CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-20 One-Time Notification	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1187	**Date: February 8, 2013**
	Change Request 8182

SUBJECT: Standardizing the standard - Operating Rules for code usage in Remittance Advice

I. SUMMARY OF CHANGES: This Change Request (CR) instructs the Medicare Administrative Contractors (MACs) and the Shared System Maintainers (SSMs) to implement Operating Rules for code usage in Electronic Remittance Advice (ERA) under the Patient Protection and Affordable Care Act. The same rules will apply to Standard Paper Remittance (SPR), and Medicare will report the same standard codes in both electronic and paper formats of remittance advice.

EFFECTIVE DATE: Other (July 1, 2013 - Analysis & Design; October 1, 2013 – Full Implementation)
IMPLEMENTATION DATE: Other (July 1, 2013 - Analysis & Design; October 7, 2013 - Full Implementation)

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs):
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

For Medicare Administrative Contractors (MACs):
The Medicare Administrative contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obliged to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:
One-Time-Notification
**Unless otherwise specified, the effective date is the date of service.*

Attachment - One-Time Notification

Pub. 100-20	Transmittal: 1187	Date: February 8, 2013	Change Request: 8182

SUBJECT: Standardizing the standard - Operating Rules for code usage in Remittance Advice

EFFECTIVE DATE: Other (July 1, 2013 - Analysis & Design; October 1, 2013 – Full Implementation)

IMPLEMENTATION DATE: Other (July 1, 2013 - Analysis & Design; October 7, 2013 - Full Implementation)

I. GENERAL INFORMATION

A. Background: HHS adopted the Phase III Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules for Information Exchange (CORE) EFT & ERA Operating Rule Set that must be implemented by January 1, 2014 under Patient Protection and Affordable Care Act of 2010. Health Insurance Portability and Accountability Act (HIPAA) amended the Act by adding Part C—Administrative Simplification—to Title XI of the Social Security Act, requiring the Secretary of the Department of Health and Human Services (HHS) (the Secretary) to adopt standards for certain transactions to enable health information to be exchanged more efficiently and to achieve greater uniformity in the transmission of health information. More recently, the National Committee on Vital and Health Statistics (NCVHS) reported to the Congress that the transition to Electronic Data Interchange (EDI) from paper has been slow and dissapointing. Through the Affordable Care Act, Congress sought to promote implementation of electronic transactions and achieve cost reduction and efficiency improvements by creating more uniformity in the implementation of standard transactions. This was done by mandating the adoption of a set of operating rules for each of the HIPAA transactions. The Affordable Care Act defines operating rules and specifies the role of operating rules in relation to the standards.

The EFT & ERA Operating Rule Set includes the following rules:

(1) Phase III CORE 380 EFT Enrollment Data Rule;

(2) Phase III CORE 382 ERA Enrollment Data Rule;

(3) Phase III Core 360 Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule;

(4) CORE-required Code Combinations for CORE-defined Business Scenarios for the Phase III Core Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule;

(5) Phase III CORE 370 EFT & ERA Reassociation (CCD+/835) Rule; and (6) Phase III CORE 350 Health Care Claim Payment/Advice (835) Infrastructure Rule; and

(6) Phase III CORE 350 Health Care Claim Payment/Advice (835) Infrastructure Rule.

This CR focuses on #s 3 and 4 under Phase III Core 360 Operating Rule.

The ERA/EFT Operating Rules mandate consistent and uniform use of RA codes - Group Code, CARC and RARC - to mitigate the confusion that may result in:

- Unnecessary manual provider follow-up

- Faulty electronic secondary billing

- Inappropriate write-offs of billable charges

- Incorrect billing of patients for co-pays and deductibles

- Posting delay

Health Innsurance Portability and Accountability Act (HIPAA) mandated the standard code sets that may be used by a healthplan to communicate to providers/suppliers explaining how a claim/line has been adjudicated , and now the ERA/EFT Operating Rules under ACA are mandating a standard use of those standard codes. The CORE Phase III ERA/EFT Operating Rules define 4 Business Scenarios and specify the maximum set of the standard codes that a healthplan may use. This list will be updated and maintained by A CORE Task Group when the 2 code committees update the lists and/or when there is need for additional combinations based on business policy change and/or Federal/State Mandate.

CORE-defined Claim Adjustment/Denial Business Scenarios and Description:

Scenario #1: Additional Information Required - Missing/Invalid/Incomplete Documentation

Refers to situations where additional documentation is needed from the billing provider or an ERA from a prior payer. The maximum set of CORE-defined code combinations to convey detailed information about the denial or adjustment for this business scenario is specified in*CORE-required Code Combinations for CORE-defined Business Scenarios.doc.*

Scenario #2: Additional Information Required – Missing/Invalid/Incomplete Data from Submitted Claim

Refers to situations where additional data are needed from the billing provider for missing or invalid data on the submitted claim, e.g., an 837 or D.0. The maximum set of CORE-defined code combinations to convey detailed information about the denial or adjustment for this business scenario is specified in*CORE-required Code Combinations for CORE-defined Business Scenarios.doc.*

Scenario #3: Billed Service Not Covered by Health Plan

Refers to situations where the billed service is not covered by the health plan. The maximum set of CORE-defined code combinations to convey detailed information about the denial or adjustment for this business scenario is specified in*CORE-required Code Combinations for CORE-defined Business Scenarios.doc.*

Scenario #4: Benefit for Billed Service Not Separately Payable

Refers to situations where the billed service or benefit is not separately payable by the health plan. The maximum set of CORE-defined code combinations to convey detailed information about the denial or adjustment for this business scenario is specified in*CORE-required Code Combinations for CORE-defined Business Scenarios.doc.*

Medicare is implementing the code combinations per the ERA/EFT Operating Rules in 2 releases - July and October 2013 - that relate to these 4 scenarios. These code combinations may or may not match what Medicare has been currently reporting. In order to be compliant with ERA/EFT Operating Rules as adopted under Section 1104 of the Affordable Care Act, the MACs must use code combinations that are included in the list developed by CAQH CORE and attached to this CR. When the contractors are analyzing and comparing the code combinations being currently used with this list, they may identify code combinations that are most appropriate to explain specific adjustments that are not included in this list. In such cases, Medicare will try to get them added to CAQH CORE list working through the CORE Code Combination Task Group. There will be a Technical Direction Letter (TDL) sent later instructing the MACs how to send their requests to CMS to add code combinations to the CORE list. CAQH CORE has agreed to update their

list of code combinations when the 2 standard code sets are updated – 3 times a year. In addition to these regular updates, CAQH CORE will also do an annual "Market Based Update" that would include new code combinations of existing codes needed to address new business needs and/or due to new Federal/State/local mandate. The recurring Remittance Advice Remark and Claim Adjustment Reason code CR will have the updated CORE list as attachment(s). .

B. Policy: Medicare implements HIPAA transactions and related Operating Rules to be compliant.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement.

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
8182.1	Contractors and Shared System Maintainers shall report only the code combinations that are listed in the attached document under Scenario #1. This requirement shall be implemented by October 7, 2013. Scenario #1: Additional Information Required – Missing/Invalid/Incomplete Documentation	X	X	X	X	X	X	X	X	X		
8182.2	Contractors and Shared System Maintainers shall report only the code combinations that are listed in the attached document under Scenario #2. This requirement shall be implemented by October 7, 2013. Scenario #2: Additional Information Required – Missing/Invalid/Incomplete Data from Submitted Claim	X	X	X	X	X	X	X	X	X		
8182.3	Contractors and Shared System Maintainers shall report only the code combinations that are listed in the attached document under Scenario #3. This requirement shall be implemented by October 7, 2013. Scenario #3: Billed Service Not Covered by Health Plan	X	X	X	X	X	X	X	X	X		
8182.4	Contractors and Shared System Maintainers shall report only the code combinations that are listed in the attached document under Scenario #4. This requirement shall be implemented by October 7, 2013. Scenario #4: Benefit for Billed Service Not Separately Payable	X	X	X	X	X	X	X	X	X		

Number	Requirement	Responsibility										
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				Other
		Part A	Part B					FISS	MCS	VMS	CWF	
8182.5	ViPs and FISS shall update Medicare Remit Easy Print (MREP) and PC Print, if needed, per attached. This requirement shall be implemented by October 7, 2013.							X		X		
8182.6	FISS, MCS and VMS shall complete analysis and provide edit lists to the MACs for their review and update of code combinations per BRs 1, 2, 3, and 4 by July 1, 2013.							X	X	X		
8182.7	FISS, MCS and VMS shall generate a monthly report to identify code combinations that have been used by MACs that are outside of the current code combinations list per Operating Rules, and shall share them with the MACs and CMS starting with the month of October, 2013. NOTE: These reports will identify the code combinations, MACs and the dates for using these additional combinations.							X	X	X		

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility						
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Other
		Part A	Part B					
8182.8	MLN Article : A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web sites and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education	X	X	X	X	X	X	

Number	Requirement	Responsibility						
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Other
		Part A	Part B					
	article shall be included in the contractor's next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.							

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): sumita sen, sumita.sen@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR) or Contractor Manager, as applicable.

VI. FUNDING

Section A: For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs):
No additional funding will be provided by CMS; Contractors activities are to be carried out with their operating budgets

Section B: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS do not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Committee on Operating Rules for Information Exchange (CORE®)

CORE-required Code Combinations for CORE-defined Business Scenarios for the Phase III CORE 360 Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule

Table of Contents

CAQH Committee on Operating Rules for Information Exchange (CORE)
Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule
CORE-required Code Combinations for CORE-defined Business Scenarios
version 3.0.0 June 2012

1 Introduction

This list accompanies the Phase III CORE 360 Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule Version 3.0.0. Highlights from the rule requirements include:

- CORE is establishing a *minimum* set of CORE-defined Claim Adjustment/Denial Business Scenarios as defined in the rule and a *maximum* set of CORE-required CARC/RARC/CAGC and CARC/NCPDP Reject Code/CAGC[1] Combinations to convey detailed information about the payment adjustment or denial. This document specifies the maximum set of CORE-required CARC/RARC/CAGC and CARC/NCPDP Reject Code/CAGC Combinations. The specific Business Scenarios in the rule were selected as they represent some of the most confusing and high volume scenarios that are exchanged between health plans and providers. Identifying a *maximum* set of code combinations for use with these Business Scenarios was selected for similar reasons – to reduce confusion and drive industry approaches to a long-standing problem.
- When using the CORE-defined Business Scenarios, entities are not allowed to add to the code combinations associated with each Business Scenario as this set of CARC/RARC/CAGC and CARC/NCPDP Reject Code/CAGC Combinations represents a *maximum* set. The only exception to this maximum is when the respective code committees create a new code or adjust an existing code; then the new or adjusted code can be used immediately with the Business Scenarios and the CORE Process for Maintaining the CORE-defined Claim Adjustment Reason Code, Remittance Advice Remark Code & Claim Adjustment Group Code Combinations for updating the Code Combinations will review the ongoing use of these codes within the maximum set of codes for the Business Scenarios. (See §3.5 of the Phase III CORE 360 Uniform Use of CARC and RARC Codes (835) Rule Version 3.0.0.)
- When the specific CORE-required CARC/RARC/CAGC and CARC/NCPDP Reject Code/CAGC Combinations within a Business Scenario are not applicable to meet the health plan's business requirements in describing the payment adjustment or denial, the health plan is not required to use the combinations. Should a health plan want to create new Business Scenarios which do not conflict with the existing CORE-defined Business Scenarios, this rule does not prohibit that, but it is expected the health plan will send the new Scenarios for consideration in an updated rule.
- In the case that additional CARC/RARC/CAGC and CARC/NCPDP Reject Code/CAGC Combinations for an existing CORE-defined Business Scenario is needed beyond what is currently included in the maximum set, then such code combinations must be requested in accordance with the CORE process for updating the *CORE-required Code Combinations for CORE-defined Business Scenarios.doc.*
- Consistent with the v5010 X12 835 or the CARC definition itself, not all CARCs require a RARC. Therefore, any CARC in the CORE-required Code Combination tables may be used without the corresponding RARC, except for CARCs that require RARCs as specified by the v5010 X12 835 or the CARC definition itself.
- The pharmacy industry adjudicates claims differently than the medical sector of health care, both with regard to process as well as with regard to codes used in that process. The pharmacy industry adjudicates claims and reports the results in real time using the NCPDP Telecommunication Standard. Using the NCPDP Telecommunication Standard, pharmacies send a real time request and receive an immediate real time response from the processor. If the claim is rejected, the NCPDP Reject Codes must be used consistently and uniformly across all trading partners. Each NCPDP Reject Code is tied to a specific reason/field in the NCPDP Telecommunication standard. Agreement on the use of these Reject Codes allows the pharmacy to ensure all required data for real time adjudication is available. Once the adjudication process is completed, the

[1] http://www.ncpdp.org/members/members_download.aspx. NCPDP Reject Codes are in Appendix A.

processor then reports the final result of adjudication via a real time response which includes payment information, payment reductions, etc. If necessary, adjustments are reported on the v5010 X12 835 using an appropriate CARC code which the pharmacy industry has agreed upon. NCPDP has created a mapping document to tie claim response fields to CARC Codes in the v5010 X12 835. The reporting of a rejected claim in a v5010 X12 835 transaction occurs only rarely, given that the pharmacy already has the rejection information from the real time processing of the claim and the v5010 X12 835 does not require the subsequent reporting of a rejected claim. Any such reporting is based on non-real time claims processing and mutual trading partner agreement using the NCPDP Reject Codes combined with CARC 16. (See §2.2 of the Phase III CORE 360 Uniform Use of CARC and RARC Codes (835) Rule Version 3.0.0.)

