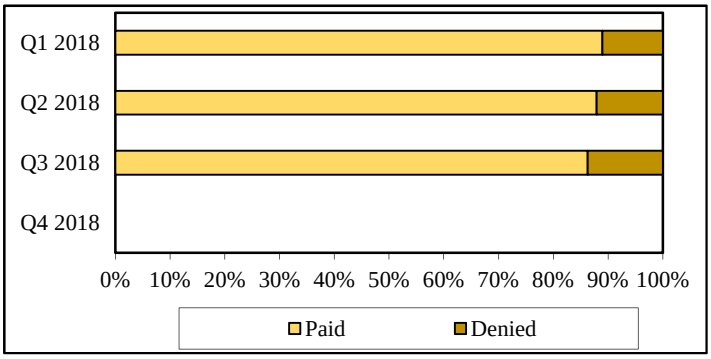
	Aetna		ACLA		Healthy Blue		LHCC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	0	0	186	91	305	125	95	46	46	25
101 - 250	1	0	14	12	210	75	39	16	24	9
> 250 claims	0	0	2	2	23	9	5	2	19	5

Top Denial Reasons this Quarter (An X means it was a top denial reason for the MCO.)

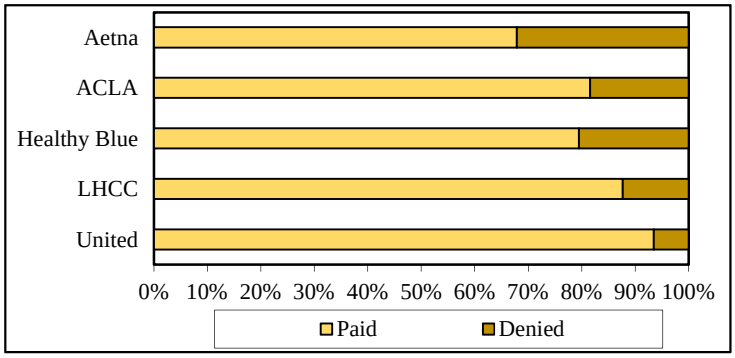
CARC Code	Description	Aetna	ACLA	HBL	LHCC	UHC
260	Processed under Medicaid ACA Enhanced Fee Schedule			X		
197	Precertification/authorization/notification absent.		X	X		
B7	This provider was not certified/eligible to be paid for this procedu		X			
16	Claim/service lacks information or has submission/billing error(s	X	X			
59	Processed based on multiple or concurrent procedure rules. (For	X			X	

Summary of Information on Claims for Therapy Services

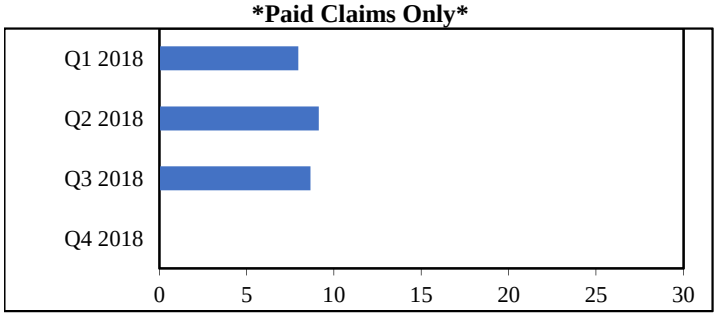
Paid and Denied Trend in Most Recent Four Quarters Across All



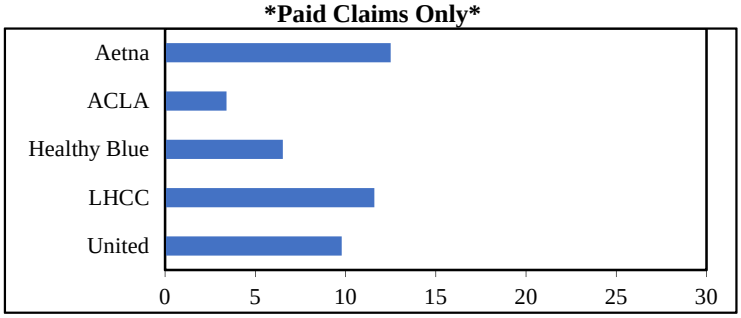
Paid and Denied Trend Quarter 3 2018 only For Each MCO



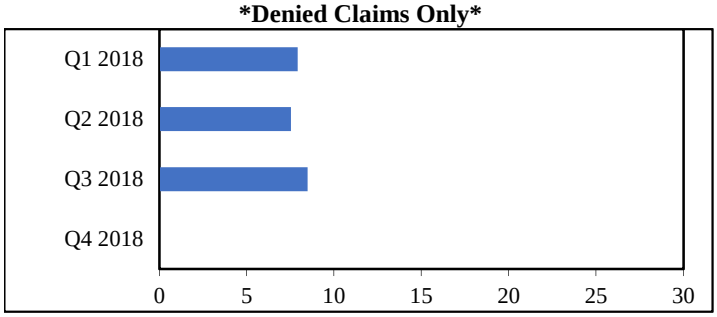
Claims Turnaround Time Most Recent 4 Qtrs All MCOs
Paid Claims Only



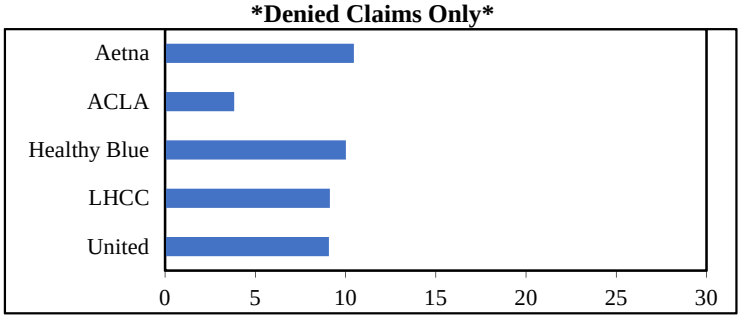
Claims Turnaround Time Quarter 3 2018 only Each MCOs
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCO within Three Provider Volume Ranges (# of claims submitted to the MCO in Quarter 3 2018 only)

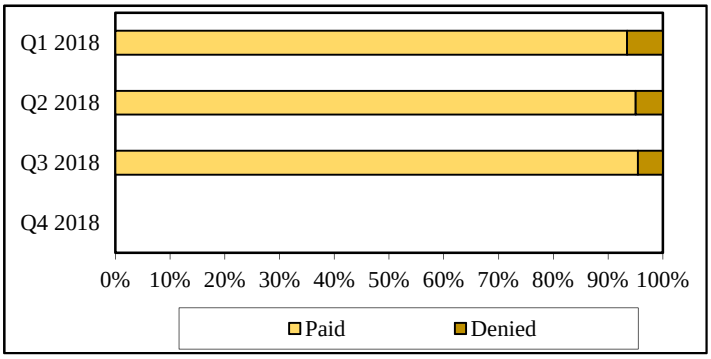
	Aetna		ACLA		Healthy Blue		LHCC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	1	1	67	43	183	122	27	4	20	9
101 - 250	2	1	2	2	38	31	8	0	16	6
> 250 claims	1	1	0	0	1	0	4	0	7	1

Top Denial Reasons this Quarter (An X means it was a top denial reason for the MCO.)

