CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1252	**Date: July 09, 2013**
	Change Request 7910

Transmittal 1236, dated May 22, 2013, is being rescinded and replaced by Transmittal 1252, dated July 09, 2013. The original BR7910.2 is being re-inserted as a business requirement, and the related attachment (the original Attachment III) is added back. Therefore, there will be four attachments (I, II, III and IV) being re-issued with this transmittal. All other information remains the same.

SUBJECT: Standardizing the Standard - Phase I

I. SUMMARY OF CHANGES: This Change Request (CR) is instructing the Shared Systems (SSs) to hard code all deactivated Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) to make sure that no deactivated code is reported on the remittance advice - electronic and paper, and COB Claims. Additionally the CR instructs the SSs to check that every RARC reported on the remittance advice has an associated CARC with the exception of Informational RARCs that start with the word "Alert" and every CARC is associated with at least one RARC that is not informational when it is required.

EFFECTIVE DATE: January 1, 2013
IMPLEMENTATION DATE: January 7, 2013 (Analysis and Design for FISS, MCS, and VMS); April 1, 2013 (Full Implementation for FISS and MCS, Analysis and Design for VMS); July 1, 2013 (Analysis and Design for VMS); October 7, 2013 (Analysis and Design for VMS); January 6, 2014 (Full Implementation for VMS).

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: 1252	July 09, 2013	Change Request: 7910

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SUBJECT: Standardizing the Standard - Phase I

EFFECTIVE DATE: January 1, 2013
IMPLEMENTATION DATE: January 7, 2013 (Analysis and Design for FISS, MCS, and VMS); April 1, 2013 (Full Implementation for FISS and MCS, Analysis and Design for VMS); July 1, 2013 (Analysis and Design for VMS); October 7, 2013 (Analysis and Design for VMS); January 6, 2014 (Full Implementation for VMS).

I. GENERAL INFORMATION

A. Background: The Health Insurance Portability and Accountability Act (HIPAA) adopted ANSI ASC X12 Transaction 835 – Health Care Claim Payment/Advice – as the standard for remittance advice. Medicare implemented ANSI ASC X12 835 version 4010A1 in 2003 and now in version 5010A1. Per the 4010A1 Implementation Guide and the 5010A1 Technical Report 3, any adjustment in payment must be reported using 3 sets of valid codes – Group Code, Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC). Codes that are deactivated are not valid codes. It has come to our attention that Medicare is still using codes that have been deactivated in the past. This is not HIPAA compliant and creates problems for Medicare Coordination of Benefit (COB) partners as well as providers. This Change Request (CR) instructs the Shared Systems (SSs) to hardcode all deactivated CARCs and RARCs so that no deactivated code is reported on the 835 and the paper remittance advice – SPR as well as 837 COB.

Secondly, it has been identified that Medicare is using RARCs without any associated CARC even when the RARC is not an “Informational” RARC starting with the word “Alert”. Informational RARCs are special type of RARCs that provide general information about the payer adjudication policy and do not provide any specific explanation for an adjustment. These “Informational” RARCs are allowed to be used without any CARC to make the provider aware of payer adjudication policy in general e.g. Medicare Appeal policy. The CR is instructing the SSs to implement an edit that will check that every RARC has an associated CARC with it except when the RARC is an “Informational’ RARC. Note that an “Informational” RARC may be used with a CARC – as a primary RARC when the CARC does not require a RARC or as a secondary RARC when the CARC requires a RARC.

This CR applies to 835 and 837 COB version 5010 only.

B. Policy: Medicare shall report only valid (active) CARCs and RARCs on the remittance advice – electronic and paper and 837 COB. Medicare also shall report a RARC without a CARC only when the RARC is an “Informational” RARC starting with the word “Alert”. An “Informational” RARC is allowed to be reported on the remittance advice with a CARC as the primary RARC when the CARC does not require a RARC per the CARC list as posted on the WPC website or as a secondary RARC when the CARC requires a RARC per the CARC list as posted on the WPC web site.

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	
7910.1	FISS/MCS/VMS shall hard code all Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) that have been deactivated or will be deactivated in the future to make sure that those codes are not reported on the remittance advice – electronic and paper – and COB Claims. For all currently deactivated codes – see Attachment I (CARCs) and Attachment II (RARCs) For all future deactivated codes – see future CARC/RARC update recurring CRs							X	X	X		
7910.2	FISS/MCS/VMS shall implement an edit to check that every RARC has an associated CARC with the following exception: 'Informational" RARCs that start with the word "Alert" can be reported on the remittance advice without any CARC. For all current 'Informational" RARCs – see Attachment III For all future "Informational" RARCs – see future CARC/RARC update recurring CRs							X	X	X		
7910.3	FISS/MCS/VMS shall implement an edit to check that every CARC that requires a RARC has at least one associated RARC that is not "Informational". For all CARCs that require at least one RARC that is not :Informational - see Attachment IV For all future "Informational" RARCs – see future CARC/RARC update recurring CRs							X	X	X		
7910.4	All contractors shall make changes so that no deactivated CARC or RARC is selected and sent to	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	
	the relevant SS to report on the remittance advice.											
7910.5	All contractors shall make appropriate changes so that no RARC (except an "Informational" RARC) is selected and sent to the relevant SS to be reported on the remittance advice without a CARC.	X	X	X	X	X	X					
7910.6	All contractors shall make appropriate changes so that at least one RARC that is not an Informational RARC (see Attachment III for a list of Informational RARCs as of 7/1/2012) is selected with every CARC that requires a RARC. See Attachment IV for a list of CARCs that require a RARC that is not an Informational RARC.	X	X	X	X	X	X					

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility						
		A/B MAC		DME MAC	FI	CARRIER	RHHI	Other
		Part A	Part B					
	None							

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.

Attachments (4)

Attachment # I

CR 7910

Claim Adjustment Reason Codes - Deactivated and To Be Deactivated (As of 7/1/2012)

Claim adjustment reason codes communicate an adjustment, meaning that they must communicate why a claim or service line was paid differently than it was billed. If there is no adjustment to a claim/line, then there is no adjustment reason code.

