CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1360	Date: March 18, 2014
	Change Request 8518

Transmittal 1358, dated March 14, 2014, is being rescinded and replaced by Transmittal 1360, dated March 18, 2014 to include two attachments, both v3.0.3 and v 3.0.4 of the Council for Affordable Quality Health Care (CAQH) Committee on Operating Rules for Information Exchange (CORE) Mandated CARC/RARC Code Combination List. Version 3.0.4 published January 31, 2014 and must be implemented no later than May 1, 2014. Attached document 1 (v 3.0.3) shows the changes made between version 3.0.2 and 3.0.3 and attached document 3 (v 3.0.4) shows the changes made between v 3.0.3 to v 3.0.4. Additionally, the implementation date for v 3.0.4 for Part A and Part B MACs has been delayed to May 5, 2014. All other information remains the same.

SUBJECT: Implement Operating Rules - Phase III ERA EFT: CORE 360 Uniform Use of Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) Rule - Update from CAQH CORE - October 1, 2013 version 3.0.3

I. SUMMARY OF CHANGES:

This Change Request (CR) instructs the contractors and the Shared System Maintainers (SSMs) to update the CORE 360 Uniform Use of CARC and RARC Rule per Attachment. The Attachment shows the CORE Code Combination Updates based on Codes Updates published on July 1 and July 15, 2013.

EFFECTIVE DATE: January 1, 2014 - 90 days from publication date of 10-1-2013 IMPLEMENTATION DATE: April 7, 2014 - Earliest implementation date per Medicare release schedule; the implementation date for Part A and Part B MACs has been delayed to May 5, 2014.

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 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

Transmittal 1358, dated March 14, 2014, is being rescinded and replaced by Transmittal 1360, dated March 18, 2014 to include two attachments, both v3.0.3 and v 3.0.4 of the Council for Affordable Quality Health Care (CAQH) Committee on Operating Rules for Information Exchange (CORE) Mandated CARC/RARC Code Combination List. Version 3.0.4 published January 31, 2014 and must be implemented no later than May 1, 2014. Attached document 1 (v 3.0.3) shows the changes made between version 3.0.2 and 3.0.3 and attached document 3 (v 3.0.4) shows the changes made between v 3.0.3 to v 3.0.4. Additionally, the implementation date for v 3.0.4 for Part A and Part B MACs has been delayed to May 5, 2014. All other information remains the same.

SUBJECT: Implement Operating Rules - Phase III ERA EFT: CORE 360 Uniform Use of Claim Adjustment Reason Codes (CARC) and Remittance Advice Remark Codes (RARC) Rule - Update from CAQH CORE - October 1, 2013 version 3.0.3

EFFECTIVE DATE: January 1, 2014 - 90 days from publication date of 10-1-2013 IMPLEMENTATION DATE: April 7, 2014 - Earliest implementation date per Medicare release schedule; the implementation date for Part A and Part B MACs has been delayed to May 5, 2014.

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 disappointing. 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.

This CR deals with the regular update in CAQH CORE defined code combinations per Operating Rule 360 - Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) Rule.

CAQH CORE has published Code Combination version 3.0.3 on October 1, 2013. This update is based on July, 2013 Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code updates as posted at the WPC Web site.

For CARC and RARC updates go to http://www.wpc-edi.com/reference and for CAQH CORE defined code combination updates go to http://www.caqh.org/CORECodeCombinations.php .

NOTE: Per ACA mandate all health plans including Medicare must comply with CORE 360 Uniform Use of CARCs and RARCs (835) rule or CORE developed maximum set of CARC/RARC/Group Code for a minimum set of 4 Business Scenarios. Medicare can use any code combination if the business scenario is not

one of the 4 CORE defined business scenarios but for the 4 CORE defined business scenarios, Medicare must use the code combinations from the lists published by CAQH CORE. .

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

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility										
			A/E	3	D M E			M F	Sha Sys aint M	tem aine V	ers C	Other
				Н	A C			I S S	C S	M S	W F	
8518.1	Contractors and Shared System Maintainers shall report only the code combinations that are listed in the current version of <i>CORE Code Combinations</i> for use with CAQH CORE 360 Rule - <i>February</i> 2014 CORE Code Combinations v3.0.4. NOTE: The document is available at: http://www.caqh.org/CORECodeCombinations.ph	X	X	X	X					X		
8518.2	Contractors and Shared System Maintainers shall make the necessary changes per attached Change Log that lists all updates since version 3.0.2 that was implemented under CR 8365. NOTE: Attachment 2 - Change Log for v 3.0.3 and v 3.0.4	X	X	X	X					X		

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility							
		A/B MAC				D M			Other
		A	В	H H H	E M A				
8518.3	MLN Article: A provider education article related to this instruction will be available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article	X	X	X	X				

Number	Requirement	Responsibility								
		A/B MAC								Other
		A	В	H H H	M A C					
	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 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

[&]quot;Should" denotes a recommendation.

X-Ref	Recommendations or other supporting information:
Requirement	
Number	

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 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 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.

ATTACHMENT(S): 3

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 version 3.0.3 October 1, 2013

Change Log for CORE-required Code Combinations for CORE-defined Business Scenarios

Version	Description	Publication Date
3.0.0	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) based on published CARC & RARC lists as of June 2011, balloted and approved by CORE members	06/01/2012
3.0.1	Compliance-based adjustments as part of the CAQH CORE Code Combinations Maintenance Process based on published CARC & RARC lists as of November 2011	01/31/2013
3.0.2	Compliance-based adjustments as part of the CAQH CORE Code Combinations Maintenance Process based on published CARC & RARC lists as of March 2013	05/24/2013
3.0.3	Compliance-based adjustments as part of the CAQH CORE Code Combinations Maintenance Process based on published CARC & RARC lists as of July 2013	10/01/2013
	Detailed Description of Updates for the October 2013 v3.0.3 CORE	
CORE-defined Business Scenario	Adjustment	Detailed Description of Adjustment
Business Scenario #1 – Additional	· 5 CARC descriptions modified	· Description of CARC 163 was modified
Information Required – Missing/Invalid/Incomplete Documentation		· Description of CARC 164 was modified
management and meaning the accumentation		· Description of CARC 250 was modified
		· Description of CARC 251 was modified
		· Description of CARC 252 was modified
	· 18 RARCs added	· RARC N590 was associated with CARC 251
		· RARC N590 was associated with CARC 252
		· RARC N594 was associated with CARC 250
		· RARC N594 was associated with CARC 251
		· RARC N594 was associated with CARC 252
		· RARC N595 was associated with CARC 250
		· RARC N595 was associated with CARC 251
		· RARC N595 was associated with CARC 252
		· RARC N596 was associated with CARC 250
		· RARC N596 was associated with CARC 251
		· RARC N596 was associated with CARC 252
		· RARC N630 was associated with CARC 165
		· RARC N667 was associated with CARC 250
		· RARC N667 was associated with CARC 251
		· RARC N667 was associated with CARC 252
		· RARC N668 was associated with CARC 250
		· RARC N668 was associated with CARC 251
		· RARC N668 was associated with CARC 252
Business Scenario #2 – Additional	· 3 CARC descriptions modified	· Description of CARC 16 was modified
Information Required –		· Description of CARC 18 was modified
Missing/Invalid/Incomplete Data from Submitted Claim		· Description of CARC 236 was modified
	· 29 RARCs added	· RARC N574 was associated with CARC 183
		· RARC N574 was associated with CARC 184
		· RARC N575 was associated with CARC 16
		· RARC N592 was associated with CARC 175
		· RARC N595 was associated with CARC 16
		· RARC N596 was associated with CARC 15