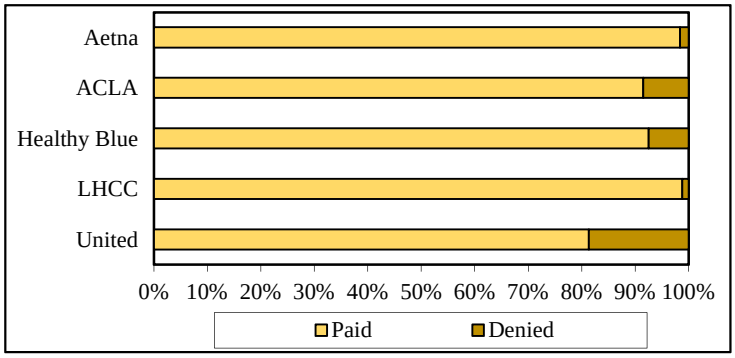
CARC Code	Description	Aetna	ACLA	HBL	LHCC	UHC
197	Precertification/authorization/notification absent.	X	X	X		
256	Service not payable per managed care contract.			X		
97	The benefit for this service is included in the payment/allowance	X				X
198	Precertification/authorization exceeded.			X		X
60	Charges for outpatient services are not covered when performed v					X

Summary of Information on Claims for NEMT Services

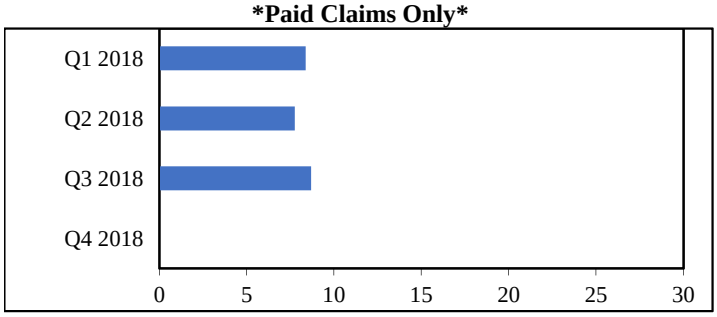
Paid and Denied Trend in Most Recent Four Quarters Across All



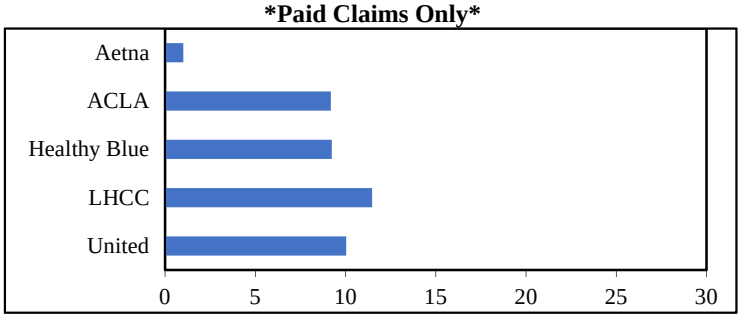
Paid and Denied Trend Quarter 3 2018 only For Each MCO



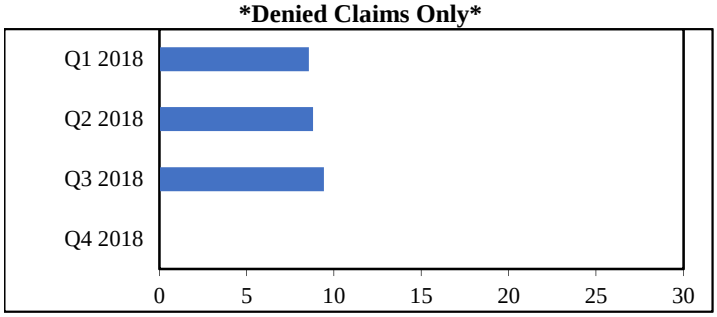
Claims Turnaround Time Most Recent 4 Qtrs All MCOs
Paid Claims Only



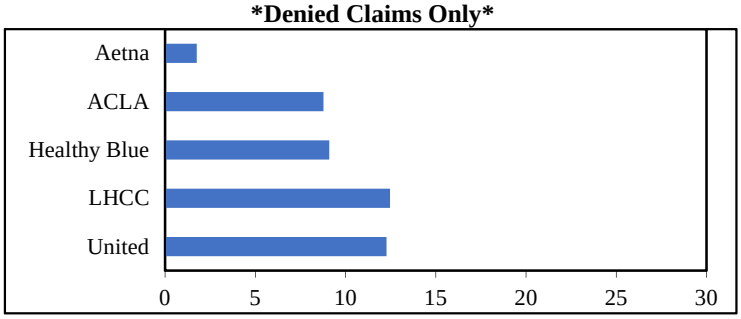
Claims Turnaround Time Quarter 3 2018 only Each MCOs
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCO within Three Provider Volume Ranges (# of claims submitted to the MCO in Quarter 3 2018 only)

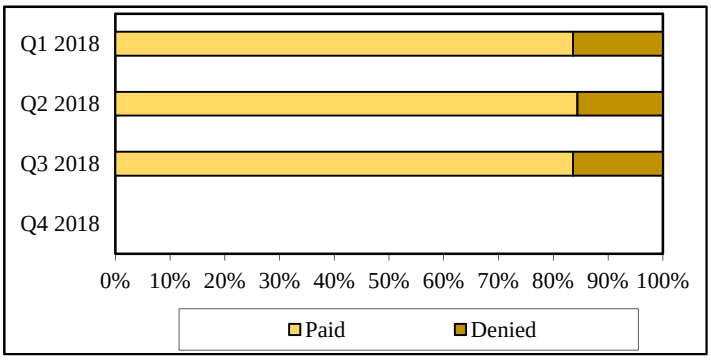
	Aetna		ACLA		Healthy Blue		LHCC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	69	12	77	38	48	20	21	4	161	89
101 - 250	73	5	80	30	80	26	57	4	10	6
> 250 claims	47	6	37	9	37	8	69	0	4	4

Top Denial Reasons this Quarter (An X means it was a top denial reason for the MCO.)