2 Code Combinations for Business Scenario #1: Additional Information Required – Missing/Invalid/Incomplete Documentation

Table 2-1				
Scenario #1: Additional Information Required – Missing/Invalid/Incomplete Documentation Refers to situations where additional documentation is needed from the billing provider or an ERA from a prior payer.				
CARC	**CARC Description**[2]	**RARC**	**RARC Description**[3]	**ASC X12 CAGC**
16	Claim/service lacks information which is needed for adjudication. 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).	M1	X-ray not taken within the past 12 months or near enough to the start of treatment.	CO or PI
		M19	Missing oxygen certification/re-certification.	CO or PI
		M21	Missing/incomplete/invalid place of residence for this service/item provided in a home.	CO or PI
		M23	Missing invoice.	CO or PI
		M29	Missing operative note/report.	CO or PI
		M30	Missing pathology report.	CO or PI
		M31	Missing radiology report.	CO or PI
		M42	The medical necessity form must be personally signed by the attending physician.	CO or PI
		M47	Missing/incomplete/invalid internal or document control number.	CO or PI
		M51	Missing/incomplete/invalid procedure code(s).	CO or PI
		M60	Missing Certificate of Medical Necessity.	CO or PI
		M64	Missing/incomplete/invalid other diagnosis.	CO or PI
		M127	Missing patient medical record for this service.	CO or PI
		M130	Missing invoice or statement certifying the actual cost of the lens, less discounts, and/or the type of intraocular lens used.	CO or PI
		M131	Missing physician financial relationship form.	CO or PI
		M132	Missing pacemaker registration form.	CO or PI
		M135	Missing/incomplete/invalid plan of treatment.	CO or PI
		M141	Missing physician certified plan of care.	CO or PI
		M142	Missing American Diabetes Association Certificate of Recognition.	CO or PI
		M143	The provider must update license information with the payer.	CO or PI
		MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.	CO or PI

[2] Washington Publishing Company
[3] Washington Publishing Company

Table 2-1				
Scenario #1: Additional Information Required – Missing/Invalid/Incomplete Documentation Refers to situations where additional documentation is needed from the billing provider or an ERA from a prior payer.				
CARC	**CARC Description[2]**	**RARC**	**RARC Description[3]**	**ASC X12 CAGC**
		MA27	Missing/incomplete/invalid entitlement number or name shown on the claim.	CO or PI
		MA61	Missing/incomplete/invalid social security number or health insurance claim number.	CO or PI
		MA64	Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.	CO or PI
		MA75	Missing/incomplete/invalid patient or authorized representative signature.	CO or PI
		MA76	Missing/incomplete/invalid provider identifier for home health agency or hospice when physician is performing care plan oversight services.	CO or PI
		MA81	Missing/incomplete/invalid provider/supplier signature.	CO or PI
		MA83	Did not indicate whether we are the primary or secondary payer.	CO or PI
		MA88	Missing/incomplete/invalid insured's address and/or telephone number for the primary payer.	CO or PI
		MA92	Missing plan information for other insurance.	CO or PI
		MA96	Claim rejected. Coded as a Medicare Managed Care Demonstration but patient is not enrolled in a Medicare managed care plan.	CO or PI
		MA111	Missing/incomplete/invalid purchase price of the test(s) and/or the performing laboratory's name and address.	CO or PI
		MA112	Missing/incomplete/invalid group practice information.	CO or PI
		MA114	Missing/incomplete/invalid information on where the services were furnished.	CO or PI
		MA122	Missing/incomplete/invalid initial treatment date.	CO or PI
		MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	CO or PI
		N3	Missing consent form.	CO or PI
		N4	Missing/incomplete/invalid prior insurance carrier EOB	CO or PI
		N26	Missing itemized bill/statement	CO or PI
		N28	Consent form requirements not fulfilled.	CO or PI

Table 2-1				
Scenario #1: Additional Information Required – Missing/Invalid/Incomplete Documentation Refers to situations where additional documentation is needed from the billing provider or an ERA from a prior payer.				
CARC	**CARC Description[2]**	**RARC**	**RARC Description[3]**	**ASC X12 CAGC**
		N29	Missing documentation/orders/notes/summary/report/chart.	CO or PI
		N40	Missing radiology film(s)/image(s).	CO or PI
		N42	No record of mental health assessment.	CO or PI
		N59	Please refer to your provider manual for additional program and provider information.	CO or PI
		N66	Missing/incomplete/invalid documentation.	CO or PI
		N80	Missing/incomplete/invalid prenatal screening information.	CO or PI
		N102	This claim has been denied without reviewing the medical record because the requested records were not received or were not received timely.	CO or PI
		N146	Missing screening document.	CO or PI
		N175	Missing review organization approval.	CO or PI
		N178	Missing pre-operative photos or visual field results.	CO or PI
		N179	Additional information has been requested from the member. The charges will be reconsidered upon receipt of that information.	CO or PI
		N186	Non-Availability Statement (NAS) required for this service. Contact the nearest Military Treatment Facility (MTF) for assistance.	CO or PI
		N191	The provider must update insurance information directly with payer.	CO or PI
		N197	The subscriber must update insurance information directly with payer.	CO or PI
		N202	Additional information/explanation will be sent separately	CO or PI
		N204	Services under review for possible pre-existing condition. Send medical records for prior 12 months.	CO or PI
		N205	Information provided was illegible.	CO or PI
		N206	The supporting documentation does not match the claim.	CO or PI
		N214	Missing/incomplete/invalid history of the related initial surgical procedure(s).	CO or PI
		N221	Missing Admitting History and Physical report.	CO or PI
		N222	Incomplete/invalid Admitting History and Physical report.	CO or PI

Table 2-1				
Scenario #1: Additional Information Required – Missing/Invalid/Incomplete Documentation Refers to situations where additional documentation is needed from the billing provider or an ERA from a prior payer.				
CARC	**CARC Description[2]**	**RARC**	**RARC Description[3]**	**ASC X12 CAGC**
		N223	Missing documentation of benefit to the patient during initial treatment period.	CO or PI
		N224	Incomplete/invalid documentation of benefit to the patient during initial treatment period.	CO or PI
		N225	Incomplete/invalid documentation/orders/notes/summary/report/chart.	CO or PI
		N227	Incomplete/invalid Certificate of Medical Necessity.	CO or PI
		N228	Incomplete/invalid consent form.	CO or PI
		N231	Incomplete/invalid invoice or statement certifying the actual cost of the lens, less discounts, and/or the type of intraocular lens used.	CO or PI
		N232	Incomplete/invalid itemized bill/statement.	CO or PI
		N233	Incomplete/invalid operative note/report.	CO or PI
		N234	Incomplete/invalid oxygen certification/re-certification.	CO or PI
		N235	Incomplete/invalid pacemaker registration form.	CO or PI
		N236	Incomplete/invalid pathology report.	CO or PI
		N237	Incomplete/invalid patient medical record for this service.	CO or PI
		N238	Incomplete/invalid physician certified plan of care	CO or PI
		N239	Incomplete/invalid physician financial relationship form.	CO or PI
		N240	Incomplete/invalid radiology report.	CO or PI
		N241	Incomplete/invalid review organization approval.	CO or PI
		N242	Incomplete/invalid radiology film(s)/image(s).	CO or PI
		N243	Incomplete/invalid/not approved screening document.	CO or PI
		N244	Incomplete/invalid pre-operative photos/visual field results.	CO or PI
		N245	Incomplete/invalid plan information for other insurance.	CO or PI
		N286	Missing/incomplete/invalid referring provider primary identifier.	CO or PI
		N331	Missing/incomplete/invalid physician order date.	CO or PI
		N350	Missing/incomplete/invalid description of service for a Not Otherwise Classified (NOC) code or for an Unlisted/By Report procedure.	CO or PI

Table 2-1				
Scenario #1: Additional Information Required – Missing/Invalid/Incomplete Documentation Refers to situations where additional documentation is needed from the billing provider or an ERA from a prior payer.				
CARC	**CARC Description[2]**	**RARC**	**RARC Description[3]**	**ASC X12 CAGC**
		N354	Incomplete/invalid invoice.	CO or PI
		N366	Requested information not provided. The claim will be reopened if the information previously requested is submitted within one year after the date of this denial notice.	CO or PI
		N375	Missing/incomplete/invalid questionnaire/information required to determine dependent eligibility.	CO or PI
		N391	Missing emergency department records.	CO or PI
		N392	Incomplete/invalid emergency department records.	CO or PI
		N393	Missing progress notes/report.	CO or PI
		N394	Incomplete/invalid progress notes/report.	CO or PI
		N395	Missing laboratory report.	CO or PI
		N396	Incomplete/invalid laboratory report.	CO or PI
		N398	Missing elective consent form.	CO or PI
		N399	Incomplete/invalid elective consent form.	CO or PI
		N401	Missing periodontal charting.	CO or PI
		N402	Incomplete/invalid periodontal charting.	CO or PI
		N403	Missing facility certification.	CO or PI
		N404	Incomplete/invalid facility certification.	CO or PI
		N439	Missing anesthesia physical status report/indicators.	CO or PI
		N440	Incomplete/invalid anesthesia physical status report/indicators.	CO or PI
		N445	Missing document for actual cost or paid amount.	CO or PI
		N446	Incomplete/invalid document for actual cost or paid amount.	CO or PI
		N451	Missing Admission Summary Report.	CO or PI
		N452	Incomplete/invalid Admission Summary Report.	CO or PI
		N453	Missing Consultation Report.	CO or PI
		N454	Incomplete/invalid Consultation Report.	CO or PI
		N455	Missing Physician Order.	CO or PI
		N456	Incomplete/invalid Physician Order.	CO or PI
		N457	Missing Diagnostic Report.	CO or PI
		N458	Incomplete/invalid Diagnostic Report.	CO or PI