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	I	· RARC N622 was associated with CARC 110
		· RARC N625 was associated with CARC 16
		· RARC N630 was associated with CARC 183
		RARC N644 was associated with CARC 4
		RARC N644 was associated with CARC 236
		· RARC N647 was associated with CARC A8
		· RARC N653 was associated with CARC 16
		RARC N657 was associated with CARC 10
		RARC N657 was associated with CARC 11
		RARC N657 was associated with CARC 12
		RARC N657 was associated with CARC 146
		• RARC N657 was associated with CARC 16
		· RARC N657 was associated with CARC 181
		· RARC N657 was associated with CARC 182
		· RARC N657 was associated with CARC 189
		· RARC N657 was associated with CARC 199
		· RARC N657 was associated with CARC 236
		· RARC N657 was associated with CARC 240
		· RARC N657 was associated with CARC 4
		· RARC N657 was associated with CARC 9
		· RARC N657 was associated with CARC A8
		· RARC N668 was associated with CARC 175
Business Scenario #3 – Billed Service Not	· 1 code combination removed	· RARC N7 was removed from combination with CARC 96
Covered by Health Plan		due to modification of RARC description
	· 2 RARC descriptions modified	· Description of CARC N10 was modified
		· Description of CARC N441 was modified
	· 4 CARC descriptions modified	· Description of CARC 173 was modified
		· Description of CARC 238 was modified
		· Description of CARC 242 was modified
		· Description of CARC 243 was modified
	· 5 CARCs added	· CARC 254 was added
		· CARC 256 was added
		· CARC W5 was added
		· CARC W6 was added
		· CARC W9 was added
	· 134 RARCs added	RARC M139 was associated with CARC 256
	· 134 RANCS added	
		RARC M14 was associated with CARC 256
		· RARC M37 was associated with CARC 256
		D.D.G. 1 1 1 G.D.G. 4 4 4
		· RARC M38 was associated with CARC 256
		· RARC M39 was associated with CARC 256
		RARC M39 was associated with CARC 256 RARC M61 was associated with CARC 256
		RARC M39 was associated with CARC 256 RARC M61 was associated with CARC 256 RARC M81 was associated with CARC 256
		RARC M39 was associated with CARC 256 RARC M61 was associated with CARC 256 RARC M81 was associated with CARC 256 RARC M82 was associated with CARC 256
		RARC M39 was associated with CARC 256 RARC M61 was associated with CARC 256 RARC M81 was associated with CARC 256
		RARC M39 was associated with CARC 256 RARC M61 was associated with CARC 256 RARC M81 was associated with CARC 256 RARC M82 was associated with CARC 256
		RARC M39 was associated with CARC 256 RARC M61 was associated with CARC 256 RARC M81 was associated with CARC 256 RARC M82 was associated with CARC 256 RARC M89 was associated with CARC 256
		RARC M39 was associated with CARC 256 RARC M61 was associated with CARC 256 RARC M81 was associated with CARC 256 RARC M82 was associated with CARC 256 RARC M89 was associated with CARC 256 RARC M90 was associated with CARC 256
		RARC M39 was associated with CARC 256 RARC M61 was associated with CARC 256 RARC M81 was associated with CARC 256 RARC M82 was associated with CARC 256 RARC M89 was associated with CARC 256 RARC M90 was associated with CARC 256 RARC M96 was associated with CARC 256
		RARC M39 was associated with CARC 256 RARC M61 was associated with CARC 256 RARC M81 was associated with CARC 256 RARC M82 was associated with CARC 256 RARC M89 was associated with CARC 256 RARC M90 was associated with CARC 256 RARC M96 was associated with CARC 256 RARC M97 was associated with CARC 256
		RARC M39 was associated with CARC 256 RARC M61 was associated with CARC 256 RARC M81 was associated with CARC 256 RARC M82 was associated with CARC 256 RARC M89 was associated with CARC 256 RARC M90 was associated with CARC 256 RARC M96 was associated with CARC 256 RARC M97 was associated with CARC 256 RARC M97 was associated with CARC 256
		RARC M39 was associated with CARC 256 RARC M61 was associated with CARC 256 RARC M81 was associated with CARC 256 RARC M82 was associated with CARC 256 RARC M89 was associated with CARC 256 RARC M90 was associated with CARC 256 RARC M96 was associated with CARC 256 RARC M97 was associated with CARC 256 RARC M97 was associated with CARC 256 RARC M103 was associated with CARC 256
		RARC M39 was associated with CARC 256 RARC M61 was associated with CARC 256 RARC M81 was associated with CARC 256 RARC M82 was associated with CARC 256 RARC M89 was associated with CARC 256 RARC M90 was associated with CARC 256 RARC M96 was associated with CARC 256 RARC M97 was associated with CARC 256 RARC M104 was associated with CARC 256 RARC M103 was associated with CARC 256 RARC N104 was associated with CARC 256
		RARC M39 was associated with CARC 256 RARC M61 was associated with CARC 256 RARC M81 was associated with CARC 256 RARC M82 was associated with CARC 256 RARC M89 was associated with CARC 256 RARC M90 was associated with CARC 256 RARC M96 was associated with CARC 256 RARC M97 was associated with CARC 256 RARC M103 was associated with CARC 256 RARC N103 was associated with CARC 256 RARC N104 was associated with CARC 256 RARC N104 was associated with CARC 256 RARC N104 was associated with CARC 256 RARC N105 was associated with CARC 256 RARC N106 was associated with CARC 256
		RARC M39 was associated with CARC 256 RARC M61 was associated with CARC 256 RARC M81 was associated with CARC 256 RARC M82 was associated with CARC 256 RARC M89 was associated with CARC 256 RARC M90 was associated with CARC 256 RARC M96 was associated with CARC 256 RARC M97 was associated with CARC 256 RARC M103 was associated with CARC 256 RARC N104 was associated with CARC 256 RARC N104 was associated with CARC 256 RARC N104 was associated with CARC 256 RARC N117 was associated with CARC 256 RARC N118 was associated with CARC 256
		RARC M39 was associated with CARC 256 RARC M61 was associated with CARC 256 RARC M81 was associated with CARC 256 RARC M82 was associated with CARC 256 RARC M89 was associated with CARC 256 RARC M90 was associated with CARC 256 RARC M96 was associated with CARC 256 RARC M97 was associated with CARC 256 RARC M103 was associated with CARC 256 RARC N103 was associated with CARC 256 RARC N104 was associated with CARC 256 RARC N117 was associated with CARC 256 RARC N118 was associated with CARC 256 RARC N130 was associated with CARC 254 RARC N130 was associated with CARC 256
		RARC M39 was associated with CARC 256 RARC M61 was associated with CARC 256 RARC M81 was associated with CARC 256 RARC M82 was associated with CARC 256 RARC M89 was associated with CARC 256 RARC M90 was associated with CARC 256 RARC M96 was associated with CARC 256 RARC M97 was associated with CARC 256 RARC M103 was associated with CARC 256 RARC N103 was associated with CARC 256 RARC N104 was associated with CARC 256 RARC N117 was associated with CARC 256 RARC N118 was associated with CARC 256 RARC N130 was associated with CARC 256
		RARC M39 was associated with CARC 256 RARC M61 was associated with CARC 256 RARC M81 was associated with CARC 256 RARC M82 was associated with CARC 256 RARC M89 was associated with CARC 256 RARC M90 was associated with CARC 256 RARC M96 was associated with CARC 256 RARC M97 was associated with CARC 256 RARC M103 was associated with CARC 256 RARC N104 was associated with CARC 256 RARC N104 was associated with CARC 256 RARC N117 was associated with CARC 256 RARC N118 was associated with CARC 256 RARC N118 was associated with CARC 256 RARC N130 was associated with CARC W6
		RARC M39 was associated with CARC 256 RARC M61 was associated with CARC 256 RARC M81 was associated with CARC 256 RARC M82 was associated with CARC 256 RARC M89 was associated with CARC 256 RARC M90 was associated with CARC 256 RARC M96 was associated with CARC 256 RARC M97 was associated with CARC 256 RARC M103 was associated with CARC 256 RARC N103 was associated with CARC 256 RARC N104 was associated with CARC 256 RARC N117 was associated with CARC 256 RARC N118 was associated with CARC 256 RARC N130 was associated with CARC 256

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· RARC N246 was associated with CARC 256
· RARC N365 was associated with CARC 256
· RARC N428 was associated with CARC 256
· RARC N448 was associated with CARC 256
· RARC N52 was associated with CARC 256
· RARC N576 was associated with CARC 109
· RARC N576 was associated with CARC 96
· RARC N578 was associated with CARC 33
· RARC N578 was associated with CARC 96
· RARC N584 was associated with CARC 138
· RARC N584 was associated with CARC 95
· RARC N584 was associated with CARC 96
· RARC N584 was associated with CARC B5
· RARC N587 was associated with CARC 119
· RARC N587 was associated with CARC 149
· RARC N587 was associated with CARC 222
· RARC N587 was associated with CARC 35
· RARC N588 was associated with CARC 96
· RARC N589 was associated with CARC 96
· RARC N590 was associated with CARC 96
· RARC N592 was associated with CARC 176
· RARC N592 was associated with CARC 96
· RARC N593 was associated with CARC 95
· RARC N593 was associated with CARC 96
· RARC N593 was associated with CARC B5
· RARC N594 was associated with CARC 95
· RARC N595 was associated with CARC 95
· RARC N596 was associated with CARC 95
· RARC N598 was associated with CARC 22
· RARC N607 was associated with CARC 160
· RARC N607 was associated with CARC 167
· RARC N607 was associated with CARC 50
· RARC N607 was associated with CARC 51
· RARC N607 was associated with CARC 96
· RARC N612 was associated with CARC B7
· RARC N619 was associated with CARC 200
· RARC N619 was associated with CARC 27
· RARC N621 was associated with CARC 96
· RARC N622 was associated with CARC 160
· RARC N622 was associated with CARC 26
· RARC N622 was associated with CARC 27
· RARC N622 was associated with CARC 96
· RARC N623 was associated with CARC 114
· RARC N623 was associated with CARC 256
· RARC N623 was associated with CARC 55
· RARC N623 was associated with CARC 56
· RARC N624 was associated with CARC 96
· RARC N627 was associated with CARC 174
· RARC N627 was associated with CARC 222
· RARC N627 was associated with CARC 233
· RARC N627 was associated with CARC 249
· RARC N627 was associated with CARC 39
· RARC N627 was associated with CARC 40
· RARC N627 was associated with CARC 49
· RARC N627 was associated with CARC 50
· RARC N627 was associated with CARC 60
· RARC N627 was associated with CARC 95
· RARC N628 was associated with CARC 231