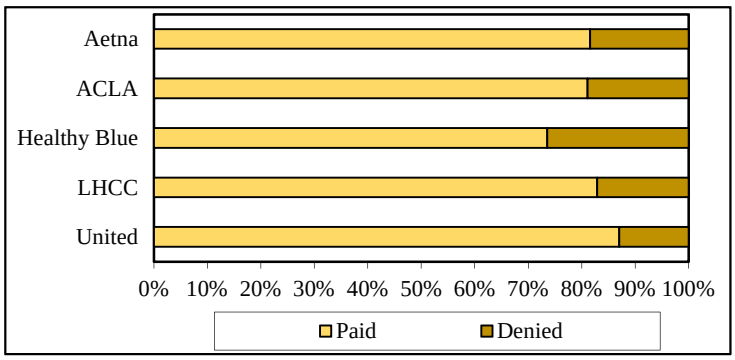
CARC Code	Description	Aetna	ACLA	HBL	LHCC	UHC
16	Claim/service lacks information or has submission/billing error(s	X	X	X	X	
97	The benefit for this service is included in the payment/allowance	X		X	X	X
18	Exact duplicate claim/service (Use only with Group Code OA ex	X		X	X	
8	The procedure code is inconsistent with the provider type/special	X		X	X	
133	The disposition of this service line is pending further review. (Us	X		X	X	

Summary of Information on Claims for Medical Supplies Services

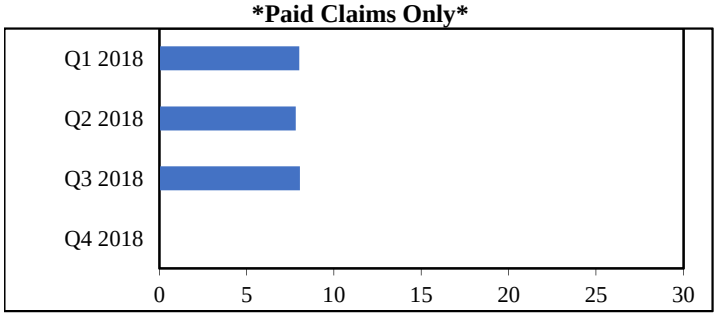
Paid and Denied Trend in Most Recent Four Quarters Across All



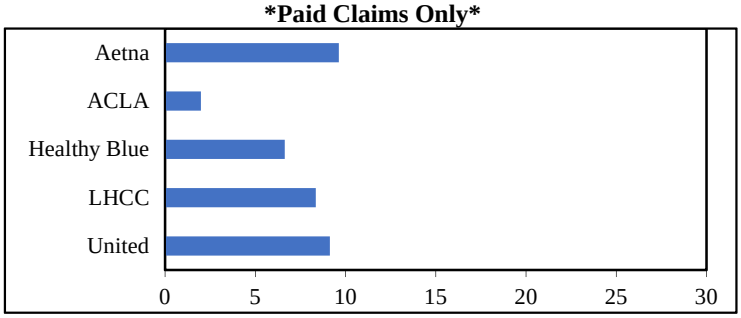
Paid and Denied Trend Quarter 3 2018 only For Each MCO



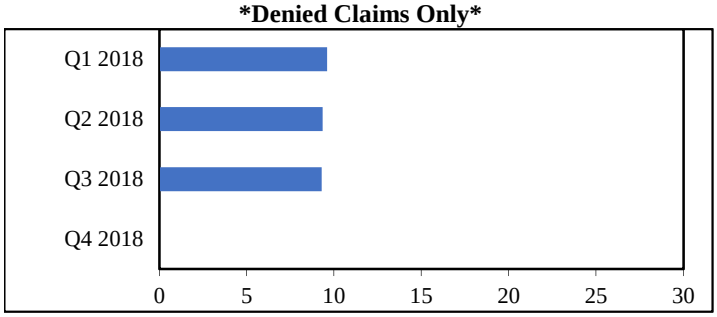
Claims Turnaround Time Most Recent 4 Qtrs All MCOs
Paid Claims Only



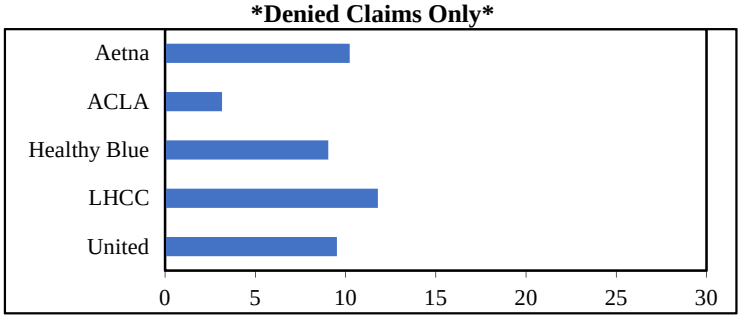
Claims Turnaround Time Quarter 3 2018 only Each MCOs
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCO within Three Provider Volume Ranges (# of claims submitted to the MCO in Quarter 3 2018 only)

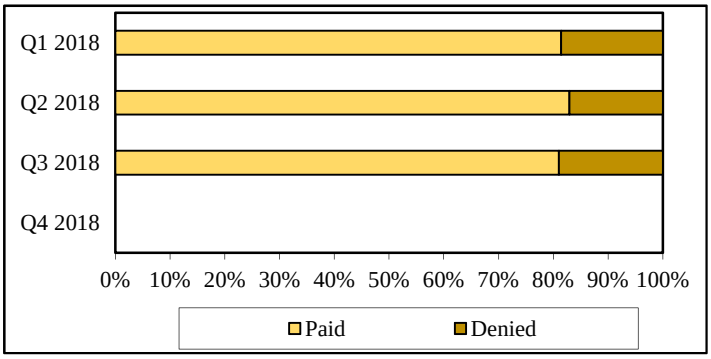
	Aetna		ACLA		Healthy Blue		LHCC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	1,113	683	205	118	102	41	107	48	359	240
101 - 250	61	51	10	10	3	2	48	31	46	17
> 250 claims	6	6	0	0	0	0	6	4	25	8

Top Denial Reasons this Quarter (An X means it was a top denial reason for the MCO.)

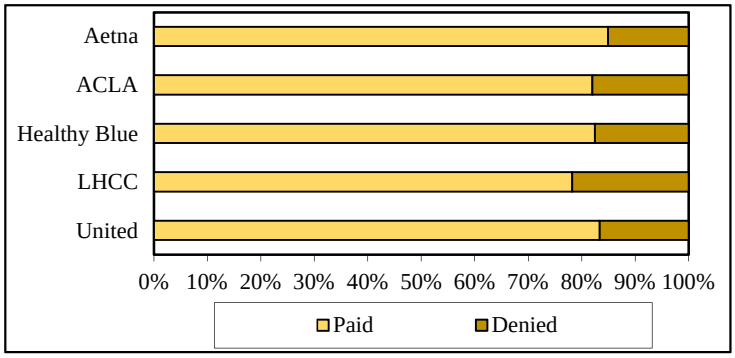
CARC Code	Description	Aetna	ACLA	HBL	LHCC	UHC
16	Claim/service lacks information or has submission/billing error(s	X	X		X	
97	The benefit for this service is included in the payment/allowance	X				X
18	Exact duplicate claim/service (Use only with Group Code OA ex	X			X	X
96	Non-covered charge(s). At least one Remark Code must be provi	X	X			
197	Precertification/authorization/notification absent.		X	X	X	

Summary of Information on Claims for All Other Professional Claim Services (except Mental Health)