Table 2-1				
Scenario #1: Additional Information Required – Missing/Invalid/Incomplete Documentation Refers to situations where additional documentation is needed from the billing provider or an ERA from a prior payer.				
CARC	**CARC Description[2]**	**RARC**	**RARC Description[3]**	**ASC X12 CAGC**
		N459	Missing Discharge Summary.	CO or PI
		N460	Incomplete/invalid Discharge Summary.	CO or PI
		N461	Missing Nursing Notes.	CO or PI
		N462	Incomplete/invalid Nursing Notes.	CO or PI
		N463	Missing support data for claim.	CO or PI
		N464	Incomplete/invalid support data for claim.	CO or PI
		N465	Missing Physical Therapy Notes/Report.	CO or PI
		N466	Incomplete/invalid Physical Therapy Notes/Report.	CO or PI
		N467	Missing Report of Tests and Analysis Report.	CO or PI
		N468	Incomplete/invalid Report of Tests and Analysis Report.	CO or PI
		N473	Missing certification.	CO or PI
		N474	Incomplete/invalid certification.	CO or PI
		N475	Missing completed referral form.	CO or PI
		N476	Incomplete/invalid completed referral form.	CO or PI
		N477	Missing Dental Models.	CO or PI
		N478	Incomplete/invalid Dental Models.	CO or PI
		N479	Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).	CO or PI
		N480	Incomplete/invalid Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).	CO or PI
		N481	Missing Models.	CO or PI
		N482	Incomplete/invalid Models	CO or PI
		N483	Missing Periodontal Charts.	CO or PI
		N484	Incomplete/invalid Periodontal Charts.	CO or PI
		N485	Missing Physical Therapy Certification.	CO or PI
		N486	Incomplete/invalid Physical Therapy Certification.	CO or PI
		N487	Missing Prosthetics or Orthotics Certification.	CO or PI
		N488	Incomplete/invalid Prosthetics or Orthotics Certification.	CO or PI
		N489	Missing referral form.	CO or PI
		N490	Incomplete/invalid referral form.	CO or PI

Table 2-1				
Scenario #1: Additional Information Required – Missing/Invalid/Incomplete Documentation Refers to situations where additional documentation is needed from the billing provider or an ERA from a prior payer.				
CARC	**CARC Description[2]**	**RARC**	**RARC Description[3]**	**ASC X12 CAGC**
		N491	Missing/Incomplete/Invalid Exclusionary Rider Condition.	CO or PI
		N493	Missing Doctor First Report of Injury.	CO or PI
		N494	Incomplete/invalid Doctor First Report of Injury.	CO or PI
		N495	Missing Supplemental Medical Report.	CO or PI
		N496	Incomplete/invalid Supplemental Medical Report.	CO or PI
		N497	Missing Medical Permanent Impairment or Disability Report.	CO or PI
		N498	Incomplete/invalid Medical Permanent Impairment or Disability Report.	CO or PI
		N499	Missing Medical Legal Report.	CO or PI
		N500	Incomplete/invalid Medical Legal Report.	CO or PI
		N542	Missing income verification.	CO or PI
		N543	Incomplete/invalid income verification	CO or PI
112	Service not furnished directly to the patient and/or not documented.			CO or PI
116	The advance indemnification notice signed by the patient did not comply with requirements.			CO or PI
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.)	N29	Missing documentation/orders/notes/summary/report/chart.	CO or PI
163	Attachment referenced on the claim was not received.			CO or PI
164	Attachment referenced on the claim was not received in a timely fashion.			CO or PI
165	Referral absent or exceeded.			CO or PI
197	Precertification/authorization/notification absent.			CO or PI

3 Code Combinations for Business Scenario #2: Additional Information Required – Missing/Invalid/Incomplete Data from Submitted Claim

Table 3-1				
Scenario #2: Missing/Invalid/Incomplete Data from Submitted Claim Refers to situations where additional data is needed from the billing provider for missing or invalid data on the submitted claim, e.g., an 837 or D.0.				
CARC	**CARC Description[4]**	**RARC**	**RARC Description[5]**	**ASC X12 CAGC**
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.	N517	Resubmit a new claim with the requested information.	CO or PI
		N519	Invalid combination of HCPCS modifiers.	CO or PI
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.	N517	Resubmit a new claim with the requested information.	CO or PI
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.	N517	Resubmit a new claim with the requested information.	CO or PI
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.			CO or PI
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.			CO or PI
13	The date of death precedes the date of service.			CO or PI
14	The date of birth follows the date of service.			CO or PI
15	The authorization number is missing, invalid, or does not apply to the billed services or provider.	N517	Resubmit a new claim with the requested information.	CO or PI
18	Duplicate claim/service.	N522	Duplicate of a claim processed, or to be processed, as a crossover claim.	CO or PI
69	Day outlier amount.			CO or PI

[4] Washington Publishing Company
[5] Washington Publishing Company

Table 3-1				
Scenario #2: Missing/Invalid/Incomplete Data from Submitted Claim Refers to situations where additional data is needed from the billing provider for missing or invalid data on the submitted claim, e.g., an 837 or D.0.				
CARC	**CARC Description[4]**	**RARC**	**RARC Description[5]**	**ASC X12 CAGC**
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.			CO or PI
110	Billing date predates service date.			CO or PI
125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is not an ALERT).	M7	No rental payments after the item is purchased, or after the total of issued rental payments equals the purchase price.	CO or PI
		M12	Diagnostic tests performed by a physician must indicate whether purchased services are included on the claim.	CO or PI
		M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	CO or PI
		M18	Certain services may be approved for home use. Neither a hospital nor a Skilled Nursing Facility (SNF) is considered to be a patient's home.	CO or PI
		M19	Missing oxygen certification/re-certification.	CO or PI
		M20	Missing/incomplete/invalid HCPCS.	CO or PI
		M21	Missing/incomplete/invalid place of residence for this service/item provided in a home.	CO or PI
		M22	Missing/incomplete/invalid number of miles traveled.	CO or PI
		M24	Missing/incomplete/invalid number of doses per vial.	CO or PI
		M42	The medical necessity form must be personally signed by the attending physician.	CO or PI
		M44	Missing/incomplete/invalid condition code	CO or PI
		M45	Missing/incomplete/invalid occurrence code(s).	CO or PI
		M46	Missing/incomplete/invalid occurrence span code(s).	CO or PI
		M47	Missing/incomplete/invalid internal or document control number.	CO or PI
		M49	Missing/incomplete/invalid value code(s) or amount(s).	CO or PI
		M50	Missing/incomplete/invalid revenue code(s).	CO or PI
		M51	Missing/incomplete/invalid procedure code(s).	CO or PI

Table 3-1				
Scenario #2: Missing/Invalid/Incomplete Data from Submitted Claim Refers to situations where additional data is needed from the billing provider for missing or invalid data on the submitted claim, e.g., an 837 or D.0.				
CARC	**CARC Description[4]**	**RARC**	**RARC Description[5]**	**ASC X12 CAGC**
		M52	Missing/incomplete/invalid "from" date(s) of service.	CO or PI
		M53	Missing/incomplete/invalid days or units of service.	CO or PI
		M54	Missing/incomplete/invalid total charges.	CO or PI
		M56	Missing/incomplete/invalid payer identifier.	CO or PI
		M59	Missing/incomplete/invalid "to" date(s) of service.	CO or PI
		M62	Missing/incomplete/invalid treatment authorization code.	CO or PI
		M64	Missing/incomplete/invalid other diagnosis.	CO or PI
		M67	Missing/incomplete/invalid other procedure code(s).	CO or PI
		M72	Did not enter full 8-digit date (MM/DD/CCYY).	CO or PI
		M76	Missing/incomplete/invalid diagnosis or condition.	CO or PI
		M77	Missing/incomplete/invalid place of service.	CO or PI
		M78	Missing/incomplete/invalid HCPCS modifier.	CO or PI
		M79	Missing/incomplete/invalid charge.	CO or PI
		M81	You are required to code to the highest level of specificity.	CO or PI
		M99	Missing/incomplete/invalid Universal Product Number/Serial Number.	CO or PI
		M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC)	CO or PI
		M122	Missing/incomplete/invalid level of subluxation.	CO or PI
		M123	Missing/incomplete/invalid name, strength, or dosage of the drug furnished.	CO or PI
		M124	Missing indication of whether the patient owns the equipment that requires the part or supply.	CO or PI
		M125	Missing/incomplete/invalid information on the period of time for which the service/supply/equipment will be needed.	CO or PI
		M126	Missing/incomplete/invalid individual lab codes included in the test.	CO or PI
		M129	Missing/incomplete/invalid indicator of x-ray availability for review.	CO or PI

Table 3-1				
Scenario #2: Missing/Invalid/Incomplete Data from Submitted Claim Refers to situations where additional data is needed from the billing provider for missing or invalid data on the submitted claim, e.g., an 837 or D.0.				
CARC	**CARC Description[4]**	**RARC**	**RARC Description[5]**	**ASC X12 CAGC**
		M133	Claim did not identify who performed the purchased diagnostic test or the amount you were charged for the test.	CO or PI
		M136	Missing/incomplete/invalid indication that the service was supervised or evaluated by a physician.	CO or PI
		MA04	Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.	CO or PI
		MA27	Missing/incomplete/invalid entitlement number or name shown on the claim.	CO or PI
		MA30	Missing/incomplete/invalid type of bill.	CO or PI
		MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.	CO or PI
		MA32	Missing/incomplete/invalid number of covered days during the billing period.	CO or PI
		MA33	Missing/incomplete/invalid noncovered days during the billing period.	CO or PI
		MA34	Missing/incomplete/invalid number of coinsurance days during the billing period.	CO or PI
		MA35	Missing/incomplete/invalid number of lifetime reserve days.	CO or PI
		MA36	Missing/incomplete/invalid patient name.	CO or PI
		MA37	Missing/incomplete/invalid patient's address.	CO or PI
		MA38	Missing/incomplete/invalid birth date.	CO or PI
		MA39	Missing/incomplete/invalid gender.	CO or PI
		MA40	Missing/incomplete/invalid admission date.	CO or PI
		MA41	Missing/incomplete/invalid admission type.	CO or PI
		MA42	Missing/incomplete/invalid admission source.	CO or PI
		MA43	Missing/incomplete/invalid patient status.	CO or PI
		MA47	Our records show you have opted out of Medicare, agreeing with the patient not to bill Medicare for services/tests/supplies furnished. As result, we cannot pay this claim. The patient is responsible for payment.	CO or PI
		MA48	Missing/incomplete/invalid name or address of responsible party or primary payer.	CO or PI

Table 3-1				
Scenario #2: Missing/Invalid/Incomplete Data from Submitted Claim Refers to situations where additional data is needed from the billing provider for missing or invalid data on the submitted claim, e.g., an 837 or D.0.				
CARC	**CARC Description[4]**	**RARC**	**RARC Description[5]**	**ASC X12 CAGC**
		MA50	Missing/incomplete/invalid Investigational Device Exemption number for FDA-approved clinical trial services.	CO or PI
		MA53	Missing/incomplete/invalid Competitive Bidding Demonstration Project identification.	CO or PI
		MA58	Missing/incomplete/invalid release of information indicator.	CO or PI
		MA60	Missing/incomplete/invalid patient relationship to insured.	CO or PI
		MA61	Missing/incomplete/invalid social security number or health insurance claim number.	CO or PI
		MA63	Missing/incomplete/invalid principal diagnosis.	CO or PI
		MA64	Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.	CO or PI
		MA65	Missing/incomplete/invalid admitting diagnosis.	CO or PI
		MA66	Missing/incomplete/invalid principal procedure code.	CO or PI
		MA67	Correction to a prior claim.	CO or PI
		MA69	Missing/incomplete/invalid remarks.	CO or PI
		MA70	Missing/incomplete/invalid provider representative signature.	CO or PI
		MA71	Missing/incomplete/invalid provider representative signature date.	CO or PI
		MA75	Missing/incomplete/invalid patient or authorized representative signature.	CO or PI
		MA76	Missing/incomplete/invalid provider identifier for home health agency or hospice when physician is performing care plan oversight services.	CO or PI
		MA81	Missing/incomplete/invalid provider/supplier signature.	CO or PI
		MA88	Missing/incomplete/invalid insured's address and/or telephone number for the primary payer.	CO or PI
		MA89	Missing/incomplete/invalid patient's relationship to the insured for the primary payer.	CO or PI
		MA90	Missing/incomplete/invalid employment status code for the primary insured.	CO or PI
		MA92	Missing plan information for other insurance.	CO or PI