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	I	· RARC N628 was associated with CARC 96
		· RARC N628 was associated with CARC B1
		· RARC N628 was associated with CARC B14
		· RARC N630 was associated with CARC 243
		· RARC N630 was associated with CARC 95
		RARC N630 was associated with CARC 96
		RARC N630 was associated with CARC 95
		RARC N633 was associated with CARC 222
		· RARC N633 was associated with CARC 59
		· RARC N633 was associated with CARC 96
		· RARC N636 was associated with CARC 119
		· RARC N636 was associated with CARC 96
		· RARC N637 was associated with CARC 96
		· RARC N637 was associated with CARC B14
		· RARC N640 was associated with CARC 119
		· RARC N640 was associated with CARC 150
		· RARC N640 was associated with CARC 152
		· RARC N640 was associated with CARC 222
		· RARC N640 was associated with CARC 96
		· RARC N640 was associated with CARC B5
		RARC N643 was associated with CARC 96
		RARC N644 was associated with CARC 99
		· RARC N646 was associated with CARC 54
		· RARC N647 was associated with CARC 167
		· RARC N647 was associated with CARC 96
		· RARC N650 was associated with CARC 200
		· RARC N650 was associated with CARC 26
		· RARC N650 was associated with CARC 27
		· RARC N651 was associated with CARC 204
		· RARC N651 was associated with CARC 96
		· RARC N652 was associated with CARC 26
		· RARC N653 was associated with CARC 96
		· RARC N658 was associated with CARC 202
		· RARC N658 was associated with CARC 204
		· RARC N658 was associated with CARC 212
		· RARC N658 was associated with CARC 50
		· RARC N658 was associated with CARC 96
		RARC N661 was associated with CARC 50
		· RARC N665 was associated with CARC 170
		· RARC N665 was associated with CARC 96
		· RARC N665 was associated with CARC B7
		· RARC N666 was associated with CARC 204
		· RARC N666 was associated with CARC 96
		· RARC N666 was associated with CARC B14
		· RARC N667 was associated with CARC 173
		· RARC N667 was associated with CARC 174
		· RARC N668 was associated with CARC 173
		· RARC N668 was associated with CARC 174
		· RARC N670 was associated with CARC 59
		RARC N674 was associated with CARC B15
		RARC N676 was associated with CARC 60
		· RARC N676 was associated with CARC 96
		· RARC N95 was associated with CARC 256
#4 – Benefit for Billed	· 1 CARC added	· CARC W8 was added
ately Payable	· 8 RARCs added	· RARC N626 was added to CARC 97
		· RARC N626 was associated with CARC 234
		· RARC N628 was associated with CARC 234
		· RARC No28 was associated with CARC 234

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	· RARC N637 was associated with CARC 97
	· RARC N646 was associated with CARC 97
	· RARC N666 was associated with CARC 97
	· RARC N676 was associated with CARC 234

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Code Combinations for Business Scenario #3: Billed Service Not Covered by Health Plan	BS #3
Code Combinations for Business Scenario #4: Benefit for Billed Service Not Separately Payable	BS #4
Code Combinations for Business Scenarios #1, #2, #3: Retail Pharmacy	Retail Pharmacy

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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/CAGC¹ 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 COREdefined Business Scenarios, this rule does not prohibit that, but it is expected the health plan will send the new Scenarios for consideration in
- 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 CORErequired 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, 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 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

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

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

		Table		
			- Missing/Invalid/Incomplete Documentation d from the billing provider or an ERA from a prior	naver.
CARC	CARC Description ²	RARC	RARC Description ³	ASC X12 CAGC
112	Service not furnished directly to the patient		Au Arto Description	CO or PI
	and/or not documented.			
116	The advance indemnification notice signed by the patient did not comply with requirements.	N563	Missing required provider/supplier issuance of advance patient notice of non-coverage. The patient is not liable for payment for this service.	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/c hart.	CO or PI
163	Attachment/other documentation referenced on the claim was not received.			CO or PI
164	Attachment/other documentation referenced on the claim was not received in a timely fashion.			CO or PI
165	Referral absent or exceeded.	N630	Referral not authorized by attending physician	CO, PI or PR
197	Precertification/authorization/notification absent.			CO or PI
250	The attachment/other documentation content received is inconsistent with the expected content.	N555	Missing medication list.	CO or PI
250	The attachment/other documentation content received is inconsistent with the expected content.	N556	Incomplete/invalid medication list.	CO or PI
250	The attachment/other documentation content received is inconsistent with the expected content.	N594	Records reflect the injured party did not complete an Application for Benefits for this loss.	CO or PI
250	The attachment/other documentation content received is inconsistent with the expected content.	N595	Records reflect the injured party did not complete an Assignment of Benefits for this loss.	CO or PI
250	The attachment/other documentation content received is inconsistent with the expected content.	N596	Records reflect the injured party did not complete a Medical Authorization for this loss.	CO or PI
250	The attachment/other documentation content received is inconsistent with the expected content.	N667	Missing prescription	CO or PI
250	The attachment/other documentation content received is inconsistent with the expected content.	N668	Incomplete/invalid prescription	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	M1	X-ray not taken within the past 12 months or near enough to the start of treatment.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	M19	Missing oxygen certification/re-certification.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	M21	Missing/incomplete/invalid place of residence for this service/item provided in a home.	CO or PI

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$Code\ Combinations\ for\ Business\ Scenario\ \#1:\ Additional\ Information\ Required\ -\ Missing/Invalid/Incomplete$

		Table 2		
			Missing/Invalid/Incomplete Documentation	
CARC	· · · · · · · · · · · · · · · · · · ·		from the billing provider or an ERA from a prior	
251	CARC Description ² The ettechment (other decumentation content	M23	RARC Description ³	ASC X12 CAGO
251	The attachment/other documentation content received did not contain the content required	W123	Missing invoice.	CO or PI
	to process this claim or service.			
251	The attachment/other documentation content	M29	Missing operative note/report.	CO or PI
	received did not contain the content required			
	to process this claim or service.			
251	The attachment/other documentation content	M30	Missing pathology report.	CO or PI
	received did not contain the content required			
	to process this claim or service.			
251	The attachment/other documentation content	M31	Missing radiology report.	CO or PI
	received did not contain the content required			
	to process this claim or service.			
251	The attachment/other documentation content	M42	The medical necessity form must be	CO or PI
	received did not contain the content required		personally signed by the attending physician.	
	to process this claim or service.			
251	The attachment/other documentation content	M47	Missing/incomplete/invalid internal or	CO or PI
	received did not contain the content required		document control number.	
	to process this claim or service.			
251	The attachment/other documentation content	M51	Missing/incomplete/invalid procedure	CO or PI
	received did not contain the content required		code(s).	
	to process this claim or service.			
251	The attachment/other documentation content	M60	Missing Certificate of Medical Necessity.	CO or PI
	received did not contain the content required			
	to process this claim or service.			
251	The attachment/other documentation content	M64	Missing/incomplete/invalid other diagnosis.	CO or PI
	received did not contain the content required			
	to process this claim or service.			
251	The attachment/other documentation content	M127	Missing patient medical record for this	CO or PI
	received did not contain the content required		service.	
	to process this claim or service.			
251	The attachment/other documentation content	M130	Missing invoice or statement certifying the	CO or PI
	received did not contain the content required		actual cost of the lens, less discounts, and/or	
	to process this claim or service.		the type of intraocular lens used.	
251	The attachment/other documentation content	M131	Missing physician financial relationship form.	CO or PI
	received did not contain the content required			
	to process this claim or service.]	
251	The attachment/other documentation content	M132	Missing pacemaker registration form.	CO or PI
	received did not contain the content required			
	to process this claim or service.			
251	The attachment/other documentation content	M135	Missing/incomplete/invalid plan of treatment.	CO or PI
	received did not contain the content required			
	to process this claim or service.			