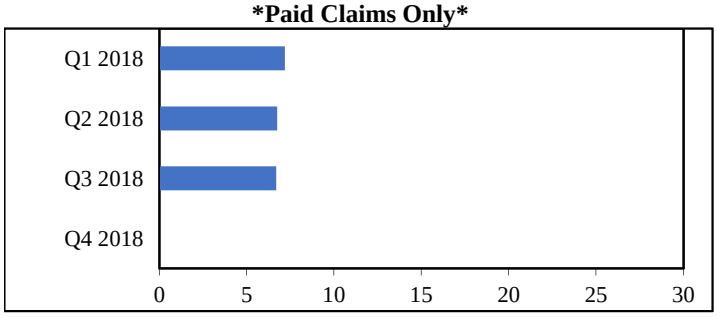
Paid and Denied Trend in Most Recent Four Quarters Across All



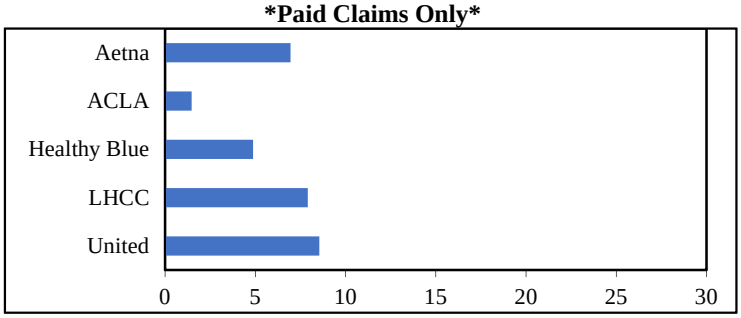
Paid and Denied Trend Most Recent Quarter For Each MCO



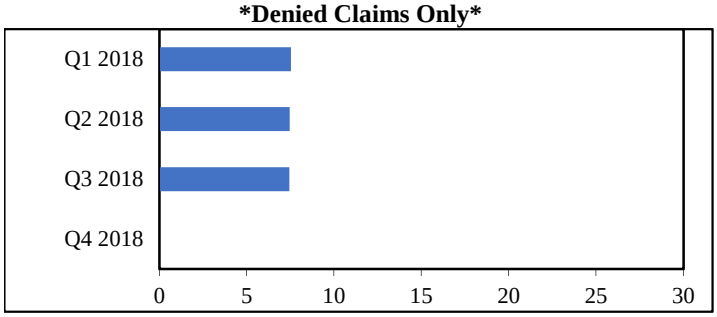
Claims Turnaround Time Most Recent 4 Qtrs All MCOs
Paid Claims Only



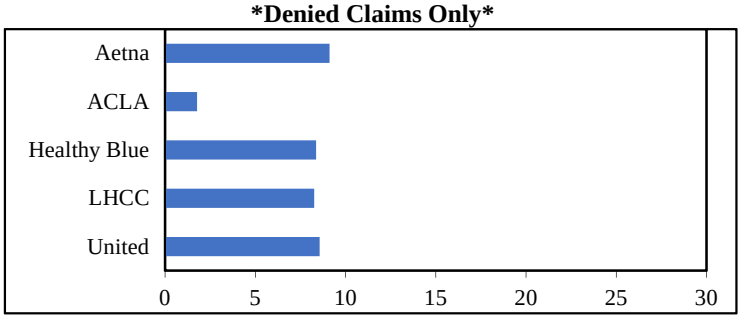
Claims Turnaround Time Quarter 3 2018 only Each MCOs
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCO within Three Provider Volume Ranges (# of claims submitted to the MCO in the most recent quarter)

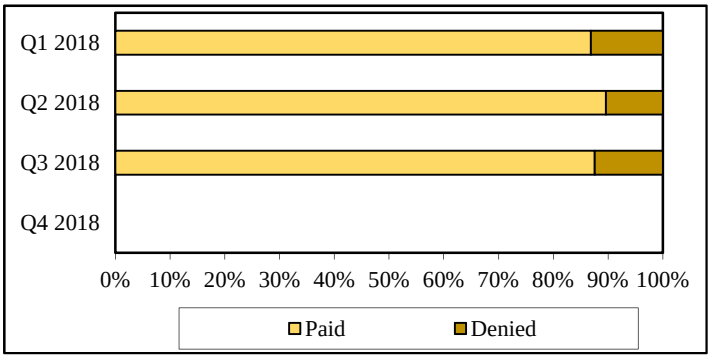
	Aetna		ACLA		Healthy Blue		LHCC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	417	180	2,686	1189	7,506	2610	4,796	1555	2,533	1365
101 - 250	167	62	124	97	966	299	625	282	455	231
> 250 claims	33	10	38	33	108	50	186	93	325	132

Top Denial Reasons this Quarter (An X means it was a top denial reason for the MCO.)

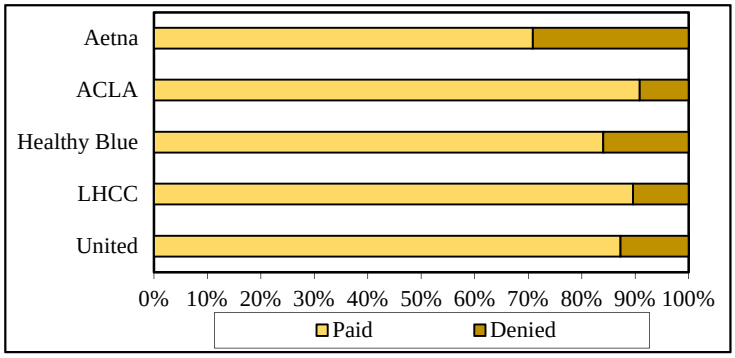
CARC Code	Description	Aetna	ACLA	HBL	LHCC	UHC
197	Precertification/authorization/notification absent.	X	X	X	X	
198	Precertification/authorization exceeded.					X
97	The benefit for this service is included in the payment/allowance	X	X			X
96	Non-covered charge(s). At least one Remark Code must be provi	X	X			
16	Claim/service lacks information or has submission/billing error(s	X	X			

Summary of Information on Claims for Mental Health Services- Rehab

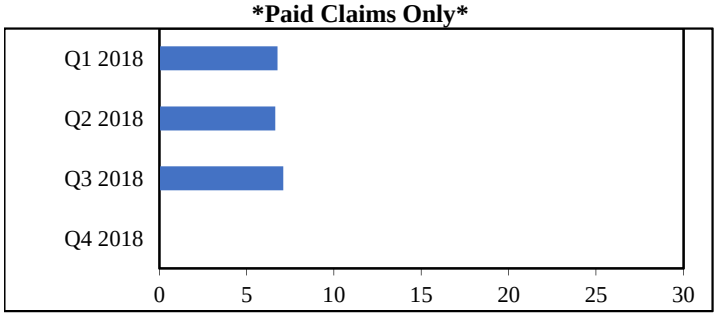
Paid and Denied Trend in Most Recent Four Quarters Across All