Table 3-1				
Scenario #2: Missing/Invalid/Incomplete Data from Submitted Claim Refers to situations where additional data is needed from the billing provider for missing or invalid data on the submitted claim, e.g., an 837 or D.0.				
CARC	**CARC Description[4]**	**RARC**	**RARC Description[5]**	**ASC X12 CAGC**
		MA94	Did not enter the statement "Attending physician not hospice employee" on the claim form to certify that the rendering physician is not an employee of the hospice.	CO or PI
		MA97	Missing/incomplete/invalid Medicare Managed Care Demonstration contract number or clinical trial registry number.	CO or PI
		MA99	Missing/incomplete/invalid Medigap information.	CO or PI
		MA100	Missing/incomplete/invalid date of current illness or symptoms.	CO or PI
		MA102	Missing/incomplete/invalid name or provider identifier for the rendering/referring/ ordering/ supervising provider.	CO or PI
		MA110	Missing/incomplete/invalid information on whether the diagnostic test(s) were performed by an outside entity or if no purchased tests are included on the claim.	CO or PI
		MA111	Missing/incomplete/invalid purchase price of the test(s) and/or the performing laboratory's name and address.	CO or PI
		MA112	Missing/incomplete/invalid group practice information.	CO or PI
		MA113	Incomplete/invalid taxpayer identification number (TIN) submitted by you per the Internal Revenue Service. Your claims cannot be processed without your correct TIN, and you may not bill the patient pending correction of your TIN. There are no appeal rights for unprocessable claims, but you may resubmit this claim after you have notified this office of your correct TIN.	CO or PI
		MA114	Missing/incomplete/invalid information on where the services were furnished.	CO or PI
		MA115	Missing/incomplete/invalid physical location (name and address, or PIN) where the service(s) were rendered in a Health Professional Shortage Area (HPSA).	CO or PI
		MA116	Did not complete the statement 'Homebound' on the claim to validate whether laboratory services were performed at home or in an institution.	CO or PI
		MA120	Missing/incomplete/invalid CLIA certification number.	CO or PI
		MA121	Missing/incomplete/invalid x-ray date.	CO or PI
		MA122	Missing/incomplete/invalid initial treatment date.	CO or PI

Table 3-1				
Scenario #2: Missing/Invalid/Incomplete Data from Submitted Claim Refers to situations where additional data is needed from the billing provider for missing or invalid data on the submitted claim, e.g., an 837 or D.0.				
CARC	**CARC Description[4]**	**RARC**	**RARC Description[5]**	**ASC X12 CAGC**
		MA128	Missing/incomplete/invalid FDA approval number.	CO or PI
		MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	CO or PI
		MA134	Missing/incomplete/invalid provider number of the facility where the patient resides.	CO or PI
		N8	Crossover claim denied by previous payer and complete claim data not forwarded. Resubmit this claim to this payer to provide adequate data for adjudication.	CO or PI
		N20	Service not payable with other service rendered on the same date.	CO or PI
		N22	This procedure code was added/changed because it more accurately describes the services rendered.	CO or PI
		N24	Missing/incomplete/invalid Electronic Funds Transfer (EFT) banking information.	CO or PI
		N27	Missing/incomplete/invalid treatment number.	CO or PI
		N28	Consent form requirements not fulfilled.	CO or PI
		N31	Missing/incomplete/invalid prescribing provider identifier.	CO or PI
		N32	Claim must be submitted by the provider who rendered the service.	CO or PI
		N34	Incorrect claim form/format for this service.	CO or PI
		N37	Missing/incomplete/invalid tooth number/letter.	CO or PI
		N39	Procedure code is not compatible with tooth number/letter.	CO or PI
		N46	Missing/incomplete/invalid admission hour.	CO or PI
		N48	Claim information does not agree with information received from other insurance carrier.	CO or PI
		N50	Missing/incomplete/invalid discharge information.	CO or PI
		N53	Missing/incomplete/invalid point of pick-up address.	CO or PI
		N54	Claim information is inconsistent with pre-certified/authorized services.	CO or PI
		N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	CO or PI

Table 3-1				
Scenario #2: Missing/Invalid/Incomplete Data from Submitted Claim Refers to situations where additional data is needed from the billing provider for missing or invalid data on the submitted claim, e.g., an 837 or D.0.				
CARC	**CARC Description[4]**	**RARC**	**RARC Description[5]**	**ASC X12 CAGC**
		N57	Missing/incomplete/invalid prescribing date.	CO or PI
		N58	Missing/incomplete/invalid patient liability amount.	CO or PI
		N59	Please refer to your provider manual for additional program and provider information.	CO or PI
		N61	Rebill services on separate claims.	CO or PI
		N62	Dates of service span multiple rate periods. Resubmit separate claims.	CO or PI
		N63	Rebill services on separate claim lines.	CO or PI
		N64	The "from" and "to" dates must be different.	CO or PI
		N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	CO or PI
		N75	Missing/incomplete/invalid tooth surface information.	CO or PI
		N76	Missing/incomplete/invalid number of riders.	CO or PI
		N77	Missing/incomplete/invalid designated provider number	CO or PI
		N80	Missing/incomplete/invalid prenatal screening information.	CO or PI
		N108	Missing/incomplete/invalid upgrade information.	CO or PI
		N129	Not eligible due to the patient's age.	CO or PI
		N147	Long term care case mix or per diem rate cannot be determined because the patient ID number is missing, incomplete, or invalid on the assignment request.	CO or PI
		N148	Missing/incomplete/invalid date of last menstrual period.	CO or PI
		N150	Missing/incomplete/invalid model number.	CO or PI
		N152	Missing/incomplete/invalid replacement claim information.	CO or PI
		N153	Missing/incomplete/invalid room and board rate.	CO or PI
		N161	This drug/service/supply is covered only when the associated service is covered.	CO or PI
		N170	A new/revised/renewed certificate of medical necessity is needed.	CO or PI
		N175	Missing review organization approval.	CO or PI

Table 3-1				
Scenario #2: Missing/Invalid/Incomplete Data from Submitted Claim Refers to situations where additional data is needed from the billing provider for missing or invalid data on the submitted claim, e.g., an 837 or D.0.				
CARC	**CARC Description[4]**	**RARC**	**RARC Description[5]**	**ASC X12 CAGC**
		N182	This claim/service must be billed according to the schedule for this plan.	CO or PI
		N188	The approved level of care does not match the procedure code submitted.	CO or PI
		N190	Missing contract indicator.	CO or PI
		N203	Missing/incomplete/invalid anesthesia time/units.	CO or PI
		N205	Information provided was illegible.	CO or PI
		N207	Missing/incomplete/invalid weight.	CO or PI
		N208	Missing/incomplete/invalid DRG code.	CO or PI
		N209	Missing/incomplete/invalid taxpayer identification number (TIN).	CO or PI
		N213	Missing/incomplete/invalid facility/discrete unit DRG/DRG exempt status information.	CO or PI
		N225	Incomplete/invalid documentation/orders/notes/summary/report/chart.	CO or PI
		N229	Incomplete/invalid contract indicator.	CO or PI
		N230	Incomplete/invalid indication of whether the patient owns the equipment that requires the part or supply.	CO or PI
		N245	Incomplete/invalid plan information for other insurance.	CO or PI
		N247	Missing/incomplete/invalid assistant surgeon taxonomy.	CO or PI
		N248	Missing/incomplete/invalid assistant surgeon name.	CO or PI
		N249	Missing/incomplete/invalid assistant surgeon primary identifier.	CO or PI
		N250	Missing/incomplete/invalid assistant surgeon secondary identifier.	CO or PI
		N251	Missing/incomplete/invalid attending provider taxonomy.	CO or PI
		N252	Missing/incomplete/invalid attending provider name.	CO or PI
		N253	Missing/incomplete/invalid attending provider primary identifier.	CO or PI
		N254	Missing/incomplete/invalid attending provider secondary identifier.	CO or PI
		N255	Missing/incomplete/invalid billing provider taxonomy.	CO or PI

Table 3-1				
Scenario #2: Missing/Invalid/Incomplete Data from Submitted Claim Refers to situations where additional data is needed from the billing provider for missing or invalid data on the submitted claim, e.g., an 837 or D.0.				
CARC	**CARC Description[4]**	**RARC**	**RARC Description[5]**	**ASC X12 CAGC**
		N256	Missing/incomplete/invalid billing provider/supplier name.	CO or PI
		N257	Missing/incomplete/invalid billing provider/supplier primary identifier.	CO or PI
		N258	Missing/incomplete/invalid billing provider/supplier address.	CO or PI
		N259	Missing/incomplete/invalid billing provider/supplier secondary identifier.	CO or PI
		N260	Missing/incomplete/invalid billing provider/supplier contact information.	CO or PI
		N261	Missing/incomplete/invalid operating provider name.	CO or PI
		N262	Missing/incomplete/invalid operating provider primary identifier.	CO or PI
		N263	Missing/incomplete/invalid operating provider secondary identifier.	CO or PI
		N264	Missing/incomplete/invalid ordering provider name.	CO or PI
		N265	Missing/incomplete/invalid ordering provider primary identifier.	CO or PI
		N266	Missing/incomplete/invalid ordering provider address.	CO or PI
		N267	Missing/incomplete/invalid ordering provider secondary identifier.	CO or PI
		N268	Missing/incomplete/invalid ordering provider contact information.	CO or PI
		N269	Missing/incomplete/invalid other provider name.	CO or PI
		N270	Missing/incomplete/invalid other provider primary identifier.	CO or PI
		N271	Missing/incomplete/invalid other provider secondary identifier.	CO or PI
		N272	Missing/incomplete/invalid other payer attending provider identifier.	CO or PI
		N273	Missing/incomplete/invalid other payer operating provider identifier.	CO or PI
		N274	Missing/incomplete/invalid other payer other provider identifier.	CO or PI
		N275	Missing/incomplete/invalid other payer purchased service provider identifier.	CO or PI

Table 3-1				
Scenario #2: Missing/Invalid/Incomplete Data from Submitted Claim Refers to situations where additional data is needed from the billing provider for missing or invalid data on the submitted claim, e.g., an 837 or D.0.				
CARC	**CARC Description[4]**	**RARC**	**RARC Description[5]**	**ASC X12 CAGC**
		N276	Missing/incomplete/invalid other payer referring provider identifier.	CO or PI
		N277	Missing/incomplete/invalid other payer rendering provider identifier.	CO or PI
		N278	Missing/incomplete/invalid other payer service facility provider identifier.	CO or PI
		N279	Missing/incomplete/invalid pay-to provider name.	CO or PI
		N280	Missing/incomplete/invalid pay-to provider primary identifier.	CO or PI
		N281	Missing/incomplete/invalid pay-to provider address.	CO or PI
		N282	Missing/incomplete/invalid pay-to provider secondary identifier.	CO or PI
		N283	Missing/incomplete/invalid purchased service provider identifier.	CO or PI
		N284	Missing/incomplete/invalid referring provider taxonomy.	CO or PI
		N285	Missing/incomplete/invalid referring provider name.	CO or PI
		N286	Missing/incomplete/invalid referring provider primary identifier.	CO or PI
		N287	Missing/incomplete/invalid referring provider secondary identifier.	CO or PI
		N288	Missing/incomplete/invalid rendering provider taxonomy.	CO or PI
		N289	Missing/incomplete/invalid rendering provider name.	CO or PI
		N290	Missing/incomplete/invalid rendering provider primary identifier.	CO or PI
		N291	Missing/incomplete/invalid rendering provider secondary identifier.	CO or PI
		N292	Missing/incomplete/invalid service facility name.	CO or PI
		N293	Missing/incomplete/invalid service facility primary identifier.	CO or PI
		N294	Missing/incomplete/invalid service facility primary address.	CO or PI
		N295	Missing/incomplete/invalid service facility secondary identifier.	CO or PI