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

	Table 2-1						
			- Missing/Invalid/Incomplete Documentation d from the billing provider or an ERA from a prior	naver			
CARC	CARC Description ²	RARC	RARC Description ³	ASC X12 CAGC			
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	M141	Missing physician certified plan of care.	CO or PI			
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	M142	Missing American Diabetes Association Certificate of Recognition.	CO or PI			
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	M143	The provider must update license information with the payer.	CO or PI			
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	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			
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	MA27	Missing/incomplete/invalid entitlement number or name shown on the claim.	CO or PI			
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	MA61	Missing/incomplete/invalid social security number or health insurance claim number.	CO or PI			
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	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			
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	MA75	Missing/incomplete/invalid patient or authorized representative signature.	CO or PI			
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	MA76	Missing/incomplete/invalid provider identifier for home health agency or hospice when physician is performing care plan oversight services.	CO or PI			
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	MA81	Missing/incomplete/invalid provider/supplier signature.	CO or PI			
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	MA83	Did not indicate whether we are the primary or secondary payer.	CO or PI			
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	MA88	Missing/incomplete/invalid insured's address and/or telephone number for the primary payer.	CO or PI			
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	MA92	Missing plan information for other insurance.	CO or PI			

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$Code\ Combinations\ for\ Business\ Scenario\ \#1:\ Additional\ Information\ Required\ -\ Missing/Invalid/Incomplete$

D - ----- --- 4 - 4' - --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 Description² RARC RARC Description³ ASC X12 CAGC MA96 Claim rejected. Coded as a Medicare 251 The attachment/other documentation content CO or PI received did not contain the content required Managed Care Demonstration but patient is not enrolled in a Medicare managed care to process this claim or service. 251 The attachment/other documentation content MA111 Missing/incomplete/invalid purchase price of CO or PI the test(s) and/or the performing laboratory's received did not contain the content required to process this claim or service. name and address. 251 The attachment/other documentation content MA112 Missing/incomplete/invalid group practice CO or PI received did not contain the content required information. to process this claim or service. 251 The attachment/other documentation content MA114 Missing/incomplete/invalid information on CO or PI received did not contain the content required where the services were furnished. to process this claim or service. 251 The attachment/other documentation content MA122 Missing/incomplete/invalid initial treatment CO or PI received did not contain the content required to process this claim or service. MA130 251 The attachment/other documentation content Your claim contains incomplete and/or CO or PI invalid information, and no appeal rights are received did not contain the content required to process this claim or service. afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information. The attachment/other documentation content N3 Missing consent form. 251 CO or PI received did not contain the content required to process this claim or service. 251 N4 CO or PI The attachment/other documentation content Missing/incomplete/invalid prior insurance received did not contain the content required carrier EOB. to process this claim or service. Missing itemized bill/statement 251 The attachment/other documentation content N26 CO or PI received did not contain the content required to process this claim or service. 251 The attachment/other documentation content N28 Consent form requirements not fulfilled. CO or PI received did not contain the content required to process this claim or service. 251 The attachment/other documentation content N29 CO or PI Missing received did not contain the content required documentation/orders/notes/summary/report/c to process this claim or service. N40 251 The attachment/other documentation content Missing radiology film(s)/image(s). CO or PI received did not contain the content required to process this claim or service. 251 N42 No record of mental health assessment. CO or PI The attachment/other documentation content

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received did not contain the content required

to process this claim or service.

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

		Table		
			Missing/Invalid/Incomplete Documentation	
	Refers to situations where additional document	ntation is needed	from the billing provider or an ERA from a prior	payer.
CARC	CARC Description ²	RARC	RARC Description ³	ASC X12 CAGO
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N59	Please refer to your provider manual for additional program and provider information.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N80	Missing/incomplete/invalid prenatal screening information.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	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
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N146	Missing screening document.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N175	Missing review organization approval.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N178	Missing pre-operative photos or visual field results.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N179	Additional information has been requested from the member. The charges will be reconsidered upon receipt of that information.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N186	Non-Availability Statement (NAS) required for this service. Contact the nearest Military Treatment Facility (MTF) for assistance.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N191	The provider must update insurance information directly with payer.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N197	The subscriber must update insurance information directly with payer.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N202	Additional information/explanation will be sent separately.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N204	Services under review for possible pre- existing condition. Send medical records for prior 12 months.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N205	Information provided was illegible.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N206	The supporting documentation does not match the claim.	CO or PI

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$Code\ Combinations\ for\ Business\ Scenario\ \#1:\ Additional\ Information\ Required\ -\ Missing/Invalid/Incomplete$

		Table		
		•	- Missing/Invalid/Incomplete Documentation	
			d from the billing provider or an ERA from a prior	
CARC	CARC Description ²	RARC	RARC Description ³	ASC X12 CAGO
251	The attachment/other documentation content	N214	Missing/incomplete/invalid history of the	CO or PI
	received did not contain the content required to process this claim or service.		related initial surgical procedure(s).	
251	The attachment/other documentation content	N221	Missing Admitting History and Physical	CO or PI
	received did not contain the content required to process this claim or service.		report.	
	to process this claim of service.			
251	The attachment/other documentation content	N222	Incomplete/invalid Admitting History and	CO or PI
	received did not contain the content required		Physical report.	
	to process this claim or service.			
251	The attachment/other documentation content	N223	Missing documentation of benefit to the	CO or PI
	received did not contain the content required		patient during initial treatment period.	
	to process this claim or service.			
251	The attachment/other documentation content	N224	Incomplete/invalid documentation of benefit	CO or PI
	received did not contain the content required		to the patient during initial treatment period.	
	to process this claim or service.			
251	The attachment/other documentation content	N225	Incomplete/invalid	CO or PI
	received did not contain the content required		documentation/orders/notes/summary/report/c	
	to process this claim or service.		hart.	
251	The attachment/other documentation content	N227	Incomplete/invalid Certificate of Medical	CO or PI
	received did not contain the content required		Necessity.	
	to process this claim or service.			
251	The attachment/other documentation content	N228	Incomplete/invalid consent form.	CO or PI
	received did not contain the content required		•	
	to process this claim or service.			
251	The attachment/other documentation content	N231	Incomplete/invalid invoice or statement	CO or PI
	received did not contain the content required		certifying the actual cost of the lens, less	
	to process this claim or service.		discounts, and/or the type of intraocular lens	
251	The attachment/other documentation content	N232	used. Incomplete/invalid itemized bill/statement.	CO or PI
	received did not contain the content required	11232		20011
	to process this claim or service.			
251	The attachment/other documentation content	N233	Incomplete/invalid operative note/report.	CO or PI
	received did not contain the content required	11233	and operative note, report.	20011
	to process this claim or service.			
251	The attachment/other documentation content	N234	Incomplete/invalid oxygen	CO or PI
	received did not contain the content required	1,201	certification/re-certification.	20 0111
	to process this claim or service.			
251	The attachment/other documentation content	N235	Incomplete/invalid pacemaker registration	CO or PI
201	received did not contain the content required	11233	form.	200111
	to process this claim or service.			
251	The attachment/other documentation content	N236	Incomplete/invalid pathology report.	CO or PI
201	received did not contain the content required	11230	incomplete, invalid pathology report.	200111
	to process this claim or service.			

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$Code\ Combinations\ for\ Business\ Scenario\ \#1:\ Additional\ Information\ Required\ -\ Missing/Invalid/Incomplete$

	Soonovia #1. Additional Information	Table	2-1 - Missing/Invalid/Incomplete Documentation	
			- Missing/Invalid/Incomplete Documentation d from the billing provider or an ERA from a prior	payer.
CARC	CARC Description ²	RARC	RARC Description ³	ASC X12 CAGC
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N237	Incomplete/invalid patient medical record for this service.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N238	Incomplete/invalid physician certified plan of care.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N239	Incomplete/invalid physician financial relationship form.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N240	Incomplete/invalid radiology report.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N241	Incomplete/invalid review organization approval.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N242	Incomplete/invalid radiology film(s)/image(s).	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N243	Incomplete/invalid/not approved screening document.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N244	Incomplete/invalid pre-operative photos/visual field results.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N245	Incomplete/invalid plan information for other insurance.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N286	Missing/incomplete/invalid referring provider primary identifier.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N331	Missing/incomplete/invalid physician order date.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N350	Missing/incomplete/invalid description of service for a Not Otherwise Classified (NOC) code or for an Unlisted/By Report procedure.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N354	Incomplete/invalid invoice.	CO or PI

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$Code\ Combinations\ for\ Business\ Scenario\ \#1:\ Additional\ Information\ Required\ -\ Missing/Invalid/Incomplete$

		Table :		
			Missing/Invalid/Incomplete Documentation	
		ntation is needed	l from the billing provider or an ERA from a prior	payer.
CARC	CARC Description ²	RARC	RARC Description ³	ASC X12 CAGO
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	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
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N375	Missing/incomplete/invalid questionnaire/information required to determine dependent eligibility.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N391	Missing emergency department records.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N392	Incomplete/invalid emergency department records.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N393	Missing progress notes/report.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N394	Incomplete/invalid progress notes/report.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N395	Missing laboratory report.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N396	Incomplete/invalid laboratory report.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N398	Missing elective consent form.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N399	Incomplete/invalid elective consent form.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N401	Missing periodontal charting.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N402	Incomplete/invalid periodontal charting.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N403	Missing facility certification.	CO or PI