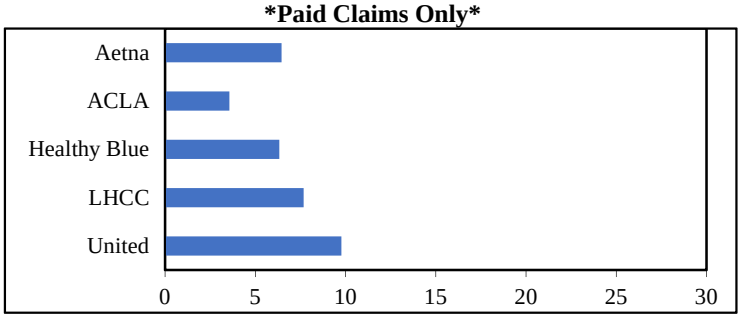
Paid and Denied Trend Quarter 3 2018 only For Each MCO



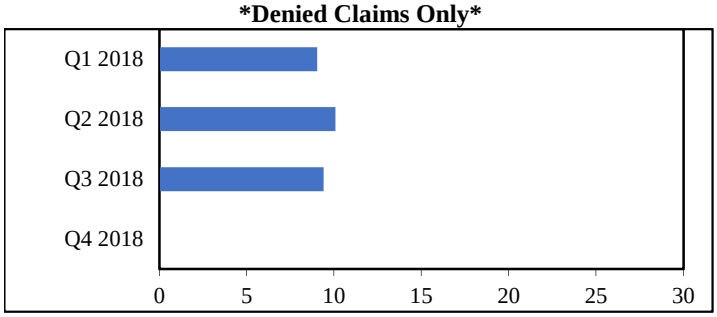
Claims Turnaround Time Most Recent 4 Qtrs All MCOs
Paid Claims Only



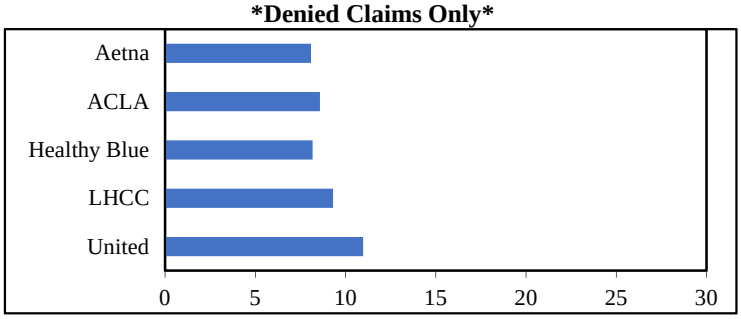
Claims Turnaround Time Quarter 3 2018 only Each MCOs
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCO within Three Provider Volume Ranges (# of claims submitted to the MCO in Quarter 3 2018 only)

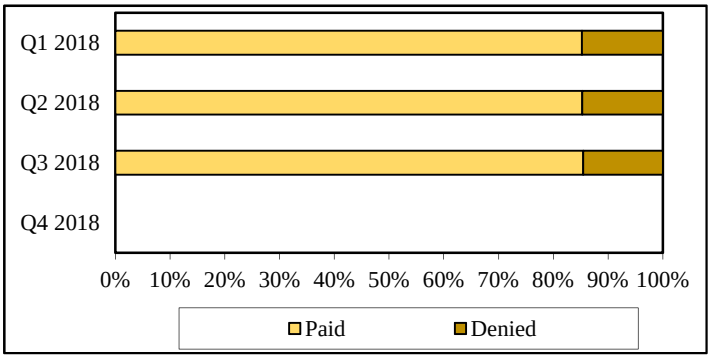
	Aetna		ACLA		Healthy Blue		LHCC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	33	24	350	104	83	28	22	10	79	44
101 - 250	0	0	23	14	170	64	21	7	69	24
> 250 claims	0	0	1	1	103	43	21	4	129	46

Top Denial Reasons this Quarter (An X means it was a top denial reason for the MCO.)

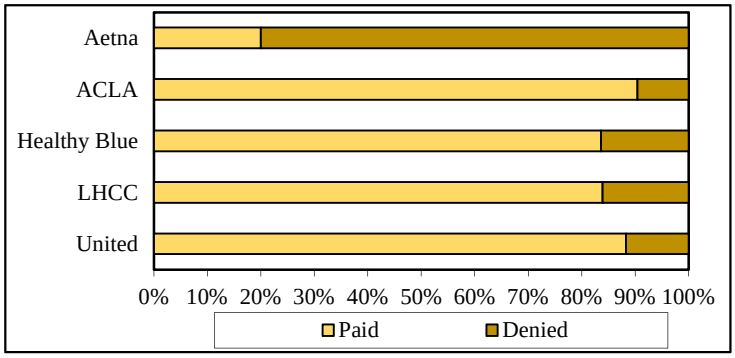
CARC Code	Description	Aetna	ACLA	HBL	LHCC	UHC
198	Precertification/authorization exceeded.		X	X	X	X
197	Precertification/authorization/notification absent.		X	X	X	
18	Exact duplicate claim/service (Use only with Group Code OA exc	X			X	X
150	Payer deems the information submitted does not support this leve			X		
27	Expenses incurred after coverage terminated.		X			X

Summary of Information on Claims for Behavioral Health Specialized Services other than Rehab

Paid and Denied Trend in Most Recent Four Quarters Across All

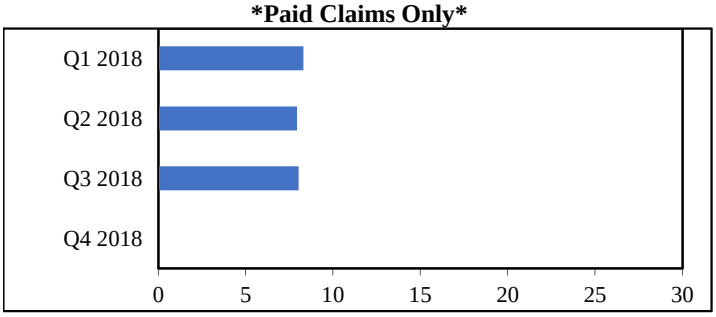


Paid and Denied Trend Quarter 3 2018 only For Each MCO



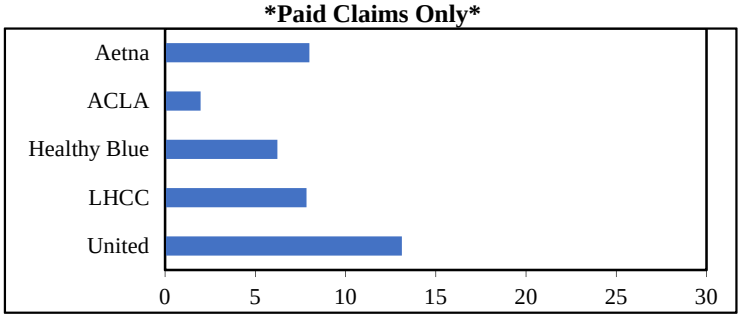
Claims Turnaround Time Most Recent 4 Qtrs All MCOs