CARC #	CARC TEXT
17	**Requested information was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the Remittance Advice Remark Code or NCPDP Reject Reason Code.)** *Start: 01/01/1995 | Last Modified: 09/21/2008 | Stop: 07/01/2009*
25	**Payment denied. Your Stop loss deductible has not been met.** *Start: 01/01/1995 | Stop: 04/01/2008*
28	**Coverage not in effect at the time the service was provided.** *Start: 01/01/1995 | Stop: 10/16/2003* *Notes: Redundant to codes 26&27.*
30	**Payment adjusted because the patient has not met the required eligibility, spend down, waiting, or residency requirements.** *Start: 01/01/1995 | Stop: 02/01/2006*
36	**Balance does not exceed co-payment amount.** *Start: 01/01/1995 | Stop: 10/16/2003*
37	**Balance does not exceed deductible.** *Start: 01/01/1995 | Stop: 10/16/2003*
41	**Discount agreed to in Preferred Provider contract.** *Start: 01/01/1995 | Stop: 10/16/2003*
42	**Charges exceed our fee schedule or maximum allowable amount. (Use CARC 45)** *Start: 01/01/1995 | Last Modified: 10/31/2006 | Stop: 06/01/2007*
43	**Gramm-Rudman reduction.**

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CARC #	CARC TEXT
	Start: 01/01/1995 | Stop: 07/01/2006
46	**This (these) service(s) is (are) not covered.**
	Start: 01/01/1995 | Stop: 10/16/2003
	Notes: Use code 96.
47	**This (these) diagnosis(es) is (are) not covered, missing, or are invalid.**
	Start: 01/01/1995 | Stop: 02/01/2006
48	**This (these) procedure(s) is (are) not covered.**
	Start: 01/01/1995 | Stop: 10/16/2003
	Notes: Use code 96.
52	**The referring/prescribing/rendering provider is not eligible to refer/prescribe/order/perform the service billed.**
	Start: 01/01/1995 | Stop: 02/01/2006
57	**Payment denied/reduced because the payer deems the information submitted does not support this level of service, this many services, this length of service, this dosage, or this day's supply.**
	Start: 01/01/1995 | Stop: 06/30/2007
	Notes: Split into codes 150, 151, 152, 153 and 154.
62	**Payment denied/reduced for absence of, or exceeded, pre-certification/authorization.**
	Start: 01/01/1995 | Last Modified: 10/31/2006 | Stop: 04/01/2007
63	**Correction to a prior claim.**
	Start: 01/01/1995 | Stop: 10/16/2003
64	**Denial reversed per Medical Review.**

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CARC #	CARC TEXT
	Start: 01/01/1995 | Stop: 10/16/2003
65	**Procedure code was incorrect. This payment reflects the correct code.**
	Start: 01/01/1995 | Stop: 10/16/2003
67	**Lifetime reserve days. (Handled in QTY, QTY01=LA)**
	Start: 01/01/1995 | Stop: 10/16/2003
68	**DRG weight. (Handled in CLP12)**
	Start: 01/01/1995 | Stop: 10/16/2003
71	**Primary Payer amount.**
	Start: 01/01/1995 | Stop: 06/30/2000
	Notes: Use code 23.
72	**Coinsurance day. (Handled in QTY, QTY01=CD)**
	Start: 01/01/1995 | Stop: 10/16/2003
73	**Administrative days.**
	Start: 01/01/1995 | Stop: 10/16/2003
77	**Covered days. (Handled in QTY, QTY01=CA)**
	Start: 01/01/1995 | Stop: 10/16/2003
79	**Cost Report days. (Handled in MIA15)**
	Start: 01/01/1995 | Stop: 10/16/2003
80	**Outlier days. (Handled in QTY, QTY01=OU)**

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CARC #	CARC TEXT
	Start: 01/01/1995 | Stop: 10/16/2003
81	**Discharges.**
	Start: 01/01/1995 | Stop: 10/16/2003
82	**PIP days.**
	Start: 01/01/1995 | Stop: 10/16/2003
83	**Total visits.**
	Start: 01/01/1995 | Stop: 10/16/2003
84	**Capital Adjustment. (Handled in MIA)**
	Start: 01/01/1995 | Stop: 10/16/2003
86	**Statutory Adjustment.**
	Start: 01/01/1995 | Stop: 10/16/2003
	Notes: Duplicative of code 45.
87	**Transfer amount.**
	Start: 01/01/1995 | Last Modified: 09/20/2009 | Stop: 01/01/2012
88	**Adjustment amount represents collection against receivable created in prior overpayment.**
	Start: 01/01/1995 | Stop: 06/30/2007
92	**Claim Paid in full.**
	Start: 01/01/1995 | Stop: 10/16/2003
93	**No Claim level Adjustments.**

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CARC #	CARC TEXT
	Start: 01/01/1995 | Stop: 10/16/2003
	Notes: As of 004010, CAS at the claim level is optional.
98	**The hospital must file the Medicare claim for this inpatient non-physician service.**
	Start: 01/01/1995 | Stop: 10/16/2003
99	**Medicare Secondary Payer Adjustment Amount.**
	Start: 01/01/1995 | Stop: 10/16/2003
113	**Payment denied because service/procedure was provided outside the United States or as a result of war.**
	Start: 01/01/1995 | Last Modified: 02/28/2001 | Stop: 06/30/2007
	Notes: Use Codes 157, 158 or 159.
120	**Patient is covered by a managed care plan.**
	Start: 01/01/1995 | Stop: 06/30/2007
	Notes: Use code 24.
123	**Payer refund due to overpayment.**
	Start: 01/01/1995 | Stop: 06/30/2007
	Notes: Refer to implementation guide for proper handling of reversals.
124	**Payer refund amount - not our patient.**
	Start: 01/01/1995 | Last Modified: 06/30/1999 | Stop: 06/30/2007
	Notes: Refer to implementation guide for proper handling of reversals.
126	**Deductible -- Major Medical**

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Claim adjustment reason codes communicate an adjustment, meaning that they must communicate why a claim or service line was paid differently than it was billed. If there is no adjustment to a claim/line, then there is no adjustment reason code.

