2008 National Health Insurer Report Card

The purpose of the AMA's National Health Insurer Report Card (NHIRC) is to provide physicians and the general public a reliable and defensible source of critical metrics concerning the timeliness, transparency and accuracy of claims processing by the health insurance companies that are responsible for paying these claims. Billions of dollars in administrative waste would be eliminated each year if third party-payers sent a timely, accurate and specific response to each physician claim.

The NHIRC is for informational purposes only. Physicians and payers are encouraged to review the NHIRC results and begin healing the health care claims process by supporting the AMA's "Heal the claims process" campaign and committing to the goal of reducing the cost of claims administration to 1 percent of collections. Visit the AMA Practice Management Center Web site at www.ama-assn.org/go/pmc for information on the "Heal the claims process" campaign.

Health Insurer	Aetna	Anthem BCBS	CIGNA	Coventry	Health Net	Humana	United Healthcare (UHC)	Medicare
Payment Timeliness								
Metric 1 Payer claim received date disclosed	100%	99.21%	0%	100%	99.76%	0.07%	99.98%	99.99%
Metric 2 First remittance response time (median days)	13	7	14	4	11	13	10	14
Metric 3 ERA activity during the data period	Not Reported (NR)	NR	NR	NR	NR	NR	NR	NR
Accuracy								
Metric 4 Allowed amount disclosed	97.77%	97.37%	19.25	99.30%	65.72%	97.33%	93.40%	98.53%
Metric 5 Contracted payment rate adherence	70.78%	72.14%	66.23%	86.74%	NR	84.20%	61.55%	98.12%
Transparency of contracted fees and payment policies on payer Web sites								
Metric 6 Contracted fee schedule	No	Yes	No	No	No	Yes	Yes	Yes
Metric 7 Contract fee schedule codes allowed per request	0	25	0	0	0	30	30	All
Metric 8 Payer-proprietary claim edits	Yes[1]	Yes[1]	Yes[1]	No[3]	Yes[1]	Yes[1]	Yes[1]	Yes
Metric 9 Medical payment policies	Yes[2]	Yes[2]	Yes[2]	No	Yes[2]	No	Yes[2]	Yes

[1] At least some payer proprietary edits are available.
[2] At least some medical payment policies are available.
[3] May not be applicable given that no payer-proprietary claim edits were identified by this analysis.

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Health Insurer	Aetna	Anthem BCBS	CIGNA	Coventry	Health Net	Humana	United Healthcare (UHC)	Medicare
Compliance with generally accepted pricing rules								
Metric 10 Percentage of claim lines reduced to $0 by edits	3.75%	3.40%	7.33%	0.31%	NR	3.17%	9.15%	1.40%
Metric 11* Source of payer claim edits CPT	1.4%	2.5%	0.6%	32.4%	NR	1.5%	4.5%	9.2%
ASA	0.0%	0.0%	0.0%	0.0%	NR	0.0%	0.0%	2.6%
NCCI	2.7%	50.4%	6.1%	50.0%	NR	9.2%	5.2%	19.0%
Medicare reimbursement policies	41.8%	31.1%	92.9%	17.6%	NR	17.3%	57.3%	49.9%
Payer-proprietary claim edits	54.1%	16.0%	0.4%	0.0%	NR	71.9%	33.0%	19.3%
Denials (Payer allows the physician's billed charge, but payment is $0)								
Metric 12 Percentages of claim lines denied	6.80%	4.62%	3.44%	2.88%	3.88%	2.90%	2.68%	6.85%

Metric 13* Reason codes (Claim adjustment reason codes [CARC]) given for denials out of 190 available reason codes.

Aetna		Anthem BCBS		CIGNA		Coventry		Humana		UHC		Medicare	
CARC	%	CARC	%	CARC	%	CARC	%	CARC	%	CARC	%	CARC	%
97	65.8%	16	20.1%	1	37.6%	26	53.6%	27	34.2%	27	37.9%	16	27.8%
17	7.8%	27	14.9%	B11	17.0%	109	11.5%	109	14.2%	29	17.5%	50	20.9%
1	6.8%	96	11.8%	96	13.7%	1	6.6%	B9	9.7%	1	7.9%	109	13.8%
other	19.6%	31	10.4%	18	5.7%	29	4.4%	16	9.4%	204	4.7%	96	8.5%
		204	8.9	38	5.5%	197	3.7%	96	5.9%	96	4.5%	31	5.8%
		1	7.7%	17	2.6%	160	3.1%	26	5.4%	51	3.0%	49	3.9%
		109	4.3%	other	17.8%	other	17.1%	38	4.9%	26	2.5%	other	19.3%
		29	3.7%					other	16.4%	49	2.5%		
		other	18.1%							other	19.6%		

Metric 14* Remark codes (RC) given for denials out of 675 available remark codes

Aetna		Anthem BCBS		CIGNA		Coventry		Humana		UHC		Medicare	
RC	%	RC	%	RC	%	RC	%	RC	%	RC	%	RC	%
N19	62.4%	N197	16.1%	MA67	83.1%	N418	37.4%	N/A		N174	59.2%	N115	16.2%
N130	16.2%	N4	11.4%	other	16.9%	N130	11.0%			M86	13.1%	M25	15.0%
N102	8.5%	M81	11.3%			M127	9.2%			MA130	8.2%	N365	10.2%
other	12.9%	N225	9.7%			N179	9.2%			other	19.5%	M27	8.0%
		N155	7.3%			N59	9.2%					N286	6.0%
		N179	6.7%			N29	8.6%					N285	4.5%
		M20	5.6%			other	15.3%					N269	4.4%
		M50	5.6%									N270	4.4%
		M51	5.6%									N290	4.2%
		M64	5.6%									M15	4.0%
		other	15.1%									M16	2.8%
												other	20.2%

The AMA NHIRC results are based on data pulled from the nationally mandated Health Insurance Portability and Accountability Act of 1996 (HIPAA) electronic standard transactions. The technical references for these transactions are the electronic remittance advice (ERA) (HIPAA ASC X12 835 Health Care Claim Payment/Advice Transaction) submitted to a physician in response to the receipt of an electronic claim submission (HIPAA ASC X12 837 Health Care Claim—professional transactions).