Paid Claims Only

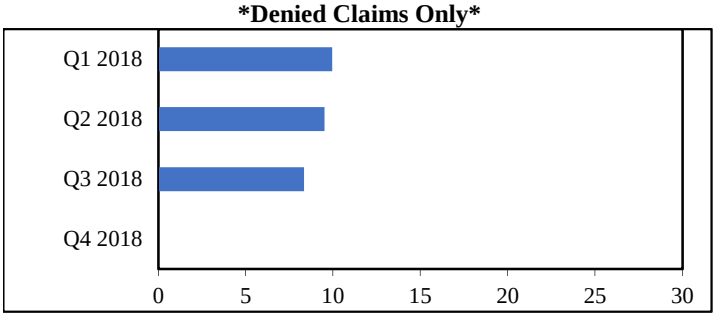


Claims Turnaround Time Quarter 3 2018 only Each MCOs

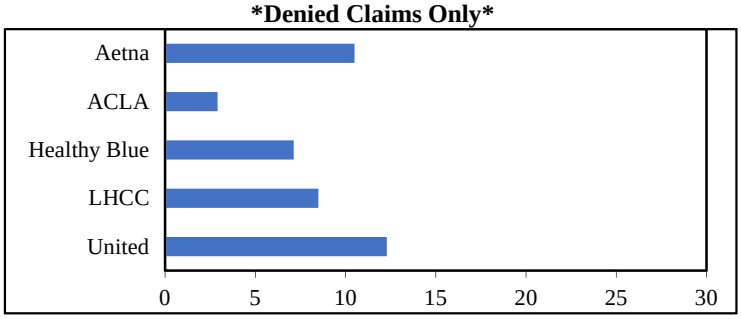
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCO within Three Provider Volume Ranges (# of claims submitted to the MCO in Quarter 3 2018 only)

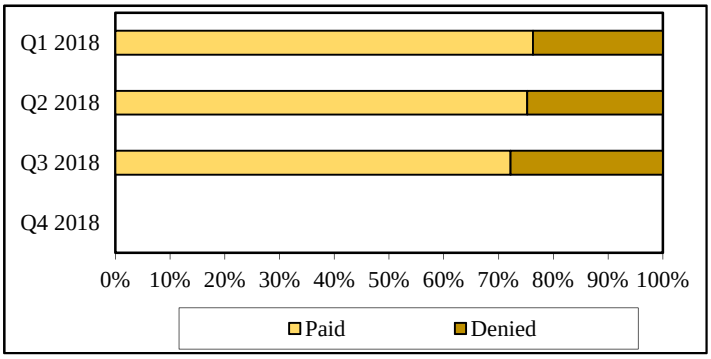
	Aetna		ACLA		Healthy Blue		LHCC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	2	1	447	121	1,525	684	953	382	225	122
101 - 250	0	0	8	7	296	131	104	40	45	26
> 250 claims	0	0	0	0	38	18	6	3	45	19

Top Denial Reasons this Quarter (An X means it was a top denial reason for the MCO.)

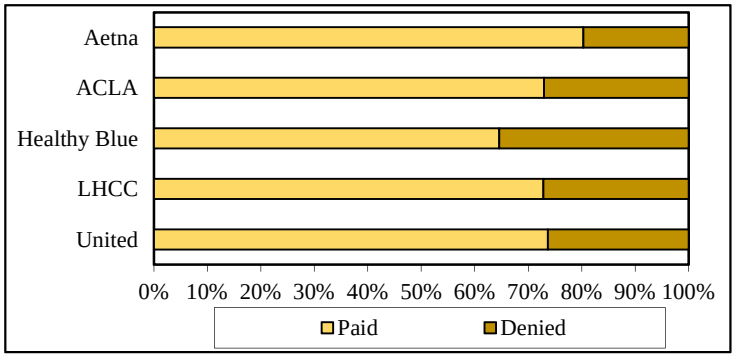
CARC Code	Description	Aetna	ACLA	HBL	LHCC	UHC
197	Precertification/authorization/notification absent.	X		X	X	
198	Precertification/authorization exceeded.	X		X		X
18	Exact duplicate claim/service (Use only with Group Code OA ex	X			X	X
16	Claim/service lacks information or has submission/billing error(s	X				
252	An attachment/other documentation is required to adjudicate this	X	X	X		

Summary of Information on Claims for Pharmacy Services

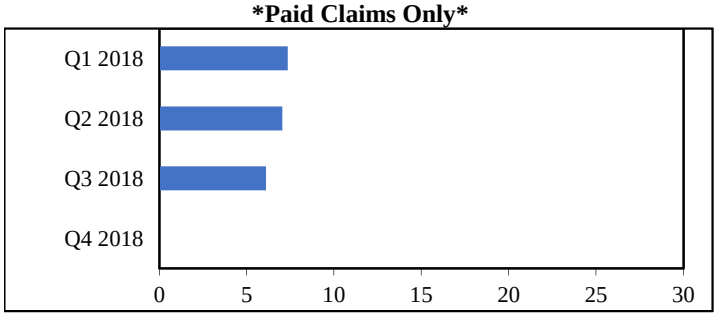
Paid and Denied Trend in Most Recent Four Quarters Across All



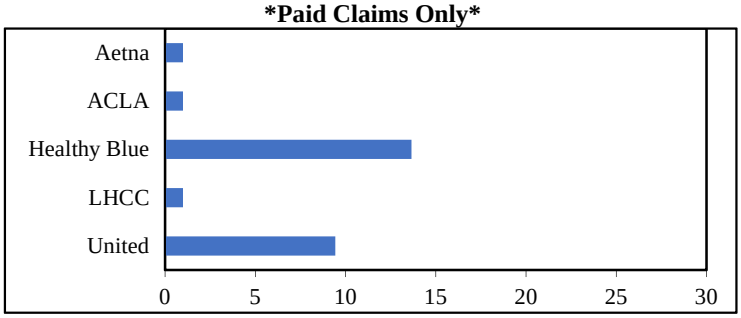
Paid and Denied Trend Quarter 3 2018 only For Each MCO



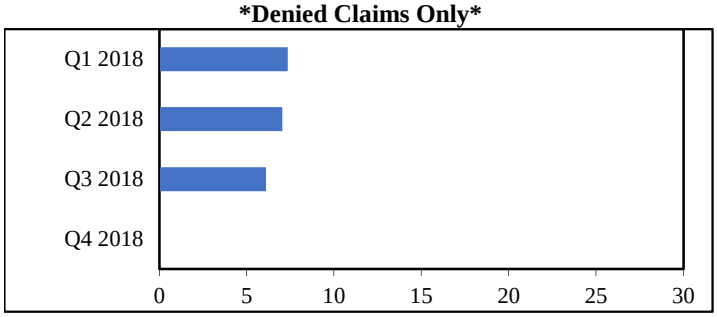
Claims Turnaround Time Most Recent 4 Qtrs All MCOs
Paid Claims Only