CARC #	CARC TEXT
	Start: 02/28/1997 | Last Modified: 09/30/2007 | Stop: 04/01/2008
	Notes: Use Group Code PR and code 1.
127	**Coinsurance -- Major Medical**
	Start: 02/28/1997 | Last Modified: 09/30/2007 | Stop: 04/01/2008
	Notes: Use Group Code PR and code 2.
141	**Claim spans eligible and ineligible periods of coverage.**
	Start: 06/30/1999 | Last Modified: 09/30/2007 | Stop: 07/01/2012
145	**Premium payment withholding**
	Start: 06/30/2002 | Last Modified: 09/30/2007 | Stop: 04/01/2008
	Notes: Use Group Code CO and code 45.
156	**Flexible spending account payments. Note: Use code 187.**
	Start: 09/30/2003 | Last Modified: 01/25/2009 | Stop: 10/01/2009
196	**Claim/service denied based on prior payer's coverage determination.**
	Start: 06/30/2006 | Stop: 02/01/2007
	Notes: Use code 136.
A2	**Contractual adjustment.**
	Start: 01/01/1995 | Last Modified: 02/28/2007 | Stop: 01/01/2008
	Notes: Use Code 45 with Group Code 'CO' or use another appropriate specific adjustment code.
A3	**Medicare Secondary Payer liability met.**

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CARC #	CARC TEXT
	Start: 01/01/1995 | Stop: 10/16/2003
A4	**Medicare Claim PPS Capital Day Outlier Amount.**
	Start: 01/01/1995 | Last Modified: 09/30/2007 | Stop: 04/01/2008
B2	**Covered visits.**
	Start: 01/01/1995 | Stop: 10/16/2003
B3	**Covered charges.**
	Start: 01/01/1995 | Stop: 10/16/2003
B6	**This payment is adjusted when performed/billed by this type of provider, by this type of provider in this type of facility, or by a provider of this specialty.**
	Start: 01/01/1995 | Stop: 02/01/2006
B17	**Payment adjusted because this service was not prescribed by a physician, not prescribed prior to delivery, the prescription is incomplete, or the prescription is not current.**
	Start: 01/01/1995 | Stop: 02/01/2006
B18	**This procedure code and modifier were invalid on the date of service.**
	Start: 01/01/1995 | Last Modified: 09/21/2008 | Stop: 03/01/2009
B19	**Claim/service adjusted because of the finding of a Review Organization.**
	Start: 01/01/1995 | Stop: 10/16/2003
B21	**The charges were reduced because the service/care was partially furnished by another physician.**
	Start: 01/01/1995 | Stop: 10/16/2003
D1	**Claim/service denied. Level of subluxation is missing or inadequate.**
	Start: 01/01/1995 | Stop: 10/16/2003

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CARC #	CARC TEXT
	Notes: Use code 16 and remark codes if necessary.
D2	**Claim lacks the name, strength, or dosage of the drug furnished.**
	Start: 01/01/1995 | Stop: 10/16/2003
	Notes: Use code 16 and remark codes if necessary.
D3	**Claim/service denied because information to indicate if the patient owns the equipment that requires the part or supply was missing.**
	Start: 01/01/1995 | Stop: 10/16/2003
	Notes: Use code 16 and remark codes if necessary.
D4	**Claim/service does not indicate the period of time for which this will be needed.**
	Start: 01/01/1995 | Stop: 10/16/2003
	Notes: Use code 16 and remark codes if necessary.
D5	**Claim/service denied. Claim lacks individual lab codes included in the test.**
	Start: 01/01/1995 | Stop: 10/16/2003
	Notes: Use code 16 and remark codes if necessary.
D6	**Claim/service denied. Claim did not include patient's medical record for the service.**
	Start: 01/01/1995 | Stop: 10/16/2003
	Notes: Use code 16 and remark codes if necessary.
D7	**Claim/service denied. Claim lacks date of patient's most recent physician visit.**
	Start: 01/01/1995 | Stop: 10/16/2003

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CARC #	CARC TEXT
	Notes: Use code 16 and remark codes if necessary.
D8	**Claim/service denied. Claim lacks indicator that 'x-ray is available for review.'**
	Start: 01/01/1995 | Stop: 10/16/2003
	Notes: Use code 16 and remark codes if necessary.
D9	**Claim/service denied. Claim lacks invoice or statement certifying the actual cost of the lens, less discounts or the type of intraocular lens used.**
	Start: 01/01/1995 | Stop: 10/16/2003
	Notes: Use code 16 and remark codes if necessary.
D10	**Claim/service denied. Completed physician financial relationship form not on file.**
	Start: 01/01/1995 | Stop: 10/16/2003
	Notes: Use code 17.
D11	**Claim lacks completed pacemaker registration form.**
	Start: 01/01/1995 | Stop: 10/16/2003
	Notes: Use code 17.
D12	**Claim/service denied. Claim does not identify who performed the purchased diagnostic test or the amount you were charged for the test.**
	Start: 01/01/1995 | Stop: 10/16/2003
	Notes: Use code 17.
D13	**Claim/service denied. Performed by a facility/supplier in which the ordering/referring physician has a financial interest.**
	Start: 01/01/1995 | Stop: 10/16/2003
	Notes: Use code 17.

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CARC #	CARC TEXT
D14	**Claim lacks indication that plan of treatment is on file.**
	Start: 01/01/1995 | Stop: 10/16/2003
	Notes: Use code 17.
D15	**Claim lacks indication that service was supervised or evaluated by a physician.**
	Start: 01/01/1995 | Stop: 10/16/2003
	Notes: Use code 17.
D16	**Claim lacks prior payer payment information.**
	Start: 01/01/1995 | Stop: 06/30/2007
	Notes: Use code 16 with appropriate claim payment remark code [N4].
D17	**Claim/Service has invalid non-covered days.**
	Start: 01/01/1995 | Stop: 06/30/2007
	Notes: Use code 16 with appropriate claim payment remark code.
D18	**Claim/Service has missing diagnosis information.**
	Start: 01/01/1995 | Stop: 06/30/2007
	Notes: Use code 16 with appropriate claim payment remark code.
D19	**Claim/Service lacks Physician/Operative or other supporting documentation**
	Start: 01/01/1995 | Stop: 06/30/2007
	Notes: Use code 16 with appropriate claim payment remark code.
D20	**Claim/Service missing service/product information.**