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

		Table		
			- Missing/Invalid/Incomplete Documentation	
	Refers to situations where additional documen	ntation is needed	d from the billing provider or an ERA from a prior	payer.
CARC	CARC Description ²	RARC	RARC Description ³	ASC X12 CAGO
251	The attachment/other documentation content	N404	Incomplete/invalid facility certification.	CO or PI
	received did not contain the content required			
	to process this claim or service.			
251	The attachment/other documentation content	N439	Missing anesthesia physical status	CO or PI
	received did not contain the content required		report/indicators.	
	to process this claim or service.			
251	The attachment/other documentation content	N440	Incomplete/invalid anesthesia physical status	CO or PI
	received did not contain the content required		report/indicators.	
	to process this claim or service.			
251	The attachment/other documentation content	N445	Missing document for actual cost or paid	CO or PI
	received did not contain the content required		amount.	
	to process this claim or service.			
251	The attachment/other documentation content	N446	Incomplete/invalid document for actual cost	CO or PI
	received did not contain the content required		or paid amount.	
	to process this claim or service.			
251	The attachment/other documentation content	N451	Missing Admission Summary Report.	CO or PI
	received did not contain the content required			
	to process this claim or service.			
251	The attachment/other documentation content	N452	Incomplete/invalid Admission Summary	CO or PI
	received did not contain the content required		Report.	
	to process this claim or service.			
251	The attachment/other documentation content	N453	Missing Consultation Report.	CO or PI
	received did not contain the content required			
	to process this claim or service.			
251	The attachment/other documentation content	N454	Incomplete/invalid Consultation Report.	CO or PI
	received did not contain the content required			
	to process this claim or service.			
251	The attachment/other documentation content	N455	Missing Physician Order.	CO or PI
	received did not contain the content required			
	to process this claim or service.			
251	The attachment/other documentation content	N456	Incomplete/invalid Physician Order.	CO or PI
	received did not contain the content required			
	to process this claim or service.			
251	The attachment/other documentation content	N457	Missing Diagnostic Report.	CO or PI
	received did not contain the content required			
	to process this claim or service.			
251	The attachment/other documentation content	N458	Incomplete/invalid Diagnostic Report.	CO or PI
	received did not contain the content required			
	to process this claim or service.			
251	The attachment/other documentation content	N459	Missing Discharge Summary.	CO or PI
	received did not contain the content required			
	to process this claim or service.			

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

		Table 2		
		•	Missing/Invalid/Incomplete Documentation	
			from the billing provider or an ERA from a prior	
CARC	CARC Description ²	RARC	RARC Description ³	ASC X12 CAGO
251	The attachment/other documentation content	N460	Incomplete/invalid Discharge Summary.	CO or PI
	received did not contain the content required to process this claim or service.			
	to process this claim or service.			
251	The attachment/other documentation content	N461	Missing Nursing Notes.	CO or PI
	received did not contain the content required			
	to process this claim or service.			
251	The attachment/other documentation content	N462	Incomplete/invalid Nursing Notes.	CO or PI
	received did not contain the content required		·	
	to process this claim or service.			
251	The attachment/other documentation content	N463	Missing support data for claim.	CO or PI
	received did not contain the content required			
	to process this claim or service.			
251	The attachment/other documentation content	N464	Incomplete/invalid support data for claim.	CO or PI
	received did not contain the content required		1	
	to process this claim or service.			
251	The attachment/other documentation content	N465	Missing Physical Therapy Notes/Report.	CO or PI
	received did not contain the content required		3 ,	
	to process this claim or service.			
251	The attachment/other documentation content	N466	Incomplete/invalid Physical Therapy	CO or PI
	received did not contain the content required		Notes/Report.	
	to process this claim or service.			
251	The attachment/other documentation content	N467	Missing Report of Tests and Analysis Report.	CO or PI
	received did not contain the content required		7	
	to process this claim or service.			
251	The attachment/other documentation content	N468	Incomplete/invalid Report of Tests and	CO or PI
	received did not contain the content required		Analysis Report.	
	to process this claim or service.			
251	The attachment/other documentation content	N473	Missing certification.	CO or PI
	received did not contain the content required			
	to process this claim or service.			
251	The attachment/other documentation content	N474	Incomplete/invalid certification.	CO or PI
	received did not contain the content required			
	to process this claim or service.			
251	The attachment/other documentation content	N475	Missing completed referral form.	CO or PI
	received did not contain the content required			
	to process this claim or service.			
251	The attachment/other documentation content	N476	Incomplete/invalid completed referral form.	CO or PI
	received did not contain the content required			
	to process this claim or service.			
251	The attachment/other documentation content	N477	Missing Dental Models.	CO or PI
-	received did not contain the content required		<i>5</i>	
	to process this claim or service.			

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

	Scenario #1 · Additional Informa	tion Required -	- Missing/Invalid/Incomplete Documentation	
			d from the billing provider or an ERA from a prio	r paver.
CARC	CARC Description ²	RARC	RARC Description ³	ASC X12 CAGO
251	The attachment/other documentation content	N478	Incomplete/invalid Dental Models.	CO or PI
201	received did not contain the content required	11.70	meomplete/myunu zoman 113aans/	00 0.11
	to process this claim or service.			
251	The attachment/other documentation content	N479	Missing Explanation of Benefits	CO or PI
	received did not contain the content required		(Coordination of Benefits or Medicare	
	to process this claim or service.		Secondary Payer).	
251	The attachment/other documentation content	N480	Incomplete/invalid Explanation of Benefits	CO or PI
	received did not contain the content required		(Coordination of Benefits or Medicare	
	to process this claim or service.		Secondary Payer).	
251	The attachment/other documentation content	N481	Missing Models.	CO or PI
	received did not contain the content required			
	to process this claim or service.			
251	The attachment/other documentation content	N482	Incomplete/invalid Models.	CO or PI
	received did not contain the content required			
	to process this claim or service.			
251	The attachment/other documentation content	N483	Missing Periodontal Charts.	CO or PI
	received did not contain the content required			
	to process this claim or service.			
251	The attachment/other documentation content	N484	Incomplete/invalid Periodontal Charts.	CO or PI
	received did not contain the content required			
	to process this claim or service.			
251	The attachment/other documentation content	N485	Missing Physical Therapy Certification.	CO or PI
	received did not contain the content required			
	to process this claim or service.			
251	The attachment/other documentation content	N486	Incomplete/invalid Physical Therapy	CO or PI
	received did not contain the content required		Certification.	
	to process this claim or service.			
251	The attachment/other documentation content	N487	Missing Prosthetics or Orthotics	CO or PI
	received did not contain the content required		Certification.	
	to process this claim or service.			
251	The attachment/other documentation content	N488	Incomplete/invalid Prosthetics or Orthotics	CO or PI
	received did not contain the content required		Certification.	
	to process this claim or service.			
251	The attachment/other documentation content	N489	Missing referral form.	CO or PI
	received did not contain the content required			
	to process this claim or service.			
251	The attachment/other documentation content	N490	Incomplete/invalid referral form.	CO or PI
	received did not contain the content required			
	to process this claim or service.			
251	The attachment/other documentation content	N491	Missing/Incomplete/Invalid Exclusionary	CO or PI
	received did not contain the content required		Rider Condition.	
	to process this claim or service.			

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$Code\ Combinations\ for\ Business\ Scenario\ \#1:\ Additional\ Information\ Required\ -\ Missing/Invalid/Incomplete$

		Table		
			Missing/Invalid/Incomplete Documentation	
	Refers to situations where additional documen	ntation is needed	from the billing provider or an ERA from a prior	payer.
CARC	CARC Description ²	RARC	RARC Description ³	ASC X12 CAGO
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N493	Missing Doctor First Report of Injury.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N494	Incomplete/invalid Doctor First Report of Injury.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N495	Missing Supplemental Medical Report.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N496	Incomplete/invalid Supplemental Medical Report.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N497	Missing Medical Permanent Impairment or Disability Report.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N498	Incomplete/invalid Medical Permanent Impairment or Disability Report.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N499	Missing Medical Legal Report.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N500	Incomplete/invalid Medical Legal Report.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N542	Missing income verification.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N543	Incomplete/invalid income verification.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N555	Missing medication list.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N556	Incomplete/invalid medication list.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N563	Missing required provider/supplier issuance of advance patient notice of non-coverage. The patient is not liable for payment for this service.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N590	Missing independent medical exam detailing the cause of injuries sustained and medical necessity of services rendered.	CO or PI

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

		Table		
			- Missing/Invalid/Incomplete Documentation	
	Refers to situations where additional document	ntation is needed	d from the billing provider or an ERA from a prior	payer.
CARC	CARC Description ²	RARC	RARC Description ³	ASC X12 CAGO
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N594	Records reflect the injured party did not complete an Application for Benefits for this loss.	CO or PI
	to process this claim or service.		1033.	
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N595	Records reflect the injured party did not complete an Assignment of Benefits for this loss.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N596	Records reflect the injured party did not complete a Medical Authorization for this loss.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N667	Missing prescription	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N668	Incomplete/invalid prescription	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	M1	X-ray not taken within the past 12 months or near enough to the start of treatment.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	M19	Missing oxygen certification/re-certification.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	M21	Missing/incomplete/invalid place of residence for this service/item provided in a home.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	M23	Missing invoice.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	M29	Missing operative note/report.	CO or PI