* may not total 100% due to rounding error

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2008 National Health Insurer Report Card—Complete Metrics

PAYMENT TIMELINESS

Metric 1—Payer claim received date disclosed
Description: What percentage of time does the payer provide the date it received the claim (payer claim received date) in its electronic remittance advice (ERA) or explanation of benefits (EOB) response to the physician?
Source: National Healthcare Exchange Services (NHXS)

Payer	Count of records	Count of claim received date on records	% of records with claim received date	Date range
Aetna	10,000	10,000	100.00%	7/02/2007 – 3/31/2008
Anthem BCBS	10,000	9,921	99.21%	7/02/2007 – 3/31/2008
CIGNA	10,000	0	0.00%	7/01/2007 – 3/31/2008
Coventry	10,000	10,000	100.00%	7/11/2007 – 3/31/2008
Health Net	5,505	5,492	99.76%	7/07/2007 – 3/29/2008
Humana	10,000	7	0.07%	7/01/2007 – 3/31/2008
UHC	10,000	9,998	99.98%	7/03/2007 – 3/31/2008
Medicare	10,000	9,999	99.99%	7/03/2007 – 3/31/2008

Metric 2—First remittance response time (median days)
Description: What is the median time period in days between the date the physician claim was received by the payer and the date the payer produced the first ERA or EOB? If a payer did not provide the payer claim received date, the most current date of service that was reported on the claim was used to perform the calculation, as noted in the disclaimer.
Source: MIT Solutions, Inc. (MITSI)

Payer	Mean	StDev	Q1	Median	Q3	IQR	Min	Max	Range	Skewness	Kurtosis	Record Count
Aetna	13.81	9.82	8	13	16	8	1	238	237	7.31	106.67	10,000
Anthem BCBS	10.63	12.94	5	7	11	6	0	241	241	5.30	48.93	10,000
CIGNA	19.57	22.48	9	14	21	12	0	295	295	4.98	35.53	10,000
Coventry	5.19	5.18	2	4	5	3	1	166	165	7.92	158.46	10,000
Health Net	17.19	27.13	1	11	25	24	1	307	306	4.58	29.88	3,330
Humana	21.85	29.05	6	13	25	19	1	293	292	3.68	18.35	10,000
UHC	11.52	8.85	8	10	13	5	1	287	286	10.72	209.54	10,000
Medicare	13.83	5.21	14	14	15	1	0	147	147	9.02	191.24	10,000

Metric 3—ERA activity during the data period (We have chosen not to report at this time)
Description: How many ERAs (one, two, three or more) does the physician receive for the same claim within the data period?

ACCURACY

Metric 4—Allowed amount disclosed
Description: On what percentage of records (lines on claims) does the payer provide the physician contracted rate (allowed amount) in its ERA response to the physician?
Source: NHXS

Payer	Count of Records	Count of allowed amount on records	% of records with allowed amounts	Date range
Aetna	186,570	182,409	97.77%	7/27/2007 – 12/30/2007
Anthem BCBS	75,031	73,058	97.37%	7/01/2007 – 12/31/2007
CIGNA	72,320	13,918	19.25%	7/02/2007 – 12/31/2007
Coventry	11,124	11,046	99.30%	7/01/2007 – 12/29/2007
Health Net	528	347	65.72%	7/07/2007 – 12/31/2007
Humana	40,020	38,951	97.33%	7/04/2007 – 12/27/2007
UHC	351,412	328,222	93.40%	7/17/2007 – 12/31/2007
Medicare	3,026,809	2,982,378	98.53%	7/11/2007 – 12/31/2007

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Metric 5—Contracted payment rate adherence
Description: On what percentage of records does the payer's allowed amount equal the contracted payment rate?
Source: MITSI

Payer	Count of records	Contracted payment rate adherence percentage	Date range
Aetna	78,650	70.78%	02/01/08 – 03/31/08
Anthem	29,497	72.14%	02/01/08 – 03/31/08
CIGNA	28,072	66.23%	02/01/08 – 03/31/08
Coventry	4,919	86.74%	02/01/08 – 03/31/08
Health Net	Not reported	Not reported	02/01/08 – 03/31/08
Humana	11,833	84.20%	02/01/08 – 03/31/08
UHC	134,542	61.55%	02/01/08 – 03/31/08
Medicare	898,672	98.12%	02/01/08 – 03/31/08

TRANSPARENCY OF CONTRACTED FEES AND PAYMENT POLICIES ON PAYER WEB SITES

Metric 6—Contracted fee schedule
Description: Is the physician's contracted fee schedule (payer allowed amount) available on the payer's Web site?

Metric 7—Contract fee schedule codes allowed per request
Description: If the contracted fee schedule is available on the payer's Web site, how many procedure codes are available per request?

Metric 8—Availability of payer proprietary code edits
Description: If the payer uses proprietary code edits, are they available on the payer's Web site? Proprietary code edits are edits other than those found in one or more of the following: AMA Current Procedural Terminology [1] (CPT ®), National Correct Coding Initiative (NCCI), Centers for Medicare and Medicaid Services (CMS) Publication 100-04 and the American Society of Anesthesia (ASA) Relative Value Guide.

Metric 9—Medical payment policies
Description: Are the payer's medical payment policies available on its Web site?

COMPLIANCE WITH GENERALLY ACCEPTED PRICING RULES

Metric 10—Percentage of claim lines (i.e., records) reduced by edits
Description: On what percentage of records does the payer apply a claim edit that reduces the payment (allowed amount) of the line to $0?