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CARC #	CARC TEXT
	Start: 01/01/1995 | Stop: 06/30/2007
	Notes: Use code 16 with appropriate claim payment remark code.
D21	**This (these) diagnosis(es) is (are) missing or are invalid**
	Start: 01/01/1995 | Stop: 06/30/2007
D22	**To be used for Workers' Compensation only) - Temporary code to be added for timeframe only until 01/01/2009. Another code to be established and/or for 06/2008 meeting for a revised code to**
	Start: 01/27/2008 | Stop: 01/01/2009
D23	**This dual eligible patient is covered by Medicare Part D per Medicare Retro-Eligibility. 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.)** *Start: 11/01/2009 | Stop: 01/01/2012*
	To Be Deactivated
38	**Services not provided or authorized by designated (network/primary care) providers.** *Start: 01/01/1995 | Last Modified: 06/30/2003 | Stop: 01/01/2013*

Attachment # II CR 7910	Remittance Advice Remarc Codes - Deactivated (As of 7-1-2012)				
Code	**Description**	**Effective Date**	**Deactivation Date**	**Last Modified Date**	**Notes**
M33	Missing/incomplete/invalid UPIN for the ordering/referring/performing provider.	01/01/1997	08/01/2004		Consider using M68
M34	Claim lacks the CLIA certification number.	01/01/1997	08/01/2004		Consider using MA120
M35	Missing/incomplete/invalid pre-operative photos or visual field results.	01/01/1997	02/05/2005		Consider using N178
M43	Payment for this service previously issued to you or another provider by another carrier/intermediary.	01/01/1997	01/31/2004		Consider using Reason Code 23
M48	Payment for services furnished to hospital inpatients (other than professional services of physicians) can only be made to the hospital. You must request payment from the hospital rather than the patient for this service.	01/01/1997	01/31/2004		Consider using M97
M57	Missing/incomplete/invalid provider identifier.	01/01/1997	06/02/2005		
M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.	01/01/1997	02/05/2005		
M63	We do not pay for more than one of these on the same day.	01/01/1997	01/31/2004		Consider using M86
M68	Missing/incomplete/invalid attending, ordering, rendering, supervising or referring physician identification.	01/01/1997	06/02/2005		
M72	Did not enter full 8-digit date (MM/DD/CCYY).	01/01/1997	10/16/2003		Consider using MA52
M78	Missing/incomplete/invalid HCPCS modifier.	01/01/1997	05/18/2006	02/28/2003	(Modified 2/28/03,) Consider using Reason Code 4
M88	We cannot pay for laboratory tests unless billed by the laboratory that did the work.	01/01/1997	08/01/2004		Consider using Reason Code B20
M92	Services subjected to review under the Home Health Medical Review Initiative.	01/01/1997	08/01/2004		
M98	Begin to report the Universal Product Number on claims for items of this type. We will soon begin to deny payment for items of this type if billed without the correct UPN.	01/01/1997	01/31/2004		Consider using M99
M101	Begin to report a G1-G5 modifier with this HCPCS. We will soon begin to deny payment for this service if billed without a G1-G5 modifier.	01/01/1997	01/31/2004		Consider using M78
M106	Information supplied does not support a break in therapy. A new capped rental period will not begin. This is the maximum approved under the fee schedule for this item or service.	01/01/1997	01/31/2004		Consider using MA 31
M108	Missing/incomplete/invalid provider identifier for the provider who interpreted the diagnostic test.	01/01/1997	06/02/2005		
M110	Missing/incomplete/invalid provider identifier for the provider from whom you purchased interpretation services.	01/01/1997	06/02/2005		
M118	Letter to follow containing further information.	01/01/1997	01/01/2011	11/01/2009	Consider using N202
M120	Missing/incomplete/invalid provider identifier for the substituting physician who furnished the service(s) under a reciprocal billing or locum tenens arrangement.	01/01/1997	06/02/2005		
M128	Missing/incomplete/invalid date of the patient's last physician visit.	01/01/1997	06/02/2005		
M140	Service not covered until after the patient's 50th birthday, i.e., no coverage prior to the day after the 50th birthday	01/01/1997	01/30/2004		Consider using M82
MA03	If you do not agree with the approved amounts and $100 or more is in dispute (less deductible and coinsurance), you may ask for a hearing within six months of the date of this notice. To meet the $100, you may combine amounts on other claims that have been denied, including reopened appeals if you received a revised decision. You must appeal each claim on time.	01/01/1997	10/01/2006	11/18/2005	Consider using MA02 (Modified 10/31/02, 6/30/03, 8/1/05, 11/18/05)
MA05	Incorrect admission date patient status or type of bill entry on claim.	01/01/1997	10/16/2003		Consider using MA30, MA40 or MA43
MA06	Missing/incomplete/invalid beginning and/or ending date(s).	01/01/1997	08/01/2004		Consider using MA31
MA11	Payment is being issued on a conditional basis. If no-fault insurance, liability insurance, Workers' Compensation, Department of Veterans Affairs, or a group health plan for employees and dependents also covers this claim, a refund may be due us. Please contact us if the patient is covered by any of these sources.	01/01/1997	01/31/2004		Consider using M32
MA29	Missing/incomplete/invalid provider name, city, state, or zip code.	01/01/1997	06/02/2005		
MA38	Missing/incomplete/invalid birth date.	01/01/1997	06/02/2005		
MA49	Missing/incomplete/invalid six-digit provider identifier for home health agency or hospice for physician(s) performing care plan oversight services.	01/01/1997	08/01/2004		Consider using MA76

