12/1/2006

28.C-2 Denial Report by Reason Summary
This report gives the unduplicated denied claim detail count and billed amount by payment cycle summarized by detail EOB (explanation of benefits) code, sorted by denied detail count (descending).

Paid Date	Detail EOB Description	Unduplicated Denied Claim (ICN) Count	Unduplicated Denied Detail Count	Billed Amount
11/21/2006	302 - SERVICE DENIED. THIS PROCEDURE REQUIRES PRIOR AUTHORIZATION.	1,800	13,518	$2,199,130.44
	037 - THE BILLED AMOUNT IS MISSING, PLEASE CORRECT AND RESUBMIT.	774	3,885	$0.00
	016 - CLAIM DENIED. DUPLICATE OF A PAID CLAIM.	410	2,276	$597,386.68
	609 - CLAIM DENIED. EXACT DUPLICATE OF A CLAIM IN PROCESS	1,042	1,429	$176,317.19
	291 - PRIOR AUTHORIZATION NUMBER INVALID.	871	1,228	$524,668.06
	466 - BEHAVIORAL HEALTH RCC REQUIRES PA	511	1,215	$564,517.01
	293 - INVALID PROVIDER NUMBER FOR PRIOR AUTHORIZATION NUMBER.	631	1,160	$222,063.64
	000 -	505	853	$696,390.32
	295 - DATE OF SERVICE IS NOT WITHIN PRIOR AUTHORIZATION EFFECTIVE DATES.	552	822	$296,877.11
	513 - CLAIM IS PAST BEHAVIORAL HEALTH TIMELY FILING GUIDELINES	325	609	$141,189.28
	104 - ANCILLARY SERVICES INCLUDED IN PER DIEM RATE.	75	432	$578,651.44
	294 - THIS PROCEDURE HAS NOT BEEN PRIOR AUTHORIZED.	181	356	$135,107.99
	292 - PRIOR AUTHORIZATION SERVICES EXHAUSTED-FILE FOR ADDITIONAL PRIOR AUTH. BENEFITS.	160	293	$120,138.16
	380 - QUANTITY CUTBACK TO REFLECT DSS MAXIMUM ALLOWED.	24	176	$71,009.76
	498 - FOR AN EXPLANATION OF THIS DENIAL REASON, CONTACT EDS PROVIDER RELATIONS.	6	174	$218,544.00
	482 - BEHAVIORAL HEALTH PROCEDURE CODE NOT PAYABLE	51	173	$10,651.04
	994 - PROVIDER TYPE REQUIRES A MODIFIER	108	149	$15,030.67
	011 - PROCEDURE NOT CONSISTENT WITH DIAGNOSIS.	37	129	$17,418.78
	254 - PLACE OF SERVICE IS MISSING/INVALID. PLEASE COMPLETE AND RESUBMIT.	17	78	$10,854.00
	043 - ADMISSION DATE REQUIRED FOR SERVICES PERFORMED IN INPATIENT HOSPITAL.	39	72	$54,789.56
	611 - CLAIM DENIED. DUPLICATE OF A PROCESSING CLAIM.	33	66	$7,465.92
	055 - REVENUE CENTER CODE IS MISSING/INVALID.	19	62	$181,516.70
	583 - HCPC CODE IS NOT ACTIVE ON FILE ON DATE OF SERVICE	7	59	$3,661.08
	045 - DETAIL DIAGNOSIS IS NOT ON FILE. PLEASE CORRECT AND RESUBMIT	41	57	$9,194.78
	610 - CLAIM DENIED. EXACT DUPLICATE OF AN OUTPATIENT CLAIM IN PROCESS.	14	48	$7,077.72
	166 - PERFORMING PROVIDER MUST BE A MEMBER OF THE BILLING PROVIDER GROUP.	14	32	$3,160.00
	010 - PROCEDURE NOT CONSISTENT PROVIDER SPECIALTY.	24	24	$3,652.00
	091 - PROCEDURE OR HCPC NOT ACTIVE ON FILE ON DATE OF SERVICE	4	20	$28,192.10
	049 - CLAIM DENIED-PROVIDER INELIGIBLE ON DATE(S) OF SERVICE.	15	19	$31,100.00
	165 - THE PERFORMING PROVIDER NUMBER IS NOT ON THE MMIS PROVIDER ELIGIBILITY FILE.	10	18	$1,940.00
	357 - FQHC PROCEDURE NOT COVERED WITHOUT OTHER SERVICES	15	15	$2,554.03
	090 - REDUCED TO MAXIMUM ALLOWED ON PRIOR AUTHORIZATION FILE.	12	12	$198,086.00
	119 - BILL MEDICARE FIRST.	6	11	$953.67
	117 - QUANTITY DISAGREES WITH DAYS ELAPSED.	10	10	$23,323.79
	966 - RN SERVICES NOT COVERED WITHOUT NURSING CARE OR NURSING ASSESSMENT SERVICE	1	9	$1,170.00
	003 - RECIPIENT INELIGIBLE FOR DATES OF SERVICE.	1	6	$330.00
	161 - PROVIDER NOT AUTHORIZED TO BILL ON TAPE.	4	4	$440.00
	446 - SAGA CLAIMS NOT COVERED AFTER 8-1-04	1	4	$360.00
	035 - NDC MISSING/INVALID. RESUBMIT WITH CORRECT NDC CODE.	1	2	$640.00
	177 - THE FROM DATE OF SERVICE IS MISSING OR INVALID OR A FUTURE DATE.	1	2	$160.00
	178 - THE THRU DATE OF SERVICE IS MISSING OR INVALID OR A FUTURE DATE.	1	2	$600.00
	489 - MODIFIER IS NOT ALLOWED WITH PROCEDURE CODE	2	2	$275.00
	536 - IMMUNIZATION ADMINISTRATION PROCEDURE NOT COVERED WITHOUT IMMUNIZATION CODE	2	2	$44.00
11/21/2006		**8,357**	**29,513**	**$7,156,631.92**