Metric 11—Source of claim edits
Description: On what percentage of records is the source of the claim edit applied by the payer based on one or more of the following: CPT, NCCI, CMS Publication 100-04, ASA Relative Value Guide or payer proprietary edits?
Source: NHXS

Payer	Total Records	Source	Record Count	% total of records	Total % of Records Allowed - $0	% by edit type
Aetna	186,570	CCI	180	0.10%		2.7%
Aetna	186,570	CMS	2,785	1.49%		41.8%
Aetna	186,570	CPT	94	0.05%		1.4%
Aetna	186,570	Payer	3,601	1.93%	3.75%	54.1%
Anthem BCBS	75,031	CCI	1,286	1.71%		50.4%
Anthem BCBS	75,031	CMS	794	1.06%		31.1%
Anthem BCBS	75,031	CPT	65	0.09%		2.5%
Anthem BCBS	75,031	Payer	408	0.54%	3.40%	16.0%

[1] CPT is a registered trademark of the American Medical Association.
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Payer	Total Records	Source	Record Count	% total of records	Total % of Records Allowed - $0	% by edit type
CIGNA	72,320	CCI	325	0.45%		6.1%
CIGNA	72,320	CMS	4,925	6.81%		92.9%
CIGNA	72,320	CPT	31	0.04%		0.6%
CIGNA	72,320	Payer	22	0.03%	7.33%	0.4%
Coventry	11,124	CCI	17	0.15%		50.0%
Coventry	11,124	CMS	6	0.05%		17.6%
Coventry	11,124	CPT	11	0.10%	0.31%	32.4%
Health Net	NR					
Humana	40,020	CCI	117	0.29%		9.2%
Humana	40,020	CMS	220	0.55%		17.3%
Humana	40,020	CPT	19	0.05%		1.5%
Humana	40,020	Payer	913	2.28%	3.17%	71.9%
UHC	351,412	CCI	1,664	0.47%		5.2%
UHC	351,412	CMS	18,431	5.24%		57.3%
UHC	351,412	CPT	1,439	0.41%		4.5%
UHC	351,412	Payer	10,612	3.02%	9.15%	33.0%
Medicare	3,026,809	ASA	1,096	0.04%		2.6%
Medicare	3,026,809	CCI	8,034	0.27%		19.0%
Medicare	3,026,809	CMS	21,075	0.70%		49.9%
Medicare	3,026,809	CPT	3,877	0.13%		9.2%
Medicare	3,026,809	Payer	8,173	0.27%	1.40%	19.3%

DENIALS

Metric 12—Percentages of claim lines (i.e., records) denied
Description: What percentage of records submitted are denied by the payer for reasons other than a claim edit? A denial is defined as: allowed amount equal to the billed charge and the payment equals $0.
Source: NHXS

Payer	Count of records	Denied records	Percent of claim lines denied	Date range
Aetna	637,239	43,317	6.80%	03/01/2007 – 3/10/2008
Anthem	250,070	11,546	4.62%	03/01/2007 – 3/10/2008
CIGNA	263,728	9,060	3.44%	03/01/2007 – 3/10/2008
Coventry	20,487	590	2.88%	03/01/2007 – 3/10/2008
Health Net	4,975	193	3.88%	03/01/2007 – 3/10/2008
Humana	143,026	4,142	2.90%	03/01/2007 – 3/10/2008
Medicare	6,938,431	475,566	6.85%	03/01/2007 – 3/10/2008
UHC	1,127,691	30,177	2.68%	03/01/2007 – 3/10/2008

Metric 13—Reason codes (Claim Adjusted Reason Codes [CARC*]) given for denials
Description: What are the most frequently reported reason codes for a denial? View Definitions.

Source: MITSI

* The most recent reason code description was reported.

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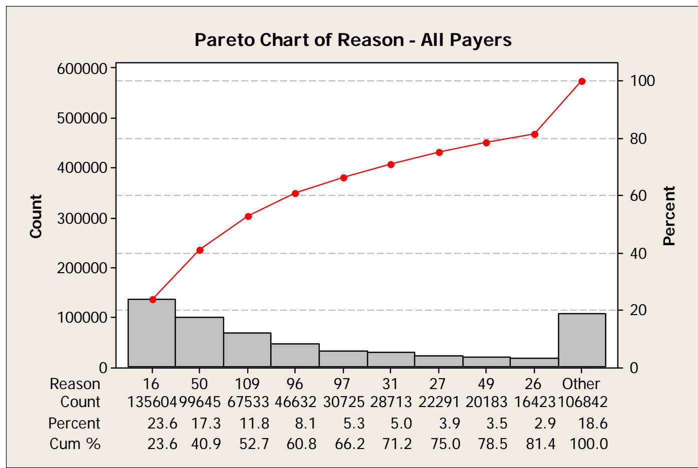