Claims Turnaround Time Quarter 3 2018 only Each MCOs
Paid Claims Only



Denied Claims Only



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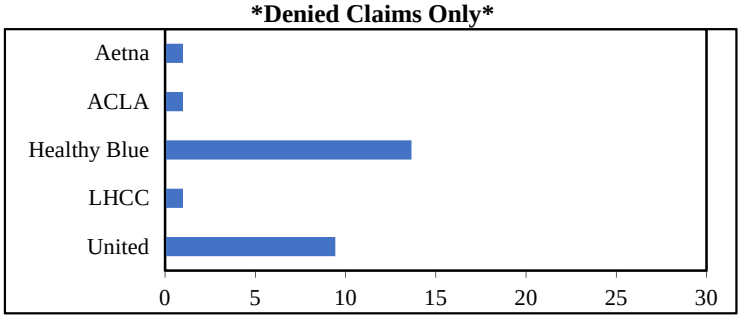


Denied Claims Rate by MCO within Three Provider Volume Ranges (# of claims submitted to the MCO in Quarter 3 2018 only)

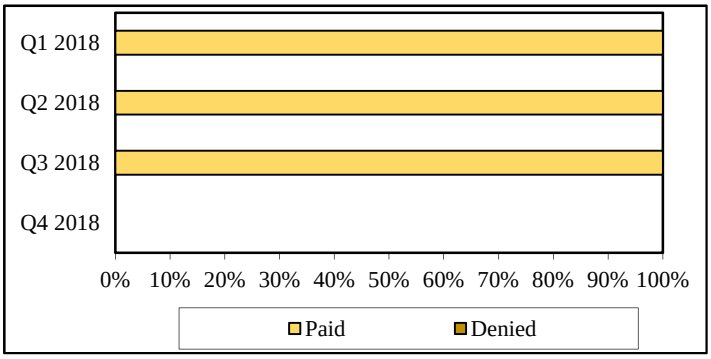
	Aetna		ACLA		Healthy Blue		LHCC		UHC	
	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied	# Providers	>10% denied
<100 claims	15,017	8640	1,240	1151	1,978	1739	11,509	11083	16,895	12341
101 - 250	1,280	1181	397	395	279	278	2,919	2888	3,518	3454
> 250 claims	128	125	651	649	812	811	975	973	1345	1340

Top Denial Reasons this Quarter (An X means it was a top denial reason for the MCO.)

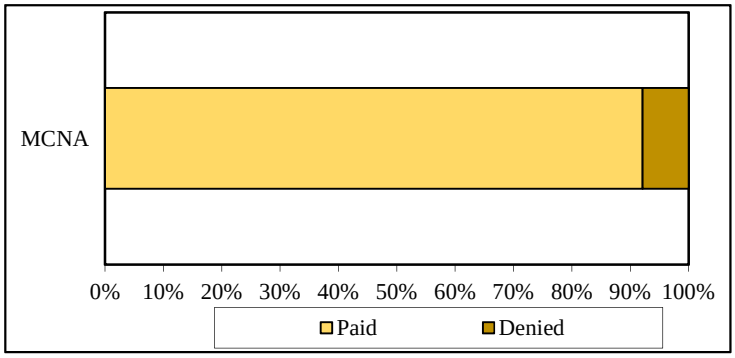
NCDCP Code	Description	Aetna	ACLA	HBL	LHCC	UHC
88	DUR Reject Error					X
79	Refill Too Soon	X	X			X
7J	Patient Relationship Code Value Not Supported				X	X
76	Plan Limitations Exceeded	X	X			X
7N	Patient ID Qualifier Value Not Supported				X	X

Summary of Information on Claims for Dental Services- Children

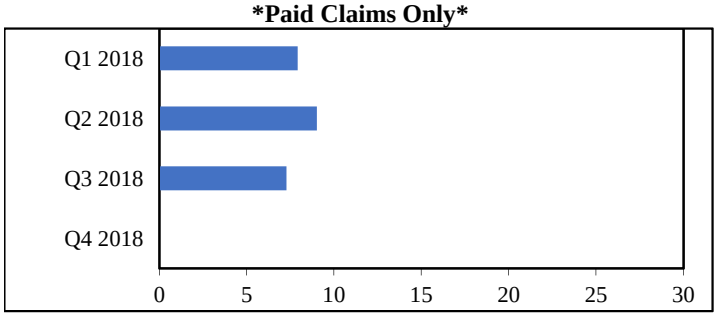
Paid and Denied Trend in Most Recent Four Quarters Across All



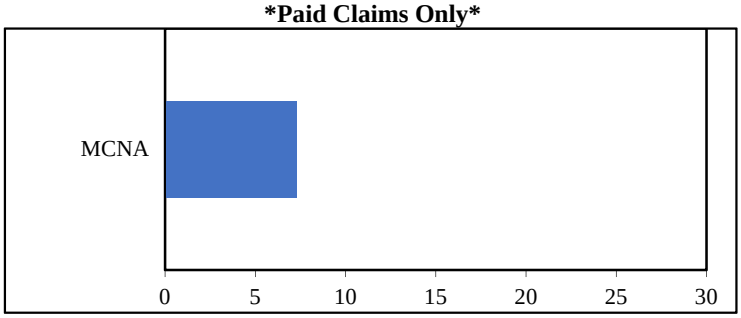
Paid and Denied Trend Quarter 3 2018 only For Each MCO



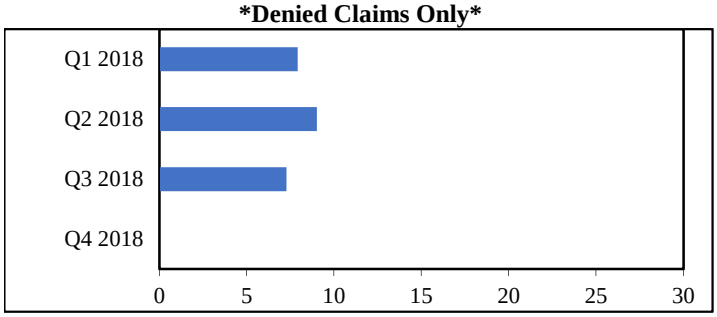
Claims Turnaround Time Most Recent 4 Qtrs All MCOs
Paid Claims Only



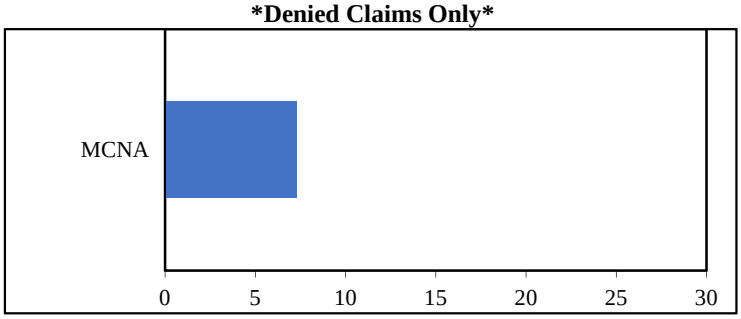
Claims Turnaround Time Quarter 3 2018 only Each MCOs
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCO within Three Provider Volume Ranges (# of claims submitted to the MCO in Quarter 3 2018 only)