Table 3-1				
Scenario #2: Missing/Invalid/Incomplete Data from Submitted Claim Refers to situations where additional data is needed from the billing provider for missing or invalid data on the submitted claim, e.g., an 837 or D.0.				
CARC	**CARC Description[4]**	**RARC**	**RARC Description[5]**	**ASC X12 CAGC**
		N296	Missing/incomplete/invalid supervising provider name.	CO or PI
		N297	Missing/incomplete/invalid supervising provider primary identifier.	CO or PI
		N298	Missing/incomplete/invalid supervising provider secondary identifier.	CO or PI
		N299	Missing/incomplete/invalid occurrence date(s).	CO or PI
		N300	Missing/incomplete/invalid occurrence span date(s).	CO or PI
		N301	Missing/incomplete/invalid procedure date(s).	CO or PI
		N302	Missing/incomplete/invalid other procedure date(s).	CO or PI
		N303	Missing/incomplete/invalid principal procedure date.	CO or PI
		N304	Missing/incomplete/invalid dispensed date.	CO or PI
		N305	Missing/incomplete/invalid accident date.	CO or PI
		N306	Missing/incomplete/invalid acute manifestation date.	CO or PI
		N307	Missing/incomplete/invalid adjudication or payment date.	CO or PI
		N308	Missing/incomplete/invalid appliance placement date.	CO or PI
		N309	Missing/incomplete/invalid assessment date.	CO or PI
		N310	Missing/incomplete/invalid assumed or relinquished care date.	CO or PI
		N312	Missing/incomplete/invalid begin therapy date.	CO or PI
		N313	Missing/incomplete/invalid certification revision date.	CO or PI
		N314	Missing/incomplete/invalid diagnosis date.	CO or PI
		N317	Missing/incomplete/invalid discharge hour.	CO or PI
		N318	Missing/incomplete/invalid discharge or end of care date.	CO or PI
		N319	Missing/incomplete/invalid hearing or vision prescription date.	CO or PI
		N320	Missing/incomplete/invalid Home Health Certification Period.	CO or PI
		N321	Missing/incomplete/invalid last admission period.	CO or PI

Table 3-1				
Scenario #2: Missing/Invalid/Incomplete Data from Submitted Claim Refers to situations where additional data is needed from the billing provider for missing or invalid data on the submitted claim, e.g., an 837 or D.0.				
CARC	**CARC Description[4]**	**RARC**	**RARC Description[5]**	**ASC X12 CAGC**
		N322	Missing/incomplete/invalid last certification date.	CO or PI
		N323	Missing/incomplete/invalid last contact date.	CO or PI
		N324	Missing/incomplete/invalid last seen/visit date.	CO or PI
		N325	Missing/incomplete/invalid last worked date.	CO or PI
		N326	Missing/incomplete/invalid last x-ray date.	CO or PI
		N327	Missing/incomplete/invalid other insured birth date.	CO or PI
		N328	Missing/incomplete/invalid Oxygen Saturation Test date.	CO or PI
		N329	Missing/incomplete/invalid patient birth date.	CO or PI
		N330	Missing/incomplete/invalid patient death date.	CO or PI
		N331	Missing/incomplete/invalid physician order date.	CO or PI
		N332	Missing/incomplete/invalid prior hospital discharge date.	CO or PI
		N333	Missing/incomplete/invalid prior placement date.	CO or PI
		N334	Missing/incomplete/invalid re-evaluation date.	CO or PI
		N335	Missing/incomplete/invalid referral date.	CO or PI
		N336	Missing/incomplete/invalid replacement date.	CO or PI
		N337	Missing/incomplete/invalid secondary diagnosis date.	CO or PI
		N338	Missing/incomplete/invalid shipped date.	CO or PI
		N339	Missing/incomplete/invalid similar illness or symptom date.	CO or PI
		N340	Missing/incomplete/invalid subscriber birth date.	CO or PI
		N341	Missing/incomplete/invalid surgery date.	CO or PI
		N342	Missing/incomplete/invalid test performed date.	CO or PI
		N343	Missing/incomplete/invalid Transcutaneous Electrical Nerve Stimulator (TENS) trial start date.	CO or PI
		N344	Missing/incomplete/invalid Transcutaneous Electrical Nerve Stimulator (TENS) trial end date.	CO or PI
		N345	Date range not valid with units submitted.	CO or PI
		N346	Missing/incomplete/invalid oral cavity designation code.	CO or PI

Table 3-1				
Scenario #2: Missing/Invalid/Incomplete Data from Submitted Claim Refers to situations where additional data is needed from the billing provider for missing or invalid data on the submitted claim, e.g., an 837 or D.0.				
CARC	**CARC Description[4]**	**RARC**	**RARC Description[5]**	**ASC X12 CAGC**
		N347	Your claim for a referred or purchased service cannot be paid because payment has already been made for this same service to another provider by a payment contractor representing the payer.	CO or PI
		N348	You chose that this service/supply/drug would be rendered/supplied and billed by a different practitioner/supplier.	CO or PI
		N349	The administration method and drug must be reported to adjudicate this service.	CO or PI
		N350	Missing/incomplete/invalid description of service for a Not Otherwise Classified (NOC) code or for an Unlisted/By Report procedure.	CO or PI
		N359	Missing/incomplete/invalid height.	CO or PI
		N378	Missing/incomplete/invalid prescription quantity.	CO or PI
		N380	The original claim has been processed, submit a corrected claim.	CO or PI
		N381	Consult our contractual agreement for restrictions/billing/payment information related to these charges.	CO or PI
		N382	Missing/incomplete/invalid patient identifier.	CO or PI
		N388	Missing/incomplete/invalid prescription number.	CO or PI
		N418	Misrouted claim. See the payer's claim submission instructions.	CO or PI
		N428	Not covered when performed in this place of service.	CO or PI
		N433	Resubmit this claim using only your National Provider Identifier (NPI).	CO or PI
		N434	Missing/Incomplete/Invalid Present on Admission indicator.	CO or PI
		N439	Missing anesthesia physical status report/indicators.	CO or PI
		N443	Missing/incomplete/invalid total time or begin/end time.	CO or PI
		N471	Missing/incomplete/invalid HIPPS Rate Code.	CO or PI
		N521	Mismatch between the submitted provider information and the provider information stored in our system.	CO or PI
129	Prior processing information appears	MA36	Missing/incomplete/invalid patient name.	CO or PI

Table 3-1				
Scenario #2: Missing/Invalid/Incomplete Data from Submitted Claim Refers to situations where additional data is needed from the billing provider for missing or invalid data on the submitted claim, e.g., an 837 or D.0.				
CARC	**CARC Description[4]**	**RARC**	**RARC Description[5]**	**ASC X12 CAGC**
	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.)	N48	Claim information does not agree with information received from other insurance carrier.	CO or PI
140	Patient/Insured health identification number and name do not match.			CO or PI
146	Diagnosis was invalid for the date(s) of service reported.	M64	Missing/incomplete/invalid other diagnosis.	CO or PI
		M76	Missing/incomplete/invalid diagnosis or condition.	CO or PI
		MA63	Missing/incomplete/invalid principal diagnosis.	CO or PI
		MA65	Missing/incomplete/invalid admitting diagnosis.	CO or PI
		N517	Resubmit a new claim with the requested information.	CO or PI
175	Prescription is incomplete.			CO or PI
181	Procedure code was invalid on the date of service.	M20	Missing/incomplete/invalid HCPCS.	CO or PI
		N517	Resubmit a new claim with the requested information.	CO or PI
182	Procedure modifier was invalid on the date of service.	N517	Resubmit a new claim with the requested information.	CO or PI
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.			CO or PI
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.			CO or PI
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.			CO or PI
189	'Not otherwise classified' or 'unlisted' procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service.	M81	You are required to code to the highest level of specificity.	CO or PI
197	Precertification/authorization/notification absent.			CO or PI

Table 3-1				
Scenario #2: Missing/Invalid/Incomplete Data from Submitted Claim Refers to situations where additional data is needed from the billing provider for missing or invalid data on the submitted claim, e.g., an 837 or D.0.				
CARC	**CARC Description[4]**	**RARC**	**RARC Description[5]**	**ASC X12 CAGC**
199	Revenue code and Procedure code do not match.			CO or PI
206	National Provider Identifier - missing.			CO or PI
207	National Provider identifier - Invalid format.	N257	Missing/incomplete/invalid billing provider/supplier primary identifier.	CO or PI
		N286	Missing/incomplete/invalid referring provider primary identifier.	CO or PI
208	National Provider Identifier - Not matched.			CO or PI
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.			CO or PI
A8	Ungroupable DRG.			CO or PI

4 Code Combinations for Business Scenario #3: Billed Service Not Covered by Health Plan

Table 4-1				
Scenario #3: Billed Service Not Covered by Health Plan Refers to situations where the billed service is not covered by the health plan.				
CARC	**CARC Description[6]**	**RARC**	**RARC Description[7]**	**ASC X12 CAGC**
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.	M77	Missing/incomplete/invalid place of service.	CO, PI or PR
		N34	Incorrect claim form/format for this service.	CO, PI or PR
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.	N22	This procedure code was added/changed because it more accurately describes the services rendered.	CO, PI or PR
		N115	This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd, or if you do not have web access, you may contact the contractor to request a copy of the LCD.	CO, PI or PR
		N129	Not eligible due to the patient's age.	CO, PI or PR
		N517	Resubmit a new claim with the requested information.	CO, PI or PR
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.	N22	This procedure code was added/changed because it more accurately describes the services rendered.	CO, PI or PR
		N115	This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd, or if you do not have web access, you may contact the contractor to request a copy of the LCD.	CO, PI or PR
		N517	Resubmit a new claim with the requested information.	CO, PI or PR
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.	N95	This provider type/provider specialty may not bill this service.	CO, PI or PR
		N517	Resubmit a new claim with the requested information.	CO, PI or PR
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.	N517	Resubmit a new claim with the requested information.	CO, PI or PR
19	This is a work-related injury/illness and thus the liability of the Worker's Compensation Carrier.	N418	Misrouted claim. See the payer's claim submission instructions.	CO, PI or PR

[6] Washington Publishing Company
[7] Washington Publishing Company

Table 4-1				
Scenario #3: Billed Service Not Covered by Health Plan Refers to situations where the billed service is not covered by the health plan.				
CARC	**CARC Description[6]**	**RARC**	**RARC Description[7]**	**ASC X12 CAGC**
20	This injury/illness is covered by the liability carrier.			CO, PI or PR
21	This injury/illness is the liability of the no-fault carrier.			CO, PI or PR
22	This care may be covered by another payer per coordination of benefits.			CO, PI or PR
23	The impact of prior payer(s) adjudication including payments and/or adjustments.			CO or PI
26	Expenses incurred prior to coverage.	N30	Patient ineligible for this service.	CO, PI or PR
		N52	Patient not enrolled in the billing provider's managed care plan on the date of service.	CO, PI or PR
		N128	This amount represents the prior to coverage portion of the allowance.	CO, PI or PR
		N210	**Alert:** You may appeal this decision.	CO, PI or PR
		N216	We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package.	CO, PI or PR
27	Expenses incurred after coverage terminated.	MA47	Our records show you have opted out of Medicare, agreeing with the patient not to bill Medicare for services/tests/supplies furnished. As result, we cannot pay this claim. The patient is responsible for payment.	CO, PI or PR
		N30	Patient ineligible for this service.	CO, PI or PR
		N45	Payment based on authorized amount.	CO, PI or PR
		N52	Patient not enrolled in the billing provider's managed care plan on the date of service.	CO, PI or PR
		N381	Consult our contractual agreement for restrictions/billing/payment information related to these charges.	CO, PI or PR
		N418	Misrouted claim. See the payer's claim submission instructions.	CO, PI or PR
28	Coverage not in effect at the time the service was provided.			CO, PI or PR
29	The time limit for filing has expired.	N30	Patient ineligible for this service.	CO, PI or PR
		N210	**Alert:** You may appeal this decision.	CO, PI or PR
31	Patient cannot be identified as our insured.			CO, PI or PR
32	Our records indicate that this dependent is not an eligible dependent as defined.	MA47	Our records show you have opted out of Medicare, agreeing with the patient not to bill Medicare for services/tests/supplies furnished. As result, we cannot pay this claim. The patient is responsible for payment.	CO, PI or PR
		N52	Patient not enrolled in the billing provider's managed care plan on the date of service.	CO, PI or PR
		N129	Not eligible due to the patient's age.	CO, PI or PR
33	Insured has no dependent coverage.			PR
34	Insured has no coverage for newborns.			CO, PI or PR
35	Lifetime benefit maximum has been reached.	N45	Payment based on authorized amount.	CO, PI or PR