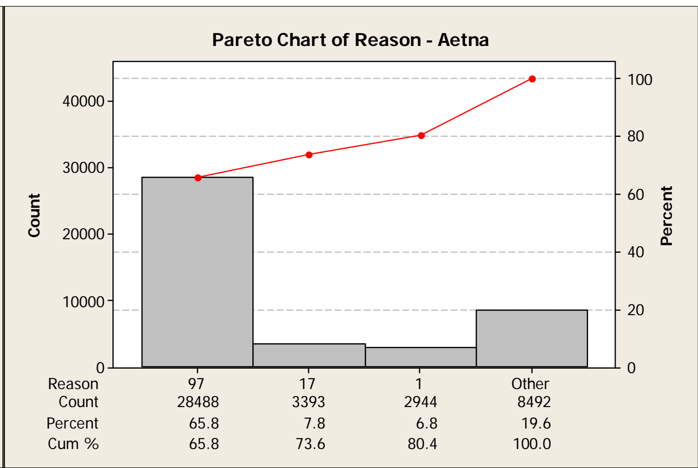

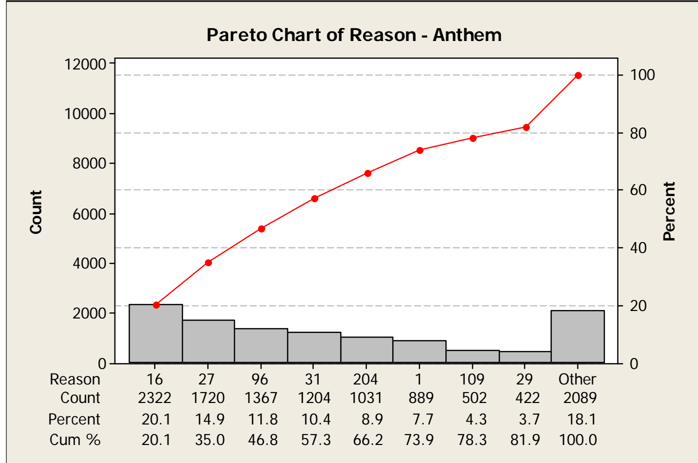

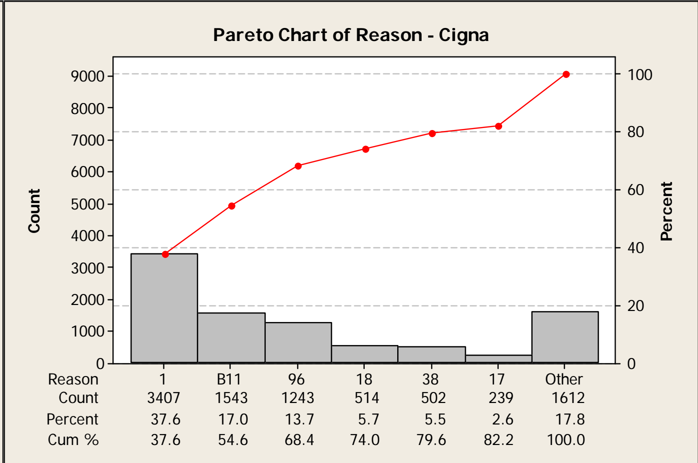

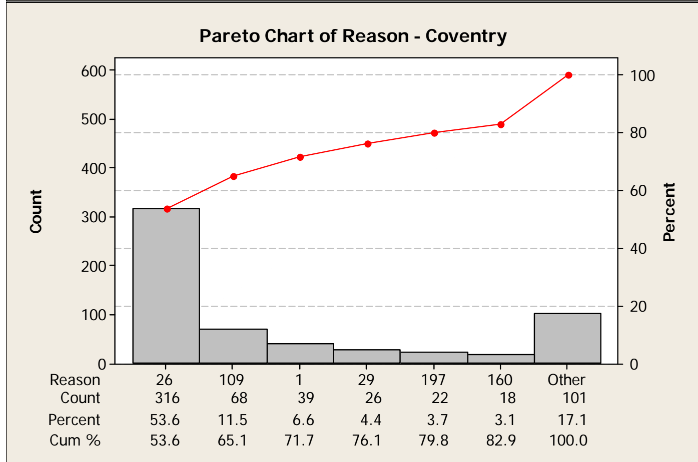

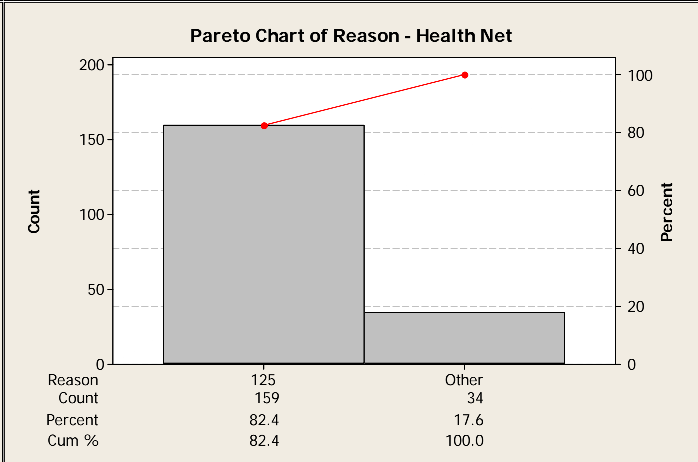

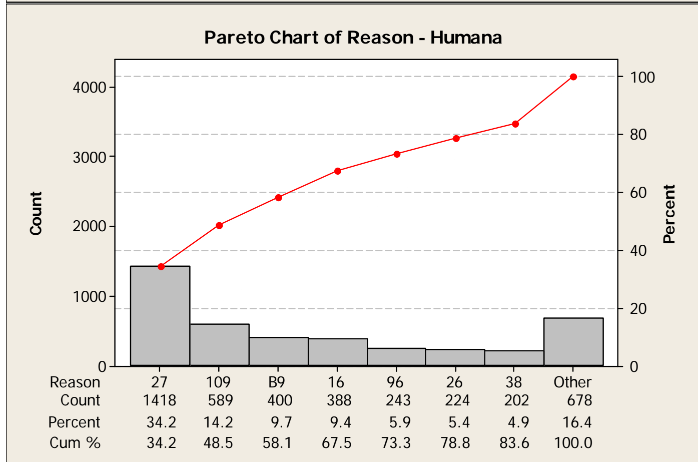

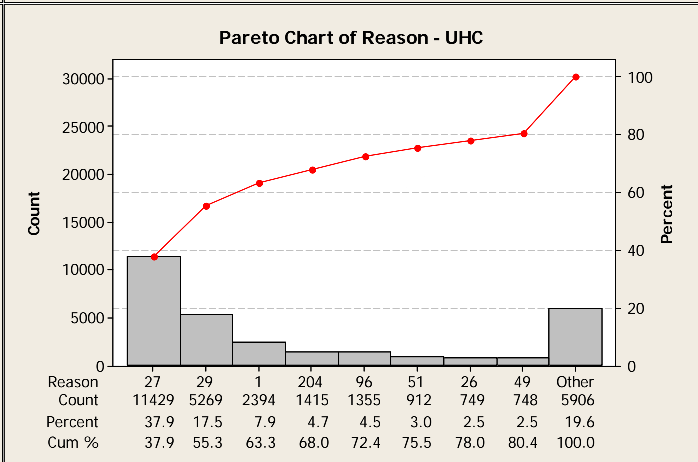

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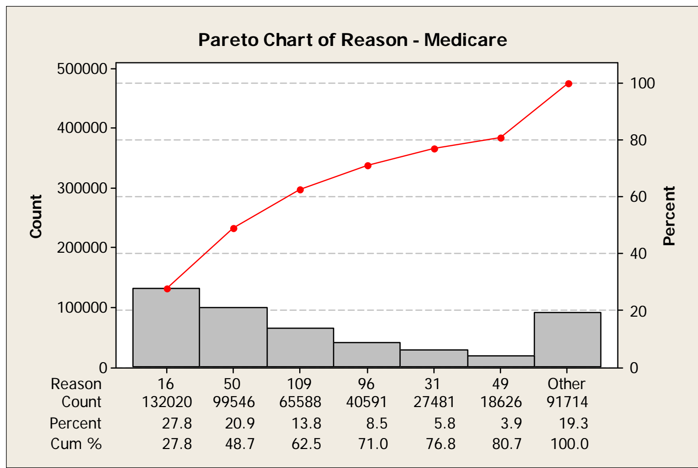

Payer	Claim Adjustment Reason Code	Records	% of Total Records w/reason codes	Reason Code Description
Aetna	97	28,488	65.7%	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
Aetna	17	3,393	7.8%	Payment adjusted because requested information was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code). This change to be effective 4/1/2008: Requested information was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code).
Aetna	1	2,944	6.8%	Deductible Amount.
Aetna	96	1,833	4.2%	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code).
Aetna	B11	1,501	3.5%	The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.
Aetna	55	753	7.7%	Claim/service denied because procedure/treatment is deemed experimental/investigational by the payer.
Aetna	197	552	1.3%	Payment adjusted for absence of precertification/ authorization.
Aetna	27	535	1.2%	Expenses incurred after coverage terminated.
Aetna	49	492	1.4%	These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam.
Aetna	16	449	1.0%	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code).
Aetna	119	427	1.0%	Benefit maximum for this time period or occurrence has been reached.
Aetna	165	394	0.9%	Payment denied/reduced for absence of or exceeded referral. This change to be effective 4/1/2008: Referral absent or exceeded.
Aetna	29	253	0.6%	The time limit for filing has expired.
Aetna	3	232	0.5%	Co-payment Amount

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Payer	Claim Adjustment Reason Code	Records	% of Total Records w/reason codes	Reason Code Description