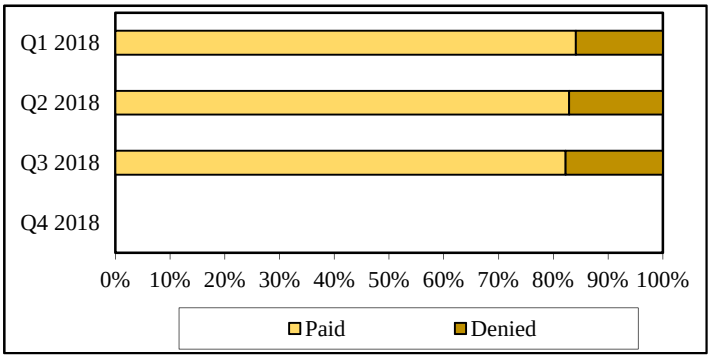
	MCNA	
	# Providers	>10% denied
<100 claims	650	303
101 - 250	175	86
> 250 claims	20	17

Top Denial Reasons this Quarter (An X means it was a top denial reason for the MCO.)

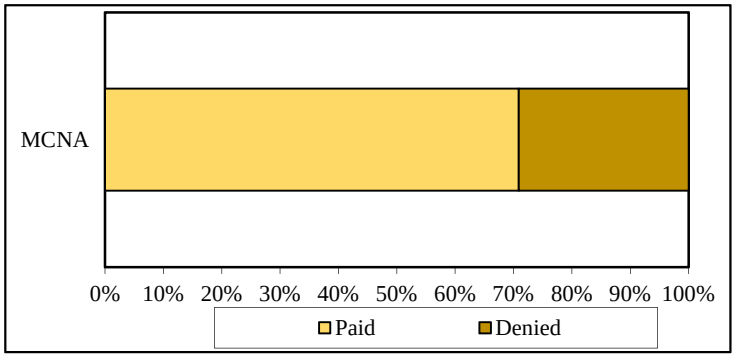
CARC Code	Description	MCNA
14	The date of birth follows the date of service.	X
1	Deductible Amount	X
32	Our records indicate that this dependent is not an eligible depend	X
21	This injury/illness is the liability of the no-fault carrier.	X
26	Expenses incurred prior to coverage.	X

Summary of Information on Claims for Dental Services- Adults

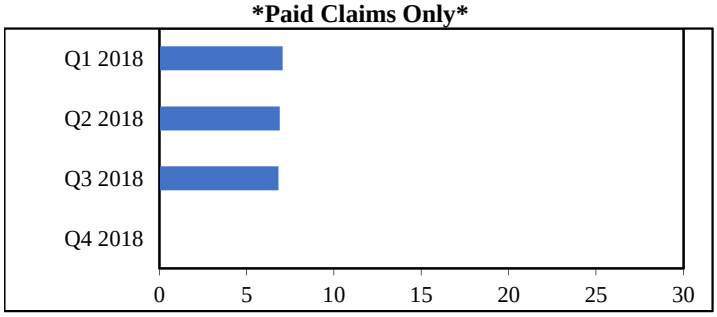
Paid and Denied Trend in Most Recent Four Quarters Across All



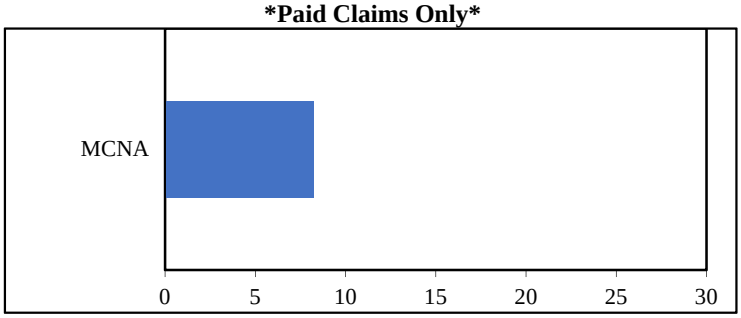
Paid and Denied Trend Quarter 3 2018 only For Each MCO



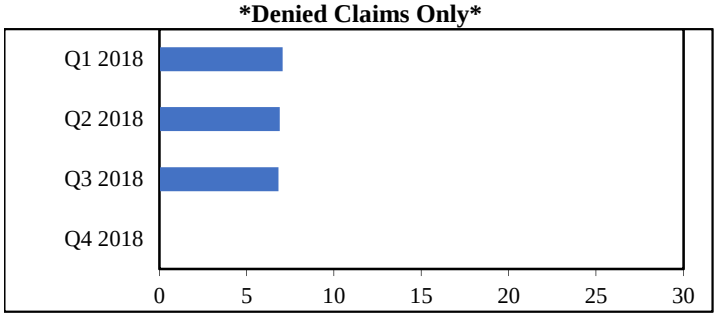
Claims Turnaround Time Most Recent 4 Qtrs All MCOs
Paid Claims Only



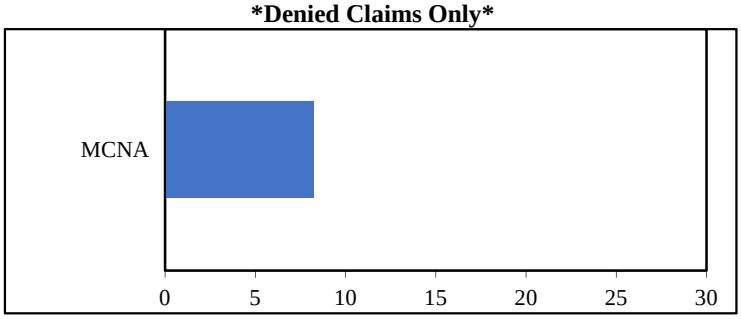
Claims Turnaround Time Quarter 3 2018 only Each MCOs
Paid Claims Only



Denied Claims Only



Denied Claims Only



Denied Claims Rate by MCO within Three Provider Volume Ranges (# of claims submitted to the MCO in Quarter 3 2018 only)

	MCNA	
	# Providers	>10% denied
<100 claims	318	285
101 - 250	2	2
> 250 claims	0	0

Note: All MCOs had little data for Dental-Adult

Top Denial Reasons this Quarter (An X means it was a top denial reason for the MCO.)

CARC Code	Description	MCNA
119	Benefit maximum for this time period or occurrence has been rea	
242	Services not provided by network/primary care providers.	
18	Exact duplicate claim/service (Use only with Group Code OA ex	X
31	Patient cannot be identified as our insured.	X
252	An attachment/other documentation is required to adjudicate this	