Attachment # II CR 7910	Remittance Advice Remarc Codes - Deactivated (As of 7-1-2012)				
MA51	Missing/incomplete/invalid CLIA certification number for laboratory services billed by physician office laboratory.	01/01/1997	02/05/2005		Consider using MA120
MA52	Missing/incomplete/invalid date.	01/01/1997	06/02/2005		
MA78	The patient overpaid you. You must issue the patient a refund within 30 days for the difference between our allowed amount total and the amount paid by the patient.	01/01/1997	01/31/2004		Consider using MA59
MA82	Missing/incomplete/invalid provider/supplier billing number/identifier or billing name, address, city, state, zip code, or phone number.	01/01/1997	06/02/2005		
MA85	Our records indicate that a primary payer exists (other than ourselves); however, you did not complete or enter accurately the insurance plan/group/program name or identification number. Enter the PlanID when effective.	01/01/1997	08/01/2004		Consider using MA92
MA86	Missing/incomplete/invalid group or policy number of the insured for the primary coverage.	01/01/1997	08/01/2004		Consider using MA92
MA87	Missing/incomplete/invalid insured's name for the primary payer.	01/01/1997	08/01/2004		Consider using MA92
MA95	A not otherwise classified or unlisted procedure code(s) was billed but a narrative description of the procedure was not entered on the claim. Refer to item 19 on the HCFA-1500.	01/01/1997	01/01/2004	02/28/2003	(Deactivated 2/28/2003) (Erroneous description corrected 9/2/2008) Consider using M51
MA98	Claim Rejected. Does not contain the correct Medicare Managed Care Demonstration contract number for this beneficiary.	01/01/1997	10/16/2003		Consider using MA97
MA101	A Skilled Nursing Facility (SNF) is responsible for payment of outside providers who furnish these services/supplies to residents.	01/01/1997	01/01/2011	06/30/2003	Consider using N538
MA102	Missing/incomplete/invalid name or provider identifier for the rendering/referring/ ordering/ supervising provider.	01/01/1997	08/01/2004		Consider using M68
MA104	Missing/incomplete/invalid date the patient was last seen or the provider identifier of the attending physician.	01/01/1997	01/31/2004		Consider using M128 or M57
MA105	Missing/incomplete/invalid provider number for this place of service.	01/01/1997	06/02/2005		
MA119	Provider level adjustment for late claim filing applies to this claim.	01/01/1997	05/01/2008	11/05/2007	Consider using Reason Code B4
MA124	Processed for IME only.	01/01/1997	01/31/2004		Consider using Reason Code 74
MA127	Reserved for future use.	10/12/2001	06/02/2005		
MA129	This provider was not certified for this procedure on this date of service.	10/12/2001	01/31/2004	01/31/2004	Consider using MA120 and Reason Code B7
N14	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.	01/01/2000	10/01/2007		Consider using Reason Code 45
N17	Per admission deductible.	01/01/2000	08/01/2004		Consider using Reason Code 1
N18	Payment based on the Medicare allowed amount.	01/01/2000	01/31/2004		Consider using N14
N38	Missing/incomplete/invalid place of service.	01/01/2000	02/05/2005		Consider using M77
N41	Authorization request denied.	01/01/2000	10/16/2003		Consider using Reason Code 39
N44	Payer's share of regulatory surcharges, assessments, allowances or health care-related taxes paid directly to the regulatory authority.	01/01/2000	10/16/2003		Consider using Reason Code 137
N60	A valid NDC is required for payment of drug claims effective October 02.	01/01/2000	01/31/2004		Consider using M119
N66	Missing/incomplete/invalid documentation.	01/01/2000	02/05/2005		Consider using N29 or N225.
N73	A Skilled Nursing Facility is responsible for payment of outside providers who furnish these services/supplies under arrangement to its residents.	01/01/2000	01/31/2004		Consider using MA101 or N200
N101	Additional information is needed in order to process this claim. Please resubmit the claim with the identification number of the provider where this service took place. The Medicare number of the site of service provider should be preceded with the letters 'HSP' and entered into item #32 on the claim form. You may bill only one site of service provider number per claim.	10/31/2001	01/31/2004		Consider uisng MA105
N145	Missing/incomplete/invalid provider identifier for this place of service.	10/31/2002	06/02/2005		
N164	Transportation to/from this destination is not covered.	02/28/2003	01/31/2004		Consider using N157
N165	Transportation in a vehicle other than an ambulance is not covered.	02/28/2003	01/31/2004		Consider using N158)
N166	Payment denied/reduced because mileage is not covered when the patient is not in the ambulance.	02/28/2003	01/31/2004		Consider using N159

Attachment # II CR 7910	Remittance Advice Remarc Codes - Deactivated (As of 7-1-2012)				
N168	The patient must choose an option before a payment can be made for this procedure/ equipment/ supply/ service.	02/28/2003	01/31/2004		Consider using N160
N169	This drug/service/supply is covered only when the associated service is covered.	02/28/2003	01/31/2004		Consider using N161
N201	A mental health facility is responsible for payment of outside providers who furnish these services/supplies to residents.	02/25/2003	01/01/2011		Consider using N538
N361	Payment adjusted based on multiple diagnostic imaging procedure rules	11/18/2005	10/01/2007	12/01/2006	(Modified 12/1/06) Consider using Reason Code 59
N411	This service is allowed one time in a 6-month period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.)	08/01/2007	02/01/2009		
N412	This service is allowed 2 times in a 12-month period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.)	08/01/2007	02/01/2009		
N413	This service is allowed 2 times in a benefit year. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.)	08/01/2007	02/01/2009		
N414	This service is allowed 4 times in a 12-month period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.)	08/01/2007	02/01/2009		
N415	This service is allowed 1 time in an 18-month period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.)	08/01/2007	02/01/2009		
N416	This service is allowed 1 time in a 3-year period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.)	08/01/2007	02/01/2009		
N417	This service is allowed 1 time in a 5-year period. (This temporary code will be deactivated on 2/1/09. Must be used with Reason Code 119.)	08/01/2007	02/01/2009		
N514	Consult plan benefit documents/guidelines for information about restrictions for this service.	11/01/2008	01/01/2011		Consider using N130
N515	Alert: Submit this claim to the patient's other insurer for potential payment of supplemental benefits. We did not forward the claim information. (use N387 instead)	11/01/2008	10/01/2009		

Attachment # III

CR # 7910

RARC Alert Codes

(As of 7-1-2012)