Aetna	95	164	0.4%	Benefits adjusted. Plan procedures not followed. This change to be effective 4/1/2008: Plan procedures not followed.
Aetna	18	138	0.3%	Duplicate claim/service.
Aetna	45	114	0.3%	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability.)
Aetna	38	104	0.2%	Services not provided or authorized by designated (network/primary care) providers.
Aetna	All other	551	1.3%	
Aetna Total		43,317		
Anthem BCBS	16	2,322	20.1%	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code).
Anthem BCBS	27	1,720	14.9%	Expenses incurred after coverage terminated.
Anthem BCBS	96	1,367	11.8%	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code).
Anthem BCBS	31	1,204	10.4%	Claim denied as patient cannot be identified as our insured.
Anthem BCBS	204	1,031	8.9%	This service/equipment/drug is not covered under the patient's current benefit plan.
Anthem BCBS	1	889	7.7%	Deductible Amount
Anthem BCBS	109	502	4.4%	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.
Anthem BCBS	29	422	3.7%	The time limit for filing has expired.
Anthem BCBS	17	297	2.6%	Payment adjusted because requested information was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.) This change to be effective 4/1/2008: Requested information was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code).
Anthem BCBS	26	242	2.1%	Expenses incurred prior to coverage.
Anthem BCBS	119	198	1.7%	Benefit maximum for this time period or occurrence has been reached.
Anthem BCBS	32	171	1.5%	Our records indicate that this dependent is not an eligible dependent as defined.
Anthem BCBS	51	155	1.3%	These are non-covered services because this is a pre-existing condition
Anthem BCBS	18	141	1.2%	Duplicate claim/service.
Anthem BCBS	3	109	0.9%	Co-payment Amount
Anthem BCBS	49	107	0.9%	These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam.
Anthem BCBS	All other	669	5.8%	
Anthem BCBS Total		11,546		
CIGNA	1	3,407	37.6%	Deductible Amount
CIGNA	B11	1,543	17.3%	The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.