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

Table 2-1 Scenario #1: Additional Information Required – Missing/Invalid/Incomplete Documentation						
				novon		
a		efers 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		
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	M30	Missing pathology report.	CO or PI		
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	M31	Missing radiology report.	CO or PI		
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	M42	The medical necessity form must be personally signed by the attending physician.	CO or PI		
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	M47	Missing/incomplete/invalid internal or document control number.	CO or PI		
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	M51	Missing/incomplete/invalid procedure code(s).	CO or PI		
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	M60	Missing Certificate of Medical Necessity.	CO or PI		
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	M64	Missing/incomplete/invalid other diagnosis.	CO or PI		
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	M127	Missing patient medical record for this service.	CO or PI		

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

	Table 2-1 Scenario #1: Additional Information Required – Missing/Invalid/Incomplete Documentation						
			· Missing/Invalid/Incomplete Documentation I from the billing provider or an ERA from a prior	payer.			
CARC	CARC Description ²	RARC	RARC Description ³	ASC X12 CAGC			
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	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			
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	M131	Missing physician financial relationship form.	CO or PI			
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	M132	Missing pacemaker registration form.	CO or PI			
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	M135	Missing/incomplete/invalid plan of treatment.	CO or PI			
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	M141	Missing physician certified plan of care.	CO or PI			
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	M142	Missing American Diabetes Association Certificate of Recognition.	CO or PI			
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	M143	The provider must update license information with the payer.	CO or PI			
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	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			

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$Code\ Combinations\ for\ Business\ Scenario\ \#1:\ Additional\ Information\ Required\ -\ Missing/Invalid/Incomplete$

	G 1 1/4 1 33/4 1 7 2	Table			
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.					
	-	ntation is needed		payer.	
CARC	CARC Description ²	RARC	RARC Description ³	ASC X12 CAGO	
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	MA27	Missing/incomplete/invalid entitlement number or name shown on the claim.	CO or PI	
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	MA61	Missing/incomplete/invalid social security number or health insurance claim number.	CO or PI	
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	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	
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	MA75	Missing/incomplete/invalid patient or authorized representative signature.	CO or PI	
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	MA76	Missing/incomplete/invalid provider identifier for home health agency or hospice when physician is performing care plan oversight services.	CO or PI	
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	MA81	Missing/incomplete/invalid provider/supplier signature.	CO or PI	
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	MA83	Did not indicate whether we are the primary or secondary payer.	CO or PI	
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	MA88	Missing/incomplete/invalid insured's address and/or telephone number for the primary payer.	CO or PI	

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

Table 2-1 Scenario #1: Additional Information Required – Missing/Invalid/Incomplete Documentation					
		•	•	novon	
CARC			from the billing provider or an ERA from a prior		
CARC	CARC Description ²	RARC	RARC Description ³	ASC X12 CAGO	
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	MA92	Missing plan information for other insurance.	CO or PI	
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	MA96	Claim rejected. Coded as a Medicare Managed Care Demonstration but patient is not enrolled in a Medicare managed care plan.	CO or PI	
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	MA111	Missing/incomplete/invalid purchase price of the test(s) and/or the performing laboratory's name and address.	CO or PI	
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	MA112	Missing/incomplete/invalid group practice information.	CO or PI	
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	MA114	Missing/incomplete/invalid information on where the services were furnished.	CO or PI	
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	MA122	Missing/incomplete/invalid initial treatment date.	CO or PI	
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	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	
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N3	Missing consent form.	CO or PI	

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$Code\ Combinations\ for\ Business\ Scenario\ \#1:\ Additional\ Information\ Required\ -\ Missing/Invalid/Incomplete$

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.					
				payer.	
CARC	CARC Description ²	RARC	RARC Description ³	ASC X12 CAGO	
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N4	Missing/incomplete/invalid prior insurance carrier EOB.	CO or PI	
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N26	Missing itemized bill/statement	CO or PI	
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N28	Consent form requirements not fulfilled.	CO or PI	
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N29	Missing documentation/orders/notes/summary/report/c hart.	CO or PI	
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N40	Missing radiology film(s)/image(s).	CO or PI	
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N42	No record of mental health assessment.	CO or PI	
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N50	Missing/incomplete/invalid discharge information.	CO or PI	
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N59	Please refer to your provider manual for additional program and provider information.	CO or PI	

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

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 CAGO		
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N80	Missing/incomplete/invalid prenatal screening information.	CO or PI		
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	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		
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N146	Missing screening document.	CO or PI		
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N170	A new/revised/renewed certificate of medical necessity is needed.	CO or PI		
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N175	Missing review organization approval.	CO or PI		
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N178	Missing pre-operative photos or visual field results.	CO or PI		
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N179	Additional information has been requested from the member. The charges will be reconsidered upon receipt of that information.	CO or PI		
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N186	Non-Availability Statement (NAS) required for this service. Contact the nearest Military Treatment Facility (MTF) for assistance.	CO or PI		

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$Code\ Combinations\ for\ Business\ Scenario\ \#1:\ Additional\ Information\ Required\ -\ Missing/Invalid/Incomplete$

Table 2-1 Scenario #1: Additional Information Required – Missing/Invalid/Incomplete Documentation						
				, navan		
	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 CAGO		
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N191	The provider must update insurance information directly with payer.	CO or PI		
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N197	The subscriber must update insurance information directly with payer.	CO or PI		
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N202	Additional information/explanation will be sent separately.	CO or PI		
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N204	Services under review for possible pre- existing condition. Send medical records for prior 12 months.	CO or PI		
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N205	Information provided was illegible.	CO or PI		
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N206	The supporting documentation does not match the claim.	CO or PI		
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N214	Missing/incomplete/invalid history of the related initial surgical procedure(s).	CO or PI		
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N221	Missing Admitting History and Physical report.	CO or PI		

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

	Table 2-1 Scenario #1: Additional Information Required – Missing/Invalid/Incomplete Documentation						
			- Missing/Invalid/Incomplete Documentation I from the billing provider or an ERA from a prior	payer.			
CARC	CARC Description ²	RARC	RARC Description ³	ASC X12 CAGC			
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N222	Incomplete/invalid Admitting History and Physical report.	CO or PI			
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N223	Missing documentation of benefit to the patient during initial treatment period.	CO or PI			
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N224	Incomplete/invalid documentation of benefit to the patient during initial treatment period.	CO or PI			
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N225	Incomplete/invalid documentation/orders/notes/summary/report/c hart.	CO or PI			
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N227	Incomplete/invalid Certificate of Medical Necessity.	CO or PI			
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N228	Incomplete/invalid consent form.	CO or PI			
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	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			
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N232	Incomplete/invalid itemized bill/statement.	CO or PI			

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$Code\ Combinations\ for\ Business\ Scenario\ \#1:\ Additional\ Information\ Required\ -\ Missing/Invalid/Incomplete$

Table 2-1					
		•	- Missing/Invalid/Incomplete Documentation		
	d from the billing provider or an ERA from a prior				
CARC	CARC Description ²	RARC	RARC Description ³	ASC X12 CAGC	
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N233	Incomplete/invalid operative note/report.	CO or PI	
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N234	Incomplete/invalid oxygen certification/re-certification.	CO or PI	
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N235	Incomplete/invalid pacemaker registration form.	CO or PI	
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N236	Incomplete/invalid pathology report.	CO or PI	
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N237	Incomplete/invalid patient medical record for this service.	CO or PI	
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N238	Incomplete/invalid physician certified plan of care	CO or PI	
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N239	Incomplete/invalid physician financial relationship form.	CO or PI	
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N240	Incomplete/invalid radiology report.	CO or PI	

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

	G 1 114	Table		
		•	- Missing/Invalid/Incomplete Documentation	
	-		d from the billing provider or an ERA from a prior	
CARC	CARC Description ²	RARC	RARC Description ³	ASC X12 CAGO
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N241	Incomplete/invalid review organization approval.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N242	Incomplete/invalid radiology film(s)/image(s).	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N243	Incomplete/invalid/not approved screening document.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N244	Incomplete/invalid pre-operative photos/visual field results.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N245	Incomplete/invalid plan information for other insurance.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N286	Missing/incomplete/invalid referring provider primary identifier.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N331	Missing/incomplete/invalid physician order date.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N350	Missing/incomplete/invalid description of service for a Not Otherwise Classified (NOC) code or for an Unlisted/By Report procedure.	CO or PI

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

	E 1 114	Table		
		•	Missing/Invalid/Incomplete Documentation	
	-		from the billing provider or an ERA from a prior	
CARC	CARC Description ²	RARC	RARC Description ³	ASC X12 CAGO
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N354	Incomplete/invalid invoice.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	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
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N375	Missing/incomplete/invalid questionnaire/information required to determine dependent eligibility.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N391	Missing emergency department records.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N392	Incomplete/invalid emergency department records.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N393	Missing progress notes/report.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N394	Incomplete/invalid progress notes/report.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N395	Missing laboratory report.	CO or PI