Table 4-1				
Scenario #3: Billed Service Not Covered by Health Plan Refers to situations where the billed service is not covered by the health plan.				
CARC	**CARC Description[6]**	**RARC**	**RARC Description[7]**	**ASC X12 CAGC**
38	Services not provided or authorized by designated (network/primary care) providers.	M115	This item is denied when provided to this patient by a non-contract or non-demonstration supplier.	CO, PI or PR
		N95	This provider type/provider specialty may not bill this service.	CO, PI or PR
		N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	CO, PI or PR
		N450	Covered only when performed by the primary treating physician or the designee.	CO, PI or PR
39	Services denied at the time authorization/pre-certification was requested.			CO, PI or PR
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.			CO, PI or PR
49	These are non-covered services because this is a routine exam or screening procedure done in conjunction with a routine exam. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO or PR
		N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	CO or PR
		N390	This service/report cannot be billed separately.	CO or PR
		N427	Payment for eyeglasses or contact lenses can be made only after cataract surgery.	CO or PR
		N429	Not covered when considered routine.	CO or PR
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.	M1	X-ray not taken within the past 12 months or near enough to the start of treatment.	CO, PI or PR
		M16	**Alert:** Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision.	CO, PI or PR
		M26	The information furnished does not substantiate the need for this level of service. If you have collected any amount from the patient for this level of service /any amount that exceeds the limiting charge for the less extensive service, the law requires you to refund that amount to the patient within 30 days of receiving this notice. The requirements for refund are in 1824(I) of the Social Security Act and 42CFR411.408. The section specifies that physicians who knowingly and willfully fail to make appropriate refunds may be subject to civil monetary penalties and/or exclusion from the program. If you have any questions about this notice, please contact this office.	CO, PI or PR

Table 4-1				
Scenario #3: Billed Service Not Covered by Health Plan Refers to situations where the billed service is not covered by the health plan.				
CARC	**CARC Description[6]**	**RARC**	**RARC Description[7]**	**ASC X12 CAGC**
		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.	CO, PI or PR
		M38	The patient is liable for the charges for this service as you informed the patient in writing before the service was furnished that we would not pay for it, and the patient agreed to pay.	CO, PI or PR
		M64	Missing/incomplete/invalid other diagnosis.	CO, PI or PR
		M76	Missing/incomplete/invalid diagnosis or condition.	CO, PI or PR
		M85	Subjected to review of physician evaluation and management services.	CO, PI or PR
		MA46	The new information was considered but additional payment will not be issued.	CO, PI or PR
		MA91	This determination is the result of the appeal you filed.	CO, PI or PR
		MA126	Pancreas transplant not covered unless kidney transplant performed.	CO, PI or PR
		N10	Payment based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor.	CO, PI or PR
		N45	Payment based on authorized amount.	CO, PI or PR
		N102	This claim has been denied without reviewing the medical record because the requested records were not received or were not received timely.	CO, PI or PR
		N109	This claim/service was chosen for complex review and was denied after reviewing the medical records.	CO, PI or PR
		N115	This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd, or if you do not have web access, you may contact the contractor to request a copy of the LCD.	CO, PI or PR
		N129	Not eligible due to the patient's age.	CO, PI or PR
		N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	CO, PI or PR
		N161	This drug/service/supply is covered only when the associated service is covered.	CO, PI or PR
		N163	Medical record does not support code billed per the code definition.	CO, PI or PR

Table 4-1				
Scenario #3: Billed Service Not Covered by Health Plan Refers to situations where the billed service is not covered by the health plan.				
CARC	**CARC Description[6]**	**RARC**	**RARC Description[7]**	**ASC X12 CAGC**
		N180	This item or service does not meet the criteria for the category under which it was billed.	CO, PI or PR
		N206	The supporting documentation does not match the claim.	CO, PI or PR
		N225	Incomplete/invalid documentation/orders/notes/summary/report/chart.	CO, PI or PR
		N229	Incomplete/invalid contract indicator.	CO, PI or PR
		N358	**Alert:** This decision may be reviewed if additional documentation as described in the contract or plan benefit documents is submitted.	CO, PI or PR
		N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO, PI or PR
		N372	Only reasonable and necessary maintenance/service charges are covered.	CO, PI or PR
		N383	Not covered when deemed cosmetic.	CO, PI or PR
		N386	This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.	CO, PI or PR
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.	N10	Payment based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor.	CO or PR
		N29	Missing documentation/orders/notes/summary/report/chart.	CO or PR
		N45	Payment based on authorized amount.	CO or PR
		N174	This is not a covered service/procedure/ equipment/bed, however patient liability is limited to amounts shown in the adjustments under group 'PR'.	CO or PR
		N204	Services under review for possible pre-existing condition. Send medical records for prior 12 months.	CO or PR
53	Services by an immediate relative or a member of the same household are not covered.			CO, PI or PR
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.			CO, PI or PR
55	Procedure/treatment is deemed experimental/investigational by the payer. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if	M49	Missing/incomplete/invalid value code(s) or amount(s).	CO, PI or PR
		MA02	**Alert:** If you do not agree with this determination, you have the right to appeal. You must file a written request for an appeal within 180 days of the date you receive this notice.	CO, PI or PR

Table 4-1				
Scenario #3: Billed Service Not Covered by Health Plan Refers to situations where the billed service is not covered by the health plan.				
CARC	**CARC Description[6]**	**RARC**	**RARC Description[7]**	**ASC X12 CAGC**
	present.	N111	No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.	CO, PI or PR
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.			CO or PI
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.			CO or PI
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.			CO or PI
60	Charges for outpatient services are not covered when performed within a period of time prior to or after inpatient services.			CO, PI or PR
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.			CO or PI
78	Non-Covered days/Room charge adjustment.			CO, PI or PR
89	Professional fees removed from charges.	N200	The professional component must be billed separately.	CO, PI or PR
95	Plan procedures not followed.			CO, PI or PR
96[8]	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittance Advice Remark Code that is not an	N216	We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package.	CO, PI or PR
		M1	X-ray not taken within the past 12 months or near enough to the start of treatment.	CO, PI or PR
		M2	Not paid separately when the patient is an inpatient.	CO, PI or PR

[8] CARC 96 is only to be used as a general business reason when the billed service is denied because it is not a covered charge per the member or provider contract; whenever possible other listed CARCs should be used to provide more specificity

Table 4-1				
Scenario #3: Billed Service Not Covered by Health Plan Refers to situations where the billed service is not covered by the health plan.				
CARC	**CARC Description[6]**	**RARC**	**RARC Description[7]**	**ASC X12 CAGC**
	ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M8	We do not accept blood gas tests results when the test was conducted by a medical supplier or taken while the patient is on oxygen.	CO, PI or PR
		M13	Only one initial visit is covered per specialty per medical group.	CO, PI or PR
		M18	Certain services may be approved for home use. Neither a hospital nor a Skilled Nursing Facility (SNF) is considered to be a patient's home.	CO, PI or PR
		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.	CO, PI or PR
		M28	This does not qualify for payment under Part B when Part A coverage is exhausted or not otherwise available.	CO, PI or PR
		M37	Not covered when the patient is under age 35.	CO, PI or PR
		M38	The patient is liable for the charges for this service as you informed the patient in writing before the service was furnished that we would not pay for it, and the patient agreed to pay.	CO, PI or PR
		M41	We do not pay for this as the patient has no legal obligation to pay for this.	CO, PI or PR
		M49	Missing/incomplete/invalid value code(s) or amount(s).	CO, PI or PR
		M55	We do not pay for self-administered anti-emetic drugs that are not administered with a covered oral anti-cancer drug.	CO, PI or PR
		M61	We cannot pay for this as the approval period for the FDA clinical trial has expired.	CO, PI or PR
		M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO, PI or PR
		M82	Service is not covered when patient is under age 50.	CO, PI or PR
		M83	Service is not covered unless the patient is classified as at high risk.	CO, PI or PR
		M86	Service denied because payment already made for same/similar procedure within set time frame.	CO, PI or PR
		M87	Claim/service(s) subjected to CFO-CAP prepayment review.	CO, PI or PR
		M89	Not covered more than once under age 40.	CO, PI or PR
		M90	Not covered more than once in a 12 month period.	CO, PI or PR

Table 4-1				
Scenario #3: Billed Service Not Covered by Health Plan Refers to situations where the billed service is not covered by the health plan.				
CARC	**CARC Description[6]**	**RARC**	**RARC Description[7]**	**ASC X12 CAGC**
		M97	Not paid to practitioner when provided to patient in this place of service. Payment included in the reimbursement issued the facility.	CO, PI or PR
		M100	We do not pay for an oral anti-emetic drug that is not administered for use immediately before, at, or within 48 hours of administration of a covered chemotherapy drug.	CO, PI or PR
		M111	We do not pay for chiropractic manipulative treatment when the patient refuses to have an x-ray taken.	CO, PI or PR
		M114	This service was processed in accordance with rules and guidelines under the DMEPOS Competitive Bidding Program or a Demonstration Project. For more information regarding these projects, contact your local contractor.	CO, PI or PR
		M117	Not covered unless submitted via electronic claim.	CO, PI or PR
		M121	We pay for this service only when performed with a covered cryosurgical ablation.	CO, PI or PR
		M134	Performed by a facility/supplier in which the provider has a financial interest.	CO, PI or PR
		M138	Patient identified as a demonstration participant but the patient was not enrolled in the demonstration at the time services were rendered. Coverage is limited to demonstration participants.	CO, PI or PR
		M139	Denied services exceed the coverage limit for the demonstration.	CO, PI or PR
		MA20	Skilled Nursing Facility (SNF) stay not covered when care is primarily related to the use of an urethral catheter for convenience or the control of incontinence.	CO, PI or PR
		MA24	Christian Science Sanitarium/ Skilled Nursing Facility (SNF) bill in the same benefit period.	CO, PI or PR
		MA25	A patient may not elect to change a hospice provider more than once in a benefit period.	CO, PI or PR
		MA47	Our records show you have opted out of Medicare, agreeing with the patient not to bill Medicare for services/tests/supplies furnished. As result, we cannot pay this claim. The patient is responsible for payment.	CO, PI or PR
		MA54	Physician certification or election consent for hospice care not received timely.	CO, PI or PR
		MA55	Not covered as patient received medical health care services, automatically revoking his/her election to receive religious non-medical health care services.	CO, PI or PR
		MA56	Our records show you have opted out of Medicare, agreeing with the patient not to bill Medicare for services/tests/supplies furnished. As result, we cannot pay this claim. The patient is responsible for payment, but under Federal law, you cannot charge the patient more than the limiting charge amount.	CO, PI or PR
		MA57	Patient submitted written request to revoke his/her election for religious non-medical health care services.	CO, PI or PR