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Payer	Claim Adjustment Reason Code	Records	% of Total Records w/reason codes	Reason Code Description
CIGNA	96	1,243	13.7%	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code).
CIGNA	18	514	5.7%	Duplicate claim/service.
CIGNA	38	502	5.5%	Services not provided or authorized by designated (network/primary care) providers.
CIGNA	17	239	2.6%	Payment adjusted because requested information was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code). This change to be effective 4/1/2008: Requested information was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code).
CIGNA	109	217	2.4%	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.
CIGNA	49	179	2.0%	These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam.
CIGNA	197	172	1.9%	Payment adjusted for absence of precertification/ authorization.
CIGNA	29	163	1.8%	The time limit for filing has expired.
CIGNA	26	134	1.5%	Expenses incurred prior to coverage.
CIGNA	27	127	1.4%	Expenses incurred after coverage terminated.
CIGNA	All other	620	6.8%	
CIGNA Total		9,060		
Coventry	26	316	53.6%	Expenses incurred prior to coverage.
Coventry	109	68	11.5%	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.
Coventry	1	39	6.6%	Deductible Amount
Coventry	29	26	4.4%	The time limit for filing has expired.
Coventry	197	22	3.7%	Payment adjusted for absence of precertification/ authorization.
Coventry	160	18	3.1%	Payment denied/reduced because injury/illness was the result of an activity that is a benefit exclusion. This change to be effective 4/1/2008: Injury/illness was the result of an activity that is a benefit exclusion.
Coventry	All other	119	17.1%	
Coventry Total		590		
Health Net	Not reported			
Humana	27	1,418	34.2%	Expenses incurred after coverage terminated.
Humana	109	589	14.2%	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.
Humana	B9	400	9.6%	Services not covered because the patient is enrolled in a Hospice.
Humana	16	388	9.4%	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code).
Humana	96	243	5.9%	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code).
Humana	26	224	5.4%	Expenses incurred prior to coverage.

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Payer	Claim Adjustment Reason Code	Records	% of Total Records w/reason codes	Reason Code Description
Humana	38	202	4.9%	Services not provided or authorized by designated (network/primary care) providers.
Humana	All other	678	13.4%	
Humana Total		4,142		
UnitedHealthcare	27	11,429	37.9%	Expenses incurred after coverage terminated.
UnitedHealthcare	29	5,269	17.5%	The time limit for filing has expired.
UnitedHealthcare	1	2,394	7.9%	Deductible Amount.
UnitedHealthcare	204	1,415	4.7%	This service/equipment/drug is not covered under the patient's current benefit plan.
UnitedHealthcare	96	1,355	4.5%	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code).
UnitedHealthcare	51	912	3.0%	These are non-covered services because this is a pre-existing condition.
UnitedHealthcare	26	749	2.5%	Expenses incurred prior to coverage.
UnitedHealthcare	49	748	2.5%	These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam.
UnitedHealthcare	109	569	1.9%	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.
UnitedHealthcare	100	544	1.8%	Payment made to patient/insured/responsible party.
UnitedHealthcare	133	537	1.8%	The disposition of this claim/service is pending further review.
UnitedHealthcare	32	519	1.7%	Our records indicate that this dependent is not an eligible dependent as defined.
UnitedHealthcare	2	488	1.6%	Coinsurance Amount.
UnitedHealthcare	17	408	1.4%	Payment adjusted because requested information was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code). This change to be effective 4/1/2008: Requested information was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code).
UnitedHealthcare	18	400	1.3%	Duplicate claim/service.
UnitedHealthcare	38	388	1.3%	Services not provided or authorized by designated (network/primary care) providers.
UnitedHealthcare	16	372	1.2%	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code).
UnitedHealthcare	119	251	0.8%	Benefit maximum for this time period or occurrence has been reached.
UnitedHealthcare	3	243	0.8%	Co-payment Amount.
UnitedHealthcare	B20	183	0.6%	Payment adjusted because procedure/service was partially or fully furnished by another provider. This change to be effective 4/1/2008: Procedure/service was partially or fully furnished by another provider.
UnitedHealthcare	22	108	0.4%	Payment adjusted because this care may be covered by another payer per coordination of benefits. This change to be effective 4/1/2008: This care may be covered by another payer per coordination of benefits.

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Payer	Claim Adjustment Reason Code	Records	% of Total Records w/reason codes	Reason Code Description
UnitedHealthcare	19	103	0.3%	Claim denied because this is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier. This change to be effective 4/1/2008: This is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.
UnitedHealthcare	A1	103	0.3%	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code).
UnitedHealthcare	All other	690	2.29%	
UnitedHealthcare Total		30,177		
Medicare	16	132,020	27.8%	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code).
Medicare	50	99,546	20.9%	These are non-covered services because this is not deemed a 'medical necessity' by the payer.
Medicare	109	65,588	13.8%	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.
Medicare	96	40,591	8.5%	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code).
Medicare	31	27,481	5.8%	Claim denied as patient cannot be identified as our insured.
Medicare	49	18,626	3.9%	These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam.
Medicare	26	14,751	3.1%	Expenses incurred prior to coverage.
Medicare	B9	14,232	3.0%	Services not covered because the patient is enrolled in a Hospice.
Medicare	All other	62,731	13.8%	
Medicare Total		475,566		

Metric 14—Remark codes given for denials
Description: What are the most frequently reported remark codes for a denial? View Definitions.
Source: MITSI

Payer	Total unique Remark Codes used out of a possible universe of 675 available
Aetna	31
Anthem BCBS	36
CIGNA	5
Coventry	14
Health Net	Not reported
Humana	0
UHC	40
Medicare	95