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$Code\ Combinations\ for\ Business\ Scenario\ \#1:\ Additional\ Information\ Required\ -\ Missing/Invalid/Incomplete$

		Table		
			Missing/Invalid/Incomplete Documentation	
			from the billing provider or an ERA from a pri	
CARC	CARC Description ²	RARC	RARC Description ³	ASC X12 CAGC
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N396	Incomplete/invalid laboratory report.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N398	Missing elective consent form.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N399	Incomplete/invalid elective consent form.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N401	Missing periodontal charting.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N402	Incomplete/invalid periodontal charting.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N403	Missing facility certification.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N404	Incomplete/invalid facility certification.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N439	Missing anesthesia physical status report/indicators.	CO or PI

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$Code\ Combinations\ for\ Business\ Scenario\ \#1:\ Additional\ Information\ Required\ -\ Missing/Invalid/Incomplete$

	0 . "4	Table		
		•	- Missing/Invalid/Incomplete Documentation	
	-		d from the billing provider or an ERA from a prior	
CARC	CARC Description ²	RARC	RARC Description ³	ASC X12 CAGO
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N440	Incomplete/invalid anesthesia physical status report/indicators.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N445	Missing document for actual cost or paid amount.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N446	Incomplete/invalid document for actual cost or paid amount.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N451	Missing Admission Summary Report.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N452	Incomplete/invalid Admission Summary Report.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N453	Missing Consultation Report.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N454	Incomplete/invalid Consultation Report.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N455	Missing Physician Order.	CO or PI

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

		Table 2	2-1	
	Scenario #1: Additional Informa	ation Required –	Missing/Invalid/Incomplete Documentation	
	Refers to situations where additional docume	ntation is needed	l from the billing provider or an ERA from a pri	or payer.
CARC	CARC Description ²	RARC	RARC Description ³	ASC X12 CAGO
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N456	Incomplete/invalid Physician Order.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N457	Missing Diagnostic Report.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N458	Incomplete/invalid Diagnostic Report.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N459	Missing Discharge Summary.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N460	Incomplete/invalid Discharge Summary.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N461	Missing Nursing Notes.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N462	Incomplete/invalid Nursing Notes.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N463	Missing support data for claim.	CO or PI

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$Code\ Combinations\ for\ Business\ Scenario\ \#1:\ Additional\ Information\ Required\ -\ Missing/Invalid/Incomplete$

	0 1 1/4 1 3 3 4 1 7 2	Table		
		•	- Missing/Invalid/Incomplete Documentation	
			d from the billing provider or an ERA from a prior	
CARC	CARC Description ²	RARC	RARC Description ³	ASC X12 CAGC
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N464	Incomplete/invalid support data for claim.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N465	Missing Physical Therapy Notes/Report.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N466	Incomplete/invalid Physical Therapy Notes/Report.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N467	Missing Report of Tests and Analysis Report.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N468	Incomplete/invalid Report of Tests and Analysis Report.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N473	Missing certification.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N474	Incomplete/invalid certification.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N475	Missing completed referral form.	CO or PI

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$Code\ Combinations\ for\ Business\ Scenario\ \#1:\ Additional\ Information\ Required\ -\ Missing/Invalid/Incomplete$

	Comparis #1. A 3.322	Table:		
			- Missing/Invalid/Incomplete Documentation	u novou
			d from the billing provider or an ERA from a prior	
CARC	CARC Description ²	RARC	RARC Description ³	ASC X12 CAGO
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N476	Incomplete/invalid completed referral form.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N477	Missing Dental Models.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N478	Incomplete/invalid Dental Models.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N479	Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N480	Incomplete/invalid Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N481	Missing Models.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N482	Incomplete/invalid Models.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N483	Missing Periodontal Charts.	CO or PI

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$Code\ Combinations\ for\ Business\ Scenario\ \#1:\ Additional\ Information\ Required\ -\ Missing/Invalid/Incomplete$

		Table	2-1	
	Scenario #1: Additional Informa	ation Required –	Missing/Invalid/Incomplete Documentation	
	Refers to situations where additional docume	ntation is needed	l from the billing provider or an ERA from a prio	r payer.
CARC	CARC Description ²	RARC	RARC Description ³	ASC X12 CAGO
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N484	Incomplete/invalid Periodontal Charts.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N485	Missing Physical Therapy Certification.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N486	Incomplete/invalid Physical Therapy Certification.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N487	Missing Prosthetics or Orthotics Certification.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N488	Incomplete/invalid Prosthetics or Orthotics Certification.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N489	Missing referral form.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N490	Incomplete/invalid referral form.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N491	Missing/Incomplete/Invalid Exclusionary Rider Condition.	CO or PI

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

	C1 #1. A 1.1' 1 TF	Table	- Missing/Invalid/Incomplete Documentation	
		•	d from the billing provider or an ERA from a prio	n navan
GARG				
CARC	CARC Description ²	RARC	RARC Description ³	ASC X12 CAGC
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N493	Missing Doctor First Report of Injury.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N494	Incomplete/invalid Doctor First Report of Injury.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N495	Missing Supplemental Medical Report.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N496	Incomplete/invalid Supplemental Medical Report.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N497	Missing Medical Permanent Impairment or Disability Report.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N498	Incomplete/invalid Medical Permanent Impairment or Disability Report.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N499	Missing Medical Legal Report.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N500	Incomplete/invalid Medical Legal Report.	CO or PI

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

	C 1 1/4 1 7 7 1 7 7	Table		
		•	Missing/Invalid/Incomplete Documentation	novon
CARC			from the billing provider or an ERA from a prior	
CARC	CARC Description ²	RARC	RARC Description ³	ASC X12 CAGO
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N542	Missing income verification.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N543	Incomplete/invalid income verification.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N555	Missing medication list.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N556	Incomplete/invalid medication list.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N563	Missing required provider/supplier issuance of advance patient notice of non-coverage. The patient is not liable for payment for this service.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N590	Missing independent medical exam detailing the cause of injuries sustained and medical necessity of services rendered.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N594	Records reflect the injured party did not complete an Application for Benefits for this loss.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N595	Records reflect the injured party did not complete an Assignment of Benefits for this loss.	CO or PI

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

		Table 2		
		•	Missing/Invalid/Incomplete Documentation from the billing provider or an ERA from a prior	or payer.
CARC	CARC Description ²	RARC	RARC Description ³	ASC X12 CAGC
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N596	Records reflect the injured party did not complete a Medical Authorization for this loss.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N667	Missing prescription	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N668	Incomplete/invalid prescription	CO or PI

²Washington Publishing Company: http://www.wpc-edi.com/reference/

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³Washington Publishing Company: http://www.wpc-edi.com/reference/

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

		Table		
	~	_	olete Data from Submitted Claim	
Refers to	situations where additional data is needed from th	e billing provid	er for missing or invalid data on the submitted clai	m, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	ASC X12 CAGO
4	The procedure code is inconsistent with the	N517	Resubmit a new claim with the requested	CO or PI
	modifier used or a required modifier is		information.	
	missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110			
	Service Payment Information REF), if			
	present.			
4	The procedure code is inconsistent with the	N519	Invalid combination of HCPCS modifiers.	CO or PI
	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.			
4	The procedure code is inconsistent with the	N572	This procedure is not payable unless non-	CO or PI
	modifier used or a required modifier is		payable reporting codes and appropriate	
	missing. Note: Refer to the 835 Healthcare		modifiers are submitted.	
	Policy Identification Segment (loop 2110			
	Service Payment Information REF), if present.			
4	The procedure code is inconsistent with the	N644	Reimbursement has been made according to	CO or PI
	modifier used or a required modifier is		the bilateral procedure rule.	
	missing. Note: Refer to the 835 Healthcare			
	Policy Identification Segment (loop 2110			
	Service Payment Information REF), if present.			
4	The procedure code is inconsistent with the	N657	This should be billed with the appropriate	CO or PI
•	modifier used or a required modifier is	11007	code for these services.	00 0111
	missing. Note: Refer to the 835 Healthcare			
	Policy Identification Segment (loop 2110			
	Service Payment Information REF), if present.			
9	The diagnosis is inconsistent with the	N517	Resubmit a new claim with the requested	CO or PI
	patient's age. Note: Refer to the 835		information.	
	Healthcare Policy Identification Segment			
	(loop 2110 Service Payment Information			
9	REF), if present. The diagnosis is inconsistent with the	N657	This should be hilled with the enprepriets	CO or PI
7	patient's age. Note: Refer to the 835	11037	This should be billed with the appropriate code for these services.	COULL
	Healthcare Policy Identification Segment			
	(loop 2110 Service Payment Information			
10	REF), if present.	**		<u></u>
10	The diagnosis is inconsistent with the patient's gender. Note: Refer to the 835	N517	Resubmit a new claim with the requested information.	CO or PI
	Healthcare Policy Identification Segment		information.	
	(loop 2110 Service Payment Information			
	REF), if present.			
10	The diagnosis is inconsistent with the	N657	This should be billed with the appropriate	CO or PI
	patient's gender. Note: Refer to the 835		code for these services.	
	Healthcare Policy Identification Segment (loop 2110 Service Payment Information			
	REF), if present.			
11	The diagnosis is inconsistent with the	N657	This should be billed with the appropriate	CO or PI
	procedure. Note: Refer to the 835 Healthcare		code for these services.	
	Policy Identification Segment (loop 2110			
	Service Payment Information REF), if			