Code	Description	Effective Date	Deactivation Date	Last Modified Date	Notes
M4	Alert: This is the last monthly installment payment for this durable medical equipment.	01/01/1997		04/01/2007	(Modified 4/1/07)
M6	Alert: You must furnish and service this item for any period of medical need for the remainder of the reasonable useful lifetime of the equipment.	01/01/1997		03/01/2009	(Modified 4/1/07, 3/1/2009)
M9	Alert: This is the tenth rental month. You must offer the patient the choice of changing the rental to a purchase agreement.	01/01/1997		04/01/2007	(Modified 4/1/07)
M16	Alert: Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision.	01/01/1997		04/01/2007	(Reactivated 4/1/04, Modified 11/18/05, 4/1/07)
M17	Alert: Payment approved as you did not know, and could not reasonably have been expected to know, that this would not normally have been covered for this patient. In the future, you will be liable for charges for the same service(s) under the same or similar conditions.	01/01/1997		04/01/2007	(Modified 4/1/07)
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.	01/01/1997		08/01/2007	(Modified 10/1/02, 8/1/05, 4/1/07, 8/1/07)
M32	Alert: This is a conditional payment made pending a decision on this service by the patient's primary payer. This payment may be subject to refund upon your receipt of any additional payment for this service from another payer. You must contact this office immediately upon receipt of an additional payment for this service.	01/01/1997		04/01/2007	(Modified 4/1/07)
M70	Alert: The NDC code submitted for this service was translated to a HCPCS code for processing, but please continue to submit the NDC on future claims for this item.	01/01/1997		08/01/2007	(Modified 4/1/2007, 8/1/07)
MA01	Alert: If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the appeal. However, in order to be eligible for an appeal, you must write to us within 120 days of the date you received this notice, unless you have a good reason for being late.	01/01/1997		04/01/2007	(Modified 10/31/02, 6/30/03, 8/1/05, 4/1/07)
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.	01/01/1997		04/01/2007	(Modified 10/31/02, 6/30/03, 8/1/05, 12/29/05, 8/1/06, 4/1/07)
MA07	Alert: The claim information has also been forwarded to Medicaid for review.	01/01/1997		04/01/2007	(Modified 4/1/07)
MA08	Alert: Claim information was not forwarded because the supplemental coverage is not with a Medigap plan, or you do not participate in Medicare.	01/01/1997		04/01/2007	(Modified 4/1/07)
MA10	Alert: The patient's payment was in excess of the amount owed. You must refund the overpayment to the patient.	01/01/1997		04/01/2007	(Modified 4/1/07)
MA13	Alert: You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.	01/01/1997		04/01/2007	(Modified 4/1/07)
MA14	Alert: The patient is a member of an employer-sponsored prepaid health plan. Services from outside that health plan are not covered. However, as you were not previously notified of this, we are paying this time. In the future, we will not pay you for non-plan services.	01/01/1997		08/01/2007	(Modified 4/1/07, 8/1/07)
MA15	Alert: Your claim has been separated to expedite handling. You will receive a separate notice for the other services reported.	01/01/1997		04/01/2007	(Modified 4/1/07)
MA18	Alert: The claim information is also being forwarded to the patient's supplemental insurer. Send any questions regarding supplemental benefits to them.	01/01/1997		04/01/2007	(Modified 4/1/07)

RARC Alert Codes
(As of 7-1-2012)

Code	Description	Effective Date	Deactivation Date	Last Modified Date	Notes
MA19	Alert: Information was not sent to the Medigap insurer due to incorrect/invalid information you submitted concerning that insurer. Please verify your information and submit your secondary claim directly to that insurer.	01/01/1997		04/01/2007	(Modified 4/1/07)
MA26	Alert: Our records indicate that you were previously informed of this rule.	01/01/1997		04/01/2007	(Modified 4/1/07)
MA28	Alert: Receipt of this notice by a physician or supplier who did not accept assignment is for information only and does not make the physician or supplier a party to the determination. No additional rights to appeal this decision, above those rights already provided for by regulation/instruction, are conferred by receipt of this notice.	01/01/1997		04/01/2007	(Modified 4/1/07)
MA44	Alert: No appeal rights. Adjudicative decision based on law.	01/01/1997		04/01/2007	(Modified 4/1/07)
MA45	Alert: As previously advised, a portion or all of your payment is being held in a special account.	01/01/1997		04/01/2007	(Modified 4/1/07)
MA59	Alert: The patient overpaid you for these services. You must issue the patient a refund within 30 days for the difference between his/her payment and the total amount shown as patient responsibility on this notice.	01/01/1997		04/01/2007	(Modified 4/1/07)
MA62	Alert: This is a telephone review decision.	01/01/1997		08/01/2007	(Modified 4/1/07, 8/1/07)
MA68	Alert: We did not crossover this claim because the secondary insurance information on the claim was incomplete. Please supply complete information or use the PLANID of the insurer to assure correct and timely routing of the claim.	01/01/1997		04/01/2007	(Modified 4/1/07)
MA72	Alert: The patient overpaid you for these assigned services. You must issue the patient a refund within 30 days for the difference between his/her payment to you and the total of the amount shown as patient responsibility and as paid to the patient on this notice.	01/01/1997		04/01/2007	(Modified 4/1/07)
MA77	Alert: The patient overpaid you. You must issue the patient a refund within 30 days for the difference between the patient's payment less the total of our and other payer payments and the amount shown as patient responsibility on this notice.	01/01/1997		04/01/2007	(Modified 4/1/07)
N1	Alert: You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.	01/01/2000		04/01/2007	(Modified 2/28/03, 4/1/07)
N21	Alert: Your line item has been separated into multiple lines to expedite handling.	01/01/2000		04/01/2007	(Modified 8/1/05, 4/1/07)
N23	Alert: Patient liability may be affected due to coordination of benefits with other carriers and/or maximum benefit provisions.	01/01/2000		04/01/2007	(Modified 8/13/01, 4/1/07)
N84	Alert: Further installment payments are forthcoming.	01/01/2000		04/01/2007	(Modified 4/1/07, 8/1/07)
N85	Alert: This is the final installment payment.	01/01/2000		04/01/2007	(Modified 4/1/07, 8/1/07)
N88	Alert: This payment is being made conditionally. An HHA episode of care notice has been filed for this patient. When a patient is treated under a HHA episode of care, consolidated billing requires that certain therapy services and supplies, such as this, be included in the HHA's payment. This payment will need to be recouped from you if we establish that the patient is concurrently receiving treatment under a HHA episode of care.	01/01/2000		04/01/2007	(Modified 4/1/07)
N89	Alert: Payment information for this claim has been forwarded to more than one other payer, but format limitations permit only one of the secondary payers to be identified in this remittance advice.	01/01/2000		04/01/2007	(Modified 4/1/07)
N132	Alert: Payments will cease for services rendered by this US Government debarred or excluded provider after the 30 day grace period as previously notified.	10/31/2002		04/01/2007	(Modified 4/1/07)