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Payer	Remark Code	Records	% of Total Records w/ remark codes	Remark Code Description
Aetna	N19	24,901	62.4%	Procedure code incidental to primary procedure.
Aetna	N130	6,449	16.2%	**Alert:** Consult plan benefit documents for information about restrictions for this service.
Aetna	N102	3,394	8.5%	This claim has been denied without reviewing the medical record because the requested records were not received or were not received timely.
Aetna	All Other	5,130	12.9%	
Aetna Total		39,874		
Anthem BCBS	N197	241	16.1%	The subscriber must update insurance information directly with payer.
Anthem BCBS	N4	171	11.4%	Missing/incomplete/invalid prior insurance carrier EOB.
Anthem BCBS	M81	170	11.3%	You are required to code to the highest level of specificity.
Anthem BCBS	N225	146	9.7%	Incomplete/invalid documentation/orders/notes/summary/report/chart.
Anthem BCBS	N155	109	7.3%	**Alert:** Our records do not indicate that other insurance is on file. Please submit **other** insurance information for our records.
Anthem BCBS	N179	100	6.7%	Additional information has been requested from the member. The charges will be reconsidered upon receipt of that information.
Anthem BCBS	M20	84	5.6%	Missing/incomplete/invalid HCPCS.
Anthem BCBS	M50	84	5.6%	Missing/incomplete/invalid revenue code(s).
Anthem BCBS	M51	84	5.6%	Missing/incomplete/invalid procedure code(s).
Anthem BCBS	M64	84	5.6%	Missing/incomplete/invalid other diagnosis.
Anthem BCBS	All other	227	15.1%	
Anthem BCBS Total		1,500		
CIGNA	MA67	49	83.1%	Correction to a prior claim.
CIGNA	All other	10	16.9%	
CIGNA Total		59		
Coventry	N418	61	37.4%	Misrouted claim. See the payer's claim submission instructions.
Coventry	N130	18	11.0%	**Alert:** Consult plan benefit documents for information about restrictions for this service.
Coventry	M127	15	9.2%	Missing patient medical record for this service.
Coventry	N179	15	9.2%	Additional information has been requested from the member. The charges will be reconsidered upon receipt of that information.
Coventry	N59	15	9.2%	**Alert:** Please refer to your provider manual for additional program and provider information.
Coventry	N29	14	8.6%	Missing documentation/orders/notes/summary/report/chart.
Coventry	All other	25	15.3%	
Coventry Total		163		
Health Net	Not available			
Humana	Not available			
UnitedHealthcare	N174	2,470	59.2%	This is not a covered service/procedure/ equipment/bed; however, patient liability is limited to amounts shown in the adjustments under group “PR.”
UnitedHealthcare	M86	546	13.1%	Service denied because payment already made for same/similar procedure within set time frame.

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Payer	Remark Code	Records	% of Total Records w/ remark codes	Remark Code Description
UnitedHealthcare	MA130	342	8.2%	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
UnitedHealthcare	All other	815	19.5%	
UnitedHealthcare Total		4,173		
Medicare	N115	41,168	16.3%	This decision was based on a local medical review policy (LMRP) or Local Coverage Determination (LCD).An LMRP/LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at http://www.cms.hhs.gov/mcd, or if you do not have Web access, you may contact the contractor to request a copy of the LMRP/LCD.
Medicare	M25	37,838	15.0%	The information furnished does not substantiate the need for this level of service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this level of service, or if you notified the patient in writing in advance that we would not pay for this level of service and he/she agreed in writing to pay, ask us to review your claim within 120 days of the date of this notice. If you do not request a appeal, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her in excess of any deductible and coinsurance amounts. We will recover the reimbursement from you as an overpayment.
Medicare	N365	25,814	10.2%	This procedure code is not payable. It is for reporting/information purposes only.
Medicare	M27	20,322	8.0%	**Alert:** The patient has been relieved of liability of payment of these items and services under the limitation of liability provision of the law. The provider is ultimately liable for the patient's waived charges, including any charges for coinsurance, since the items or services were not reasonable and necessary or constituted custodial care, and you knew or could reasonably have been expected to know, that they were not covered. You may appeal this determination. You may ask for an appeal regarding both the coverage determination and the issue of whether you exercised due care. The appeal request must be filed within 120 days of the date you receive this notice. You must make the request through this office.
Medicare	N286	15,059	6.0%	Missing/incomplete/invalid referring provider primary identifier.
Medicare	N285	11,345	4.5%	Missing/incomplete/invalid referring provider name.
Medicare	N269	11,156	4.4%	Missing/incomplete/invalid other provider name.
Medicare	N270	11,156	4.4%	Missing/incomplete/invalid other provider primary identifier.
Medicare	N290	10,686	4.2%	Missing/incomplete/invalid rendering provider primary identifier.
Medicare	M15	10,249	4.0%	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
Medicare	M16	7,152	3.0%	**Alert:** Please see our Web site, mailings, or bulletins for more details concerning this policy/procedure/decision.
Medicare	N90	6,807	3.0%	Covered only when performed by the attending physician.
Medicare	All other	44,130	17.0%	
Medicare Total		252,882		

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Descriptions of reported Claim Adjusted Reason Codes (CARCs)*

Reason Code	Description	Effective Date	Modified Date
A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code).	1/1/1995	10/31/2006
B9	Services not covered because the patient is enrolled in a Hospice.	1/1/1995	
B11	The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.	1/1/1995	
B20	Payment adjusted because procedure/service was partially or fully furnished by another provider. This change to be effective 4/1/2008: Procedure/service was partially or fully furnished by another provider.	1/1/1995	9/30/2007
1	Deductible Amount.	1/1/1995	
2	Coinsurance Amount.	1/1/1995	
3	Co-payment Amount.	1/1/1995	
16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code).	1/1/1995	6/30/2006
17	Payment adjusted because requested information was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code). This change to be effective 4/1/2008: Requested information was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code).	1/1/1995	9/30/2007
18	Duplicate claim/service.	1/1/1995	
19	Claim denied because this is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier. This change to be effective 4/1/2008: This is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.	1/1/1995	9/30/2007
22	Payment adjusted because this care may be covered by another payer per coordination of benefits. This change to be effective 4/1/2008: This care may be covered by another payer per coordination of benefits.	1/1/1995	9/30/2007
26	Expenses incurred prior to coverage.	1/1/1995	
27	Expenses incurred after coverage terminated.	1/1/1995	
29	The time limit for filing has expired.	1/1/1995	
31	Claim denied as patient cannot be identified as our insured.	1/1/1995	
32	Our records indicate that this dependent is not an eligible dependent as defined.	1/1/1995	
38	Services not provided or authorized by designated (network/primary care) providers.	1/1/1995	6/30/2003
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. (Use Group Codes PR or CO depending upon liability.)	1/1/1995	10/31/2006
49	These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam.	1/1/1995	
50	These are non-covered services because this is not deemed a 'medical necessity' by the payer.	1/1/1995	
51	These are non-covered services because this is a pre-existing condition	1/1/1995	
95	Benefits adjusted. Plan procedures not followed. This change to be effective 4/1/2008: Plan procedures not followed.	1/1/1195	9/30/2007
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code).	1/1/1995	6/30/2006

* The most recent reason code description was reported.