Table 4-1				
Scenario #3: Billed Service Not Covered by Health Plan Refers to situations where the billed service is not covered by the health plan.				
CARC	**CARC Description[6]**	**RARC**	**RARC Description[7]**	**ASC X12 CAGC**
		MA67	Correction to a prior claim.	CO, PI or PR
		MA73	Informational remittance associated with a Medicare demonstration. No payment issued under fee-for-service Medicare as patient has elected managed care.	CO, PI or PR
		MA84	Patient identified as participating in the National Emphysema Treatment Trial but our records indicate that this patient is either not a participant, or has not yet been approved for this phase of the study. Contact Johns Hopkins University, the study coordinator, to resolve if there was a discrepancy.	CO, PI or PR
		MA96	Claim rejected. Coded as a Medicare Managed Care Demonstration but patient is not enrolled in a Medicare managed care plan.	CO, PI or PR
		MA123	Your center was not selected to participate in this study, therefore, we cannot pay for these services.	CO, PI or PR
		MA126	Pancreas transplant not covered unless kidney transplant performed.	CO, PI or PR
		MA131	Physician already paid for services in conjunction with this demonstration claim. You must have the physician withdraw that claim and refund the payment before we can process your claim.	CO, PI or PR
		N6	Under FEHB law (U.S.C. 8904(b)), we cannot pay more for covered care than the amount Medicare would have allowed if the patient were enrolled in Medicare Part A and/or Medicare Part B.	CO, PI or PR
		N7	Processing of this claim/service has included consideration under Major Medical provisions.	CO, PI or PR
		N10	Payment based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor.	CO, PI or PR
		N12	Policy provides coverage supplemental to Medicare. As the member does not appear to be enrolled in the applicable part of Medicare, the member is responsible for payment of the portion of the charge that would have been covered by Medicare.	CO, PI or PR
		N15	Services for a newborn must be billed separately.	CO, PI or PR
		N16	Family/member Out-of-Pocket maximum has been met. Payment based on a higher percentage.	CO, PI or PR
		N20	Service not payable with other service rendered on the same date.	CO, PI or PR
		N30	Patient ineligible for this service.	CO, PI or PR
		N32	Claim must be submitted by the provider who rendered the service.	CO, PI or PR
		N35	Program integrity/utilization review decision.	CO, PI or PR
		N43	Bed hold or leave days exceeded.	CO, PI or PR
		N45	Payment based on authorized amount.	CO, PI or PR
		N52	Patient not enrolled in the billing provider's managed care plan on the date of service.	CO, PI or PR
		N54	Claim information is inconsistent with pre-certified/authorized services.	CO, PI or PR

Table 4-1				
Scenario #3: Billed Service Not Covered by Health Plan Refers to situations where the billed service is not covered by the health plan.				
CARC	**CARC Description[6]**	**RARC**	**RARC Description[7]**	**ASC X12 CAGC**
		N55	Procedures for billing with group/referring/performing providers were not followed.	CO, PI or PR
		N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	CO, PI or PR
		N59	Please refer to your provider manual for additional program and provider information.	CO, PI or PR
		N61	Rebill services on separate claims.	CO, PI or PR
		N70	Consolidated billing and payment applies.	CO, PI or PR
		N81	Procedure billed is not compatible with tooth surface code.	CO, PI or PR
		N83	No appeal rights. Adjudicative decision based on the provisions of a demonstration project.	CO, PI or PR
		N86	A failed trial of pelvic muscle exercise training is required in order for biofeedback training for the treatment of urinary incontinence to be covered.	CO, PI or PR
		N87	Home use of biofeedback therapy is not covered.	CO, PI or PR
		N90	Covered only when performed by the attending physician.	CO, PI or PR
		N92	This facility is not certified for digital mammography.	CO, PI or PR
		N95	This provider type/provider specialty may not bill this service.	CO, PI or PR
		N96	Patient must be refractory to conventional therapy (documented behavioral, pharmacologic and/or surgical corrective therapy) and be an appropriate surgical candidate such that implantation with anesthesia can occur.	CO, PI or PR
		N102	This claim has been denied without reviewing the medical record because the requested records were not received or were not received timely.	CO, PI or PR
		N103	Social Security records indicate that this patient was a prisoner when the service was rendered. This payer does not cover items and services furnished to an individual while they are in State or local custody under a penal authority, unless under State or local law, the individual is personally liable for the cost of his or her health care while incarcerated and the State or local government pursues such debt in the same way and with the same vigor as any other debt.	CO, PI or PR
		N104	This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS website at www.cms.gov.	CO, PI or PR
		N109	This claim/service was chosen for complex review and was denied after reviewing the medical records.	CO, PI or PR
		N110	This facility is not certified for film mammography.	CO, PI or PR
		N113	Only one initial visit is covered per physician, group practice or provider.	CO, PI or PR

Table 4-1				
Scenario #3: Billed Service Not Covered by Health Plan Refers to situations where the billed service is not covered by the health plan.				
CARC	**CARC Description[6]**	**RARC**	**RARC Description[7]**	**ASC X12 CAGC**
		N115	This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd, or if you do not have web access, you may contact the contractor to request a copy of the LCD.	CO, PI or PR
		N117	This service is paid only once in a patient's lifetime.	CO, PI or PR
		N118	This service is not paid if billed more than once every 28 days.	CO, PI or PR
		N120	Payment is subject to home health prospective payment system partial episode payment adjustment. Patient was transferred/discharged/readmitted during payment episode.	CO, PI or PR
		N121	Medicare Part B does not pay for items or services provided by this type of practitioner for beneficiaries in a Medicare Part A covered Skilled Nursing Facility (SNF) stay.	CO, PI or PR
		N124	Payment has been denied for the/made only for a less extensive service/item because the information furnished does not substantiate the need for the (more extensive) service/item. The patient is liable for the charges for this service/item as you informed the patient in writing before the service/item was furnished that we would not pay for it, and the patient agreed to pay.	CO, PI or PR
		N126	Social Security Records indicate that this individual has been deported. This payer does not cover items and services furnished to individuals who have been deported.	CO, PI or PR
		N129	Not eligible due to the patient's age.	CO, PI or PR
		N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	CO, PI or PR
		N141	The patient was not residing in a long-term care facility during all or part of the service dates billed.	CO, PI or PR
		N143	The patient was not in a hospice program during all or part of the service dates billed.	CO, PI or PR
		N157	Transportation to/from this destination is not covered.	CO, PI or PR
		N158	Transportation in a vehicle other than an ambulance is not covered.	CO, PI or PR
		N159	Payment denied/reduced because mileage is not covered when the patient is not in the ambulance.	CO, PI or PR
		N161	This drug/service/supply is covered only when the associated service is covered.	CO, PI or PR
		N163	Medical record does not support code billed per the code definition.	CO, PI or PR
		N167	Charges exceed the post-transplant coverage limit.	CO, PI or PR
		N171	Payment for repair or replacement is not covered or has exceeded the purchase price.	CO, PI or PR

Table 4-1				
Scenario #3: Billed Service Not Covered by Health Plan Refers to situations where the billed service is not covered by the health plan.				
CARC	**CARC Description[6]**	**RARC**	**RARC Description[7]**	**ASC X12 CAGC**
		N174	This is not a covered service/procedure/ equipment/bed, however patient liability is limited to amounts shown in the adjustments under group 'PR'.	CO, PI or PR
		N176	Services provided aboard a ship are covered only when the ship is of United States registry and is in United States waters. In addition, a doctor licensed to practice in the United States must provide the service.	CO, PI or PR
		N180	This item or service does not meet the criteria for the category under which it was billed.	CO, PI or PR
		N188	The approved level of care does not match the procedure code submitted.	CO, PI or PR
		N193	Specific Federal/state/local program may cover this service through another payer.	CO, PI or PR
		N194	Technical component not paid if provider does not own the equipment used.	CO, PI or PR
		N198	Rendering provider must be affiliated with the pay-to provider.	CO, PI or PR
		N202	Additional information/explanation will be sent separately	CO, PI or PR
		N216	We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package.	CO, PI or PR
		N348	You chose that this service/supply/drug would be rendered/supplied and billed by a different practitioner/supplier.	CO, PI or PR
		N351	Service date outside of the approved treatment plan service dates.	CO, PI or PR
		N356	Not covered when performed with, or subsequent to, a non-covered service.	CO, PI or PR
		N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO, PI or PR
		N365	This procedure code is not payable. It is for reporting/information purposes only.	CO, PI or PR
		N370	Billing exceeds the rental months covered/approved by the payer.	CO, PI or PR
		N372	Only reasonable and necessary maintenance/service charges are covered.	CO, PI or PR
		N376	Subscriber/patient is assigned to active military duty, therefore primary coverage may be TRICARE.	CO, PI or PR
		N381	Consult our contractual agreement for restrictions/billing/payment information related to these charges.	CO, PI or PR
		N383	Not covered when deemed cosmetic.	CO, PI or PR

Table 4-1				
Scenario #3: Billed Service Not Covered by Health Plan Refers to situations where the billed service is not covered by the health plan.				
CARC	**CARC Description[6]**	**RARC**	**RARC Description[7]**	**ASC X12 CAGC**
		N386	This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.	CO, PI or PR
		N405	This service is only covered when the donor's insurer(s) do not provide coverage for the service.	CO, PI or PR
		N406	This service is only covered when the recipient's insurer(s) do not provide coverage for the service.	CO, PI or PR
		N408	This payer does not cover deductibles assessed by a previous payer.	CO, PI or PR
		N409	This service is related to an accidental injury and is not covered unless provided within a specific time frame from the date of the accident.	CO, PI or PR
		N410	Not covered unless the prescription changes.	CO, PI or PR
		N418	Misrouted claim. See the payer's claim submission instructions.	CO, PI or PR
		N424	Patient does not reside in the geographic area required for this type of payment.	CO, PI or PR
		N425	Statutorily excluded service(s).	CO, PI or PR
		N426	No coverage when self-administered.	CO, PI or PR
		N428	Not covered when performed in this place of service.	CO, PI or PR
		N429	Not covered when considered routine.	CO, PI or PR
		N431	Not covered with this procedure.	CO, PI or PR
		N435	Exceeds number/frequency approved /allowed within time period without support documentation.	CO, PI or PR
		N441	This missed appointment is not covered.	CO, PI or PR
		N442	Payment based on an alternate fee schedule.	CO, PI or PR
		N448	This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement	CO, PI or PR
		N450	Covered only when performed by the primary treating physician or the designee.	CO, PI or PR
		N507	Plan distance requirements have not been met.	CO, PI or PR
		N525	These services are not covered when performed within the global period of another service.	CO, PI or PR
		N528	Patient is entitled to benefits for Institutional Services only.	CO, PI or PR
		N529	Patient is entitled to benefits for Professional Services only.	CO, PI or PR
108	Rent/purchase guidelines were not met. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M7	No rental payments after the item is purchased, or after the total of issued rental payments equals the purchase price.	CO, PI or PR
		N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	CO, PI or PR
109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.	N36	Claim must meet primary payer's processing requirements before we can consider payment.	CO, PI or PR
		N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	CO, PI or PR

Table 4-1				
Scenario #3: Billed Service Not Covered by Health Plan Refers to situations where the billed service is not covered by the health plan.				
CARC	**CARC Description[6]**	**RARC**	**RARC Description[7]**	**ASC X12 CAGC**
		N193	Specific Federal/state/local program may cover this service through another payer.	CO, PI or PR
		N216	We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package	CO, PI or PR
		N381	Consult our contractual agreement for restrictions/billing/payment information related to these charges.	CO, PI or PR
		N418	Misrouted claim. See the payer's claim submission instructions.	CO, PI or PR
		N448	This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement.	CO, PI or PR
111	Not covered unless the provider accepts assignment.			CO, PI or PR
114	Procedure/product not approved by the Food and Drug Administration.			CO, PI or PR
115	Procedure postponed, canceled, or delayed.			CO, PI or PR
117	Transportation is only covered to the closest facility that can provide the necessary care.			CO, PI or PR
119	Benefit maximum for this time period or occurrence has been reached.	M4	**Alert:** This is the last monthly installment payment for this durable medical equipment.	CO, PI or PR
		M38	The patient is liable for the charges for this service as you informed the patient in writing before the service was furnished that we would not pay for it, and the patient agreed to pay.	CO, PI or PR
		M53	Missing/incomplete/invalid days or units of service.	CO, PI or PR
		M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO, PI or PR
		M83	Service is not covered unless the patient is classified as at high risk.	CO, PI or PR
		M86	Service denied because payment already made for same/similar procedure within set time frame.	CO, PI or PR
		M89	Not covered more than once under age 40.	CO, PI or PR
		M90	Not covered more than once in a 12 month period.	CO, PI or PR
		M139	Denied services exceed the coverage limit for the demonstration.	CO, PI or PR
		MA115	Missing/incomplete/invalid physical location (name and address, or PIN) where the service(s) were rendered in a Health Professional Shortage Area (HPSA).	CO, PI or PR
		MA130	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	CO, PI or PR
		N45	Payment based on authorized amount.	CO, PI or PR
		N111	No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.	CO, PI or PR