RARC Alert Codes
(As of 7-1-2012)

Code	Description	Effective Date	Deactivation Date	Last Modified Date	Notes
N133	Alert: Services for predetermination and services requesting payment are being processed separately.	10/31/2002		04/01/2007	(Modified 4/1/07)
N134	Alert: This represents your scheduled payment for this service. If treatment has been discontinued, please contact Customer Service.	10/31/2002		04/01/2007	(Modified 4/1/07)
N136	Alert: To obtain information on the process to file an appeal in Arizona, call the Department's Consumer Assistance Office at (602) 912-8444 or (800) 325-2548.	10/31/2002		04/01/2007	(Modified 4/1/07)
N137	Alert: The provider acting on the Member's behalf, may file an appeal with the Payer. The provider, acting on the Member's behalf, may file a complaint with the State Insurance Regulatory Authority without first filing an appeal, if the coverage decision involves an urgent condition for which care has not been rendered. The address may be obtained from the State Insurance Regulatory Authority.	10/31/2002		04/01/2007	(Modified 8/1/04, 2/28/03, 4/1/07)
N138	Alert: In the event you disagree with the Dental Advisor's opinion and have additional information relative to the case, you may submit radiographs to the Dental Advisor Unit at the subscriber's dental insurance carrier for a second Independent Dental Advisor Review.	10/31/2002		04/01/2007	(Modified 4/1/07)
N139	Alert: Under the Code of Federal Regulations, Chapter 32, Section 199.13 a non-participating provider is not an appropriate appealing party. Therefore, if you disagree with the Dental Advisor's opinion, you may appeal the determination if appointed in writing, by the beneficiary, to act as his/her representative. Should you be appointed as a representative, submit a copy of this letter, a signed statement explaining the matter in which you disagree, and any radiographs and relevant information to the subscriber's Dental insurance carrier within 90 days from the date of this letter.	10/31/2002		04/01/2007	(Modified 4/1/07)
N140	Alert: You have not been designated as an authorized OCONUS provider therefore are not considered an appropriate appealing party. If the beneficiary has appointed you, in writing, to act as his/her representative and you disagree with the Dental Advisor's opinion, you may appeal by submitting a copy of this letter, a signed statement explaining the matter in which you disagree, and any relevant information to the subscriber's Dental insurance carrier within 90 days from the date of this letter.	10/31/2002		04/01/2007	(Modified 4/1/07)
N154	Alert: This payment was delayed for correction of provider's mailing address.	10/31/2002		04/01/2007	(Modified 4/1/07)
N155	Alert: Our records do not indicate that other insurance is on file. Please submit other insurance information for our records.	10/31/2002		04/01/2007	(Modified 4/1/07)
N156	Alert: The patient is responsible for the difference between the approved treatment and the elective treatment.	10/31/2002		04/01/2007	(Modified 4/1/07)
N162	Alert: Although your claim was paid, you have billed for a test/specialty not included in your Laboratory Certification. Your failure to correct the laboratory certification information will result in a denial of payment in the near future.	02/28/2003		04/01/2007	(Modified 4/1/07)
N177	Alert: We did not send this claim to patient's other insurer. They have indicated no additional payment can be made.	02/28/2003		04/01/2007	(Modified 6/30/03, 4/1/07)
N183	Alert: This is a predetermination advisory message, when this service is submitted for payment additional documentation as specified in plan documents will be required to process benefits.	02/28/2003		04/01/2007	(Modified 4/1/07)
N185	Alert: Do not resubmit this claim/service.	02/28/2003		04/01/2007	(Modified 4/1/07)
N187	Alert: You may request a review in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.	02/28/2003		04/01/2007	(Modified 4/1/07)
N189	Alert: This service has been paid as a one-time exception to the plan's benefit restrictions.	02/28/2003		04/01/2007	(Modified 4/1/07)

RARC Alert Codes
(As of 7-1-2012)

Code	Description	Effective Date	Deactivation Date	Last Modified Date	Notes
N196	Alert: Patient eligible to apply for other coverage which may be primary.	02/25/2003		04/01/2007	(Modified 4/1/07)
N210	Alert: You may appeal this decision	06/30/2003		04/01/2007	(Modified 4/1/07)
N211	Alert: You may not appeal this decision	06/30/2003		04/01/2007	(Modified 4/1/07)
N215	Alert: A payer providing supplemental or secondary coverage shall not require a claims determination for this service from a primary payer as a condition of making its own claims determination.	04/01/2004		04/01/2007	(Modified 4/1/07)
N220	Alert: See the payer's web site or contact the payer's Customer Service department to obtain forms and instructions for filing a provider dispute.	08/01/2004		04/01/2007	(Modified 4/1/07)
N352	Alert: There are no scheduled payments for this service. Submit a claim for each patient visit.	08/01/2005		04/01/2007	(Modified 4/1/07)
N353	Alert: Benefits have been estimated, when the actual services have been rendered, additional payment will be considered based on the submitted claim.	08/01/2005		04/01/2007	(Modified 4/1/07)
N355	Alert: The law permits exceptions to the refund requirement in two cases: - If you did not know, and could not have reasonably been expected to know, that we would not pay for this service; or - If you notified the patient in writing before providing the service that you believed that we were likely to deny the service, and the patient signed a statement agreeing to pay for the service. If you come within either exception, or if you believe the carrier was wrong in its determination that we do not pay for this service, you should request appeal of this determination within 30 days of the date of this notice. Your request for review should include any additional information necessary to support your position. If you request an appeal within 30 days of receiving this notice, you may delay refunding the amount to the patient until you receive the results of the review. If the review decision is favorable to you, you do not need to make any refund. If, however, the review is unfavorable, the law specifies that you must make the refund within 15 days of receiving the unfavorable review decision. The law also permits you to request an appeal at any time within 120 days of the date you receive this notice. However, an appeal request that is received more than 30 days after the date of this notice, does not permit you to delay making the refund. Regardless of when a review is requested, the patient will be notified that you have requested one, and will receive a copy of the determination. The patient has received a separate notice of this denial decision. The notice advises that he/she may be entitled to a refund of any amounts paid, if you should have known that we would not pay and did not tell him/her. It also instructs the patient to contact our office if he/she does not hear anything about a refund within 30 days	08/01/2005		04/01/2007	(Modified 11/18/05, Modified 4/1/07)
N358	Alert: This decision may be reviewed if additional documentation as described in the contract or plan benefit documents is submitted.	11/18/2005		04/01/2007	(Modified 4/1/07)
N360	Alert: Coordination of benefits has not been calculated when estimating benefits for this pre-determination. Submit payment information from the primary payer with the secondary claim.	11/18/2005		04/01/2007	(Modified 4/1/07)
N363	Alert: in the near future we are implementing new policies/procedures that would affect this determination.	11/18/2005		04/01/2007	(Modified 4/1/07)
N364	Alert: According to our agreement, you must waive the deductible and/or coinsurance amounts.	11/18/2005		04/01/2007	(Modified 4/1/07)
N367	Alert: The claim information has been forwarded to a Consumer Spending Account processor for review; for example, flexible spending account or health savings account.	04/01/2006		07/01/2008	(Modified 4/1/07, 11/5/07, 7/1/08)
N369	Alert: Although this claim has been processed, it is deficient according to state legislation/regulation.	04/01/2006			
N371	Alert: title of this equipment must be transferred to the patient.	08/01/2006			