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Reason Code	Description	Effective Date	Modified Date
97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	1/1/1995	10/31/2006
100	Payment made to patient/insured/responsible party.	1/1/1995	
109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.	1/1/1995	
125	Payment adjusted due to a submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code). This change to be effective 4/1/2008: Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code).	1/1/1995	9/30/2007
133	The disposition of this claim/service is pending further review.	2/28/1997	10/31/1999
160	Payment denied/reduced because injury/illness was the result of an activity that is a benefit exclusion. This change to be effective 4/1/2008: Injury/illness was the result of an activity that is a benefit exclusion.	9/30/2003	9/30/2007
165	Payment denied /reduced for absence of, or exceeded referral. This change to be effective 4/1/2008: Referral absent or exceeded.	10/31/2004	9/30/2007
197	Payment adjusted for absence of precertification/authorization.	10/31/2006	
204	This service/equipment/drug is not covered under patient's current benefit plan.	2/28/2007	

Descriptions of Reported Remark Codes

Remark Codes	Description	Effective Date	Modified Date
M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	1/1/1997	
M16	**Alert:** Please see our Web site, mailings, or bulletins for more details concerning this policy/procedure/decision.	1/1/1997	4/1/2007
M20	Missing/incomplete/invalid HCPCS.	1/1/1997	2/28/2003
M25	The information furnished does not substantiate the need for this level of service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this level of service, or if you notified the patient in writing in advance that we would not pay for this level of service and he/she agreed in writing to pay, ask us to review your claim within 120 days of the date of this notice. If you do not request an appeal, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her in excess of any deductible and coinsurance amounts. We will recover the reimbursement from you as an overpayment.	1/1/1997	11/5/2007
M27	**Alert:** The patient has been relieved of liability of payment of these items and services under the limitation of liability provision of the law. The provider is ultimately liable for the patient's waived charges, including any charges for coinsurance, since the items or services were not reasonable and necessary or constituted custodial care, and you knew or could reasonably have been expected to know, that they were not covered. You may appeal this determination. You may ask for an appeal regarding both the coverage determination and the issue of whether you exercised due care. The appeal request must be filed within 120 days of the date you receive this notice. You must make the request through this office.	1/1/1997	8/1/2007
M50	Missing/incomplete/invalid revenue code(s).	1/1/1997	2/28/2003
M51	Missing/incomplete/invalid procedure code(s).	1/1/1997	12/2/2004
M64	Missing/incomplete/invalid other diagnosis.	1/1/1997	2/28/2003
M81	Missing/incomplete/invalid provider/supplier signature.	1/1/1997	2/28/2003
M86	Service denied because payment already made for same/similar procedure within set time frame.	1/1/1997	6/30/2003

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Remark Codes	Description	Effective Date	Modified Date
M127	Missing patient medical record for this service.	1/1/1997	2/28/2003
MA67	Correction to a prior claim.	1/1/1997	
MA130	Missing invoice or statement certifying the actual cost of the lens, less discounts, and/or the type of intraocular lens used.	1/1/1997	2/28/2003
N4	Missing/incomplete/invalid prior insurance carrier EOB.	1/1/2000	2/28/2003
N19	Procedure code incidental to primary procedure.	1/1/2000	
N29	Missing documentation/orders/notes/summary/report/chart.	1/1/2000	8/1/2005
N59	**Alert:** Please refer to your provider manual for additional program and provider information.	1/1/2000	4/1/2007
N90	Covered only when performed by the attending physician.	1/1/2000	
N102	This claim has been denied without reviewing the medical record because the requested records were not received or were not received timely.	10/31/2001	
N115	This decision was based on a local medical review policy (LMRP) or Local Coverage Determination (LCD). An LMRP/LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at http://www.cms.hhs.gov/mcd, or if you do not have Web access, you may contact the contractor to request a copy of the LMRP/LCD.	5/30/2002	4/1/2004
N130	Consult plan benefit documents for information about restrictions for this service.	10/31/2002	4/1/2007
N155	**Alert:** Our records do not indicate that other insurance is on file. Please submit other insurance information for our records.	10/31/2002	4/1/2007
N174	This is not a covered service/procedure/equipment/bed; however, patient liability is limited to amounts shown in the adjustments under group "PR."	2/28/2003	
N179	Additional information has been requested from the member. The charges will be reconsidered upon receipt of that information.	2/28/2003	
N197	The subscriber must update insurance information directly with payer.	2/25/2003	
N225	Incomplete/invalid documentation/orders/notes/summary/report/chart.	8/1/2004	8/1/2005
N269	Missing/incomplete/invalid other provider name.	12/2/2004	
N270	Missing/incomplete/invalid other provider primary identifier.	12/2/2004	
N285	Missing/incomplete/invalid referring provider name.	12/2/2004	
N286	Missing/incomplete/invalid referring provider primary identifier.	12/2/2004	
N290	Missing/incomplete/invalid rendering provider primary identifier.	12/2/2004	
N365	This procedure code is not payable. It is for reporting/information purposes only.	4/1/2006	
N418	Misrouted claim. See the payer's claim submission instructions.	8/1/2007	

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