Table 4-1				
Scenario #3: Billed Service Not Covered by Health Plan Refers to situations where the billed service is not covered by the health plan.				
CARC	**CARC Description[6]**	**RARC**	**RARC Description[7]**	**ASC X12 CAGC**
		N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	CO, PI or PR
		N189	**Alert:** This service has been paid as a one-time exception to the plan's benefit restrictions.	CO, PI or PR
		N357	Time frame requirements between this service/procedure/supply and a related service/procedure/supply have not been met.	CO, PI or PR
		N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO, PI or PR
		N381	Consult our contractual agreement for restrictions/billing/payment information related to these charges.	CO, PI or PR
		N386	This decision was based on a National Coverage Determination (NCD). An NCD provides a coverage determination as to whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd/search.asp. If you do not have web access, you may contact the contractor to request a copy of the NCD.	CO, PI or PR
		N418	Misrouted claim. See the payer's claim submission instructions.	CO, PI or PR
		N435	Exceeds number/frequency approved /allowed within time period without support documentation.	CO, PI or PR
128	Newborn's services are covered in the mother's Allowance.			CO, PI or PR
138	Appeal procedures not followed or time limits not met.			CO, PI or PR
149	Lifetime benefit maximum has been reached for this service/benefit category.			CO, PI or PR
150	Payer deems the information submitted does not support this level of service.			CO, PI or PR
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.			CO, PI or PR
153	Payer deems the information submitted does not support this dosage.			CO, PI or PR
154	Payer deems the information submitted does not support this day's supply.			CO, PI or PR
155	Patient refused the service/procedure.			CO, PI or PR
157	Service/procedure was provided as a result of an act of war.			CO, PI or PR

Table 4-1				
Scenario #3: Billed Service Not Covered by Health Plan Refers to situations where the billed service is not covered by the health plan.				
CARC	**CARC Description[6]**	**RARC**	**RARC Description[7]**	**ASC X12 CAGC**
158	Service/procedure was provided outside of the United States.	N176	Services provided aboard a ship are covered only when the ship is of United States registry and is in United States waters. In addition, a doctor licensed to practice in the United States must provide the service.	PR
159	Service/procedure was provided as a result of terrorism.			CO, PI or PR
160	Injury/illness was the result of an activity that is a benefit exclusion.	N59	Please refer to your provider manual for additional program and provider information.	CO, PI or PR
		N167	Charges exceed the post-transplant coverage limit.	CO, PI or PR
		N356	Not covered when performed with, or subsequent to, a non-covered service.	CO, PI or PR
166	These services were submitted after this payers responsibility for processing claims under this plan ended.			CO, PI or PR
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.	N30	Patient ineligible for this service.	CO, PI or PR
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.	M143	The provider must update license information with the payer.	CO, PI or PR
		N90	Covered only when performed by the attending physician.	CO, PI or PR
		N95	This provider type/provider specialty may not bill this service.	CO, PI or PR
		N348	You chose that this service/supply/drug would be rendered/supplied and billed by a different practitioner/supplier.	CO, PI or PR
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.	M97	Not paid to practitioner when provided to patient in this place of service. Payment included in the reimbursement issued the facility.	CO, PI or PR
		N92	This facility is not certified for digital mammography.	CO, PI or PR
		N110	This facility is not certified for film mammography.	CO, PI or PR
		N428	Not covered when performed in this place of service.	CO, PI or PR
173	Service was not prescribed by a physician.			CO, PI or PR
174	Service was not prescribed prior to delivery.			CO, PI or PR
176	Prescription is not current.			CO, PI or PR
177	Patient has not met the required eligibility requirements.			CO, PI or PR
178	Patient has not met the required spend down requirements.			CO, PI or PR

Table 4-1				
Scenario #3: Billed Service Not Covered by Health Plan Refers to situations where the billed service is not covered by the health plan.				
CARC	**CARC Description[6]**	**RARC**	**RARC Description[7]**	**ASC X12 CAGC**
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.			CO, PI or PR
180	Patient has not met the required residency requirements.			CO, PI or PR
188	This product/procedure is only covered when used according to FDA recommendations.			CO, PI or PR
194	Anesthesia performed by the operating physician, the assistant surgeon or the attending physician.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO, PI or PR
198	Precertification/authorization exceeded.	M62	Missing/incomplete/invalid treatment authorization code.	CO, PI or PR
		N54	Claim information is inconsistent with pre-certified/authorized services.	CO, PI or PR
		N351	Service date outside of the approved treatment plan service dates.	CO, PI or PR
200	Expenses incurred during lapse in coverage.			CO, PI or PR
202	Non-covered personal comfort or convenience services.			CO, PI or PR
204	This service/equipment/drug is not covered under the patient's current benefit plan.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	CO, PI or PR
		N448	This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement.	CO, PI or PR
212	Administrative surcharges are not covered.			CO, PI or PR
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.			CO, PI or PR
228	Denied for failure of this provider, another provider or the subscriber to supply requested information to a previous payer for their adjudication.			CO, PI or 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.			CO, PI or PR

Table 4-1				
Scenario #3: Billed Service Not Covered by Health Plan Refers to situations where the billed service is not covered by the health plan.				
CARC	**CARC Description[6]**	**RARC**	**RARC Description[7]**	**ASC X12 CAGC**
233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.			CO, PI or PR
A6	Prior hospitalization or 30 day transfer requirement not met.			CO, PI or PR
B1	Non-covered visits.	N30	Patient ineligible for this service.	CO, PI or PR
B5	Coverage/program guidelines were not met or were exceeded.			CO, PI or PR
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.			CO, PI or PR
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.			CO, PI or PR
B9	Patient is enrolled in a Hospice.			CO, PI or PR
B11	The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.	N216	We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package.	CO, PI or PR
		N381	Consult our contractual agreement for restrictions/billing/payment information related to these charges.	CO, PI or PR
		N418	Misrouted claim. See the payer's claim submission instructions.	CO, PI or PR
B12	Services not documented in patients' medical records.	N199	Additional payment/recoupment approved based on payer-initiated review/audit.	CO, PI
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.			CO, PI or PR
B14	Only one visit or consultation per physician per day is covered.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO, PI or PR
		N2	This allowance has been made in accordance with the most appropriate course of treatment provision of the plan.	CO, PI or PR
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.	M51	Missing/incomplete/invalid procedure code(s).	CO, PI or PR
		M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO, PI or PR
		N20	Service not payable with other service rendered on the same date.	CO, PI or PR
B16	'New Patient' qualifications were not met.			CO, PI or PR

Table 4-1				
Scenario #3: Billed Service Not Covered by Health Plan Refers to situations where the billed service is not covered by the health plan.				
CARC	**CARC Description[6]**	**RARC**	**RARC Description[7]**	**ASC X12 CAGC**
B19	Claim/service adjusted because of the finding of a Review Organization.			CO, PI or PR
B20	Procedure/service was partially or fully furnished by another provider.			CO, PI or PR
B23	Procedure billed is not authorized per your Clinical Laboratory Improvement Amendment (CLIA) proficiency test.			CO, PI or PR

5 Code Combinations for Business Scenario #4: Benefit for Billed Service Not Separately Payable

Table 5-1				
Scenario #4: Benefit for Billed Service Not Separately Payable Refers to situations where the billed service or benefit is not separately payable by the health plan.				
CARC	**CARC Description[9]**	**RARC**	**RARC Description[10]**	**ASC X12 CAGC**
24	Charges are covered under a capitation agreement/managed care plan.			CO, PI or PR
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.	M2	Not paid separately when the patient is an inpatient.	CO, PI or PR
		M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	CO, PI or PR
		M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO, PI or PR
		M86	Service denied because payment already made for same/similar procedure within set time frame.	CO, PI or PR
		M97	Not paid to practitioner when provided to patient in this place of service. Payment included in the reimbursement issued the facility.	CO, PI or PR
		M144	Pre-/post-operative care payment is included in the allowance for the surgery/procedure.	CO, PI or PR
		N19	Procedure code incidental to primary procedure.	CO, PI or PR
		N20	Service not payable with other service rendered on the same date.	CO, PI or PR
		N22	This procedure code was added/changed because it more accurately describes the services rendered.	CO, PI or PR
		N45	Payment based on authorized amount.	CO, PI or PR
		N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	CO, PI or PR
		N63	Rebill services on separate claim lines.	CO, PI or PR
		N70	Consolidated billing and payment applies.	CO, PI or PR
		N111	No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.	CO, PI or PR
		N115	This decision was based on a Local Coverage Determination (LCD). An LCD provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at www.cms.gov/mcd, or if you do not have web access, you may contact the contractor to request a copy of the LCD.	CO, PI or PR
		N122	Add-on code cannot be billed by itself.	CO, PI or PR
		N123	This is a split service and represents a portion of the units from the originally submitted service.	CO, PI or PR
		N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	CO, PI or PR

[9] Washington Publishing Company
[10] Washington Publishing Company

Table 5-1				
Scenario #4: Benefit for Billed Service Not Separately Payable Refers to situations where the billed service or benefit is not separately payable by the health plan.				
CARC	**CARC Description[9]**	**RARC**	**RARC Description[10]**	**ASC X12 CAGC**
		N185	**Alert:** Do not resubmit this claim/service.	CO, PI or PR
		N202	Additional information/explanation will be sent separately.	CO, PI or PR
		N365	This procedure code is not payable. It is for reporting/information purposes only.	CO, PI or PR
		N370	Billing exceeds the rental months covered/approved by the payer.	CO, PI or PR
		N390	This service/report cannot be billed separately.	CO, PI or PR
		N432	Adjustment based on a Recovery Audit.	CO, PI or PR
		N525	These services are not covered when performed within the global period of another service.	CO, PI or PR
190	Payment is included in the allowance for a Skilled Nursing Facility (SNF) qualified stay.			CO, PI or PR
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.)	M15	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	CO, PI or PR
		M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO, PI or PR
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.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO, PI or PR
		M144	Pre-/post-operative care payment is included in the allowance for the surgery/procedure.	CO, PI or PR
		N22	This procedure code was added/changed because it more accurately describes the services rendered.	CO, PI or PR

6 Code Combinations for Business Scenarios #1, #2, #3: Retail Pharmacy

Retail Pharmacy uses approximately ten CARCs only when reporting a claim payment adjustment on a v5010 X12 835 except for CARC 16. CARC 16 is used if a reject is reported when the claim is not being processed in real time and trading partners agree that it is required or when the claim is not processed in real time.

Moving forward, these CARCs will be evaluated against the CORE Rules Work Group code combination evaluation criteria for inclusion in the CORE-defined Business Scenarios specific for Retail Pharmacy use, e.g., a new scenario could be Payment Made with Adjustments, and that would apply to pharmacy and medical.

Table 6-1

Scenario #1: Additional Information Required – Missing/Invalid/Incomplete Documentation
Refers to situations where additional documentation is needed from the billing provider or an ERA from a prior payer.

Scenario #2: Missing/Invalid/Incomplete Data from Submitted Claim
Refers to situations where additional data is needed from the billing provider for missing or invalid data on the submitted claim, e.g., an 837 or D.0.

Scenario #3: Billed Service Not Covered by Health Plan
Refers to situations where the billed service is not covered by the health plan.

CARC	CARC Description[11]	RARC	RARC Description[12]	ASC X12 CAGC
16	Claim/service lacks information which is needed for adjudication. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code [sic], or Remittance Advice Remark Code that is not an ALERT).	Not Applicable	For retail pharmacy the NCPDP External Code List must be used.[13]	CO or PI

[11] Washington Publishing Company
[12] Washington Publishing Company
[13] http://www.ncpdp.org/members/members_download.aspx. NCPDP Reject Codes are in Appendix A