RARC Alert Codes
(As of 7-1-2012)

Code	Description	Effective Date	Deactivation Date	Last Modified Date	Notes
N387	Alert: Submit this claim to the patient's other insurer for potential payment of supplemental benefits. We did not forward the claim information.	04/01/2007		03/01/2009	(Modified 3/1/2009)
N400	Alert: Electronically enabled providers should submit claims electronically.	08/01/2007			
N437	Alert: If the injury claim is accepted, these charges will be reconsidered.	07/01/2008			
N444	Alert: This facility has not filed the Election for High Cost Outlier form with the Division of Workers' Compensation.	07/01/2008			
N469	Alert: Claim/Service(s) subject to appeal process, see section 935 of Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).	07/01/2008			
N492	Alert: A network provider may bill the member for this service if the member requested the service and agreed in writing, prior to receiving the service, to be financially responsible for the billed charge.	07/01/2008			
N505	Alert: This response includes only services that could be estimated in real time. No estimate will be provided for the services that could not be estimated in real time.	11/01/2008			
N506	Alert: This is an estimate of the member's liability based on the information available at the time the estimate was processed. Actual coverage and member liability amounts will be determined when the claim is processed. This is not a pre-authorization or a guarantee of payment.	11/01/2008			
N508	Alert: This real time claim adjudication response represents the member responsibility to the provider for services reported. The member will receive an Explanation of Benefits electronically or in the mail. Contact the insurer if there are any questions.	11/01/2008			
N509	Alert: A current inquiry shows the member's Consumer Spending Account contains sufficient funds to cover the member liability for this claim/service. Actual payment from the Consumer Spending Account will depend on the availability of funds and determination of eligible services at the time of payment processing.	11/01/2008			
N510	Alert: A current inquiry shows the member's Consumer Spending Account does not contain sufficient funds to cover the member's liability for this claim/service. Actual payment from the Consumer Spending Account will depend on the availability of funds and determination of eligible services at the time of payment processing.	11/01/2008			
N511	Alert: Information on the availability of Consumer Spending Account funds to cover the member liability on this claim/service is not available at this time.	11/01/2008			
N512	Alert: This is the initial remit of a non-NCPDP claim originally submitted real-time without change to the adjudication.	11/01/2008			
N513	Alert: This is the initial remit of a non-NCPDP claim originally submitted real-time with a change to the adjudication.	11/01/2008			
N520	Alert: Payment made from a Consumer Spending Account.	07/01/2009			
N539	Alert: We processed appeals/waiver requests on your behalf and that request has been denied.	07/01/2010			
N544	Alert: Although this was paid, you have billed with a referring/ordering provider that does not match our system record. Unless, corrected, this will not be paid in the future.	07/01/2011			
N548	Alert: Patient's calendar year deductible has been met.	03/06/2012			
N549	Alert: Patient's calendar year out-of-pocket maximum has been met.	03/06/2012			

Code	Description	Effective Date	Deactivation Date	Last Modified Date	Notes
N550	Alert: You have not responded to requests to revalidate your provider/supplier enrollment information. Your failure to revalidate your enrollment information will result in a payment hold in the near future.	03/06/2012			

Attachment IV

CR 7910

CARCS that need at least one RARC that is not an Informational RARC as of 7-1-2012

CODE #	CODE TEXT	Start/Stop Date
16	Claim/service lacks information which is needed for adjudication. At least one must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice that is not an ALERT.)	*Start: 01/01/1995 | Last Modified: 09/20/2009*
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	*Start: 01/01/1995 | Last Modified: 09/20/2009*
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.	*Start: 01/01/1995 | Last Modified: 09/20/2009*
125	Submission/billing error(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	*Start: 01/01/1995 | Last Modified: 09/20/2009*
129	Prior processing information appears incorrect. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	*Start: 02/28/1997 | Last Modified: 01/30/2011*
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.)	*Start: 06/30/2002 | Last Modified: 09/20/2009*
226	Information requested from the Billing/Rendering 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.)	*Start: 09/21/2008 | Last Modified: 09/20/2009*
227	Information requested from the patient/insured/responsible party was not provided or was insufficient/incomplete. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	*Start: 09/21/2008 | Last Modified: 09/20/2009*
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.)	*Start: 01/24/2010*
237	Legislated/Regulatory Penalty. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	*Start: 06/05/2011*
A1	Claim/Service denied. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	*Start: 01/01/1995 | Last Modified: 09/20/2009*

Comment