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

		Table	3-1	
	Scenario #2: Missing	/Invalid/Incomp	olete Data from Submitted Claim	
	situations where additional data is needed from th	e billing provide	er for missing or invalid data on the submitted clai	m, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	ASC X12 CAGC
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.	N657	This should be billed with the appropriate code for these services.	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
15	The authorization number is missing, invalid, or does not apply to the billed services or provider.	N596	Records reflect the injured party did not complete a Medical Authorization for this loss.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M20	Missing/incomplete/invalid HCPCS.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M21	Missing/incomplete/invalid place of residence for this service/item provided in a home.	CO or PI

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

D - 6 4-	v.	•	elete Data from Submitted Claim	
CARC	situations where additional data is needed from the CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M22	Missing/incomplete/invalid number of miles traveled.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M24	Missing/incomplete/invalid number of doses per vial.	CO or PI

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

D 6	v.	•	elete Data from Submitted Claim	92 5 D.0
CARC	situations where additional data is needed from the CARC Description ⁴	RARC	RARC Description ⁵	m, e.g., an 837 or D.0. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M44	Missing/incomplete/invalid condition code.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M45	Missing/incomplete/invalid occurrence code(s).	CO or PI

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

	situations where additional data is needed from the			m, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M46	Missing/incomplete/invalid occurrence span code(s).	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M47	Missing/incomplete/invalid internal or document control number.	CO or PI

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

Refers to	Scenario #2: Missin situations where additional data is needed from t		ete Data from Submitted Claim for missing or invalid data on the submitted clai	m, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M50	Missing/incomplete/invalid revenue code(s).	CO or PI

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

Refers to	Scenario #2: Missing. situations where additional data is needed from the	•	lete Data from Submitted Claim r for missing or invalid data on the submitted clai	m, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M51	Missing/incomplete/invalid procedure code(s).	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M52	Missing/incomplete/invalid "from" date(s) of service.	CO or PI

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

Refers to	Scenario #2: Missing situations where additional data is needed from the	•	lete Data from Submitted Claim r for missing or invalid data on the submitted clai	im, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M53	Missing/incomplete/invalid days or units of service.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M54	Missing/incomplete/invalid total charges.	CO or PI

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

D 0	v.	•	elete Data from Submitted Claim	02 5 D.0
CARC	situations where additional data is needed from the CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M56	Missing/incomplete/invalid payer identifier.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M59	Missing/incomplete/invalid "to" date(s) of service.	CO or PI

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

D.C.	v.	•	elete Data from Submitted Claim	. 925 D.O.
CARC	situations where additional data is needed from the CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M60	Missing Certificate of Medical Necessity.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M62	Missing/incomplete/invalid treatment authorization code.	CO or PI

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

	- Carlotte and the Carlotte	•	lete Data from Submitted Claim	
Refers to	situations where additional data is needed from the CARC Description ⁴	e billing provide	er for missing or invalid data on the submitted clain RARC Description ⁵	m, e.g., an 837 or D.0. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M64	Missing/incomplete/invalid other diagnosis.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M67	Missing/incomplete/invalid other procedure code(s).	CO or PI

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

Refers to	Scenario #2: Missing situations where additional data is needed from the	•	lete Data from Submitted Claim	im eg an 837 or D 0
CARC	CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M76	Missing/incomplete/invalid diagnosis or condition.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M77	Missing/incomplete/invalid place of service.	CO or PI

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

Refers to	situations where additional data is needed from the	e billing provide	er for missing or invalid data on the submitted claim	m, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M79	Missing/incomplete/invalid charge.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M81	You are required to code to the highest level of specificity.	CO or PI

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

Refers to	Scenario #2: Missing situations where additional data is needed from the	•	lete Data from Submitted Claim	im eg an 837 or D 0
CARC	CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M99	Missing/incomplete/invalid Universal Product Number/Serial Number.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC)	CO or PI

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

Refers to	Scenario #2: Missing situations where additional data is needed from th	•	lete Data from Submitted Claim r for missing or invalid data on the submitted clai	im, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M122	Missing/incomplete/invalid level of subluxation.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M123	Missing/incomplete/invalid name, strength, or dosage of the drug furnished.	CO or PI

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

D.C.	, and the second se	•	olete Data from Submitted Claim	925 D.O.
CARC	situations where additional data is needed from the CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M124	Missing indication of whether the patient owns the equipment that requires the part or supply.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M125	Missing/incomplete/invalid information on the period of time for which the service/supply/equipment will be needed.	CO or PI

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

Refers to	situations where additional data is needed from th	e billing provide	r for missing or invalid data on the submitted claim	m, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M126	Missing/incomplete/invalid individual lab codes included in the test.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M129	Missing/incomplete/invalid indicator of x-ray availability for review.	CO or PI

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

Refers to	Scenario #2: Missing/ situations where additional data is needed from the	•	lete Data from Submitted Claim	m. e.g., an 837 or D 0
CARC	CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M133	Claim did not identify who performed the purchased diagnostic test or the amount you were charged for the test.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M136	Missing/incomplete/invalid indication that the service was supervised or evaluated by a physician.	CO or PI

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

D.C.	<u> </u>	•	olete Data from Submitted Claim	925 D.O.
CARC	situations where additional data is needed from the CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	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
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA27	Missing/incomplete/invalid entitlement number or name shown on the claim.	CO or PI

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

Scenario #2: Missing/Invalid/Incomplete Data from Submitted Claim						
Refers to si	ituations where additional data is needed from the	billing provide		im, e.g., an 837 or D.0. ASC X12 CAGC		
16	CARC Description ⁴ 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy	MA30	RARC Description ⁵ Missing/incomplete/invalid type of bill.	CO or PI		
16	Identification Segment (loop 2110 Service Payment Information REF), if present. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service	MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.	CO or PI		

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

Dofons to		•	lete Data from Submitted Claim	im o a on 927 or D 0
CARC	situations where additional data is needed from the	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA32	Missing/incomplete/invalid number of covered days during the billing period.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA33	Missing/incomplete/invalid noncovered days during the billing period.	CO or PI

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

	Scenario #2: Missing	Table 3 /Invalid/Incomp	lete Data from Submitted Claim	
	situations where additional data is needed from the			
CARC	CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA34	Missing/incomplete/invalid number of coinsurance days during the billing period.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA35	Missing/incomplete/invalid number of lifetime reserve days.	CO or PI

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

Refers to	Scenario #2: Missing situations where additional data is needed from the	•	lete Data from Submitted Claim r for missing or invalid data on the submitted clai	im, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA36	Missing/incomplete/invalid patient name.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA37	Missing/incomplete/invalid patient's address.	CO or PI

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

Refers to	Scenario #2: Missing situations where additional data is needed from the	•	ete Data from Submitted Claim r for missing or invalid data on the submitted cla	im, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA39	Missing/incomplete/invalid gender.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA40	Missing/incomplete/invalid admission date.	CO or PI

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

Refers to	Scenario #2: Missing situations where additional data is needed from the	•	lete Data from Submitted Claim r for missing or invalid data on the submitted clai	m, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA41	Missing/incomplete/invalid admission type.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA42	Missing/incomplete/invalid admission source.	CO or PI

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

	situations where additional data is needed from th			im, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA43	Missing/incomplete/invalid patient status.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA48	Missing/incomplete/invalid name or address of responsible party or primary payer.	CO or PI

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

Refers to	situations where additional data is needed from the	•	lete Data from Submitted Claim r for missing or invalid data on the submitted clain	n, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA50	Missing/incomplete/invalid Investigational Device Exemption number for FDA-approved clinical trial services.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA53	Missing/incomplete/invalid Competitive Bidding Demonstration Project identification.	CO or PI

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

	Scenario #2: Missing/	/Invalid/Incomp	lete Data from Submitted Claim	
Refers to	situations where additional data is needed from the	e billing provide	r for missing or invalid data on the submitted c	laim, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	ASC X12 CAGO
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA58	Missing/incomplete/invalid release of information indicator.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA60	Missing/incomplete/invalid patient relationship to insured.	CO or PI

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

	v.	•	olete Data from Submitted Claim	
Refers to	situations where additional data is needed from the CARC Description ⁴	e billing provide	er for missing or invalid data on the submitted cla RARC Description ⁵	im, e.g., an 837 or D.0. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA61	Missing/incomplete/invalid social security number or health insurance claim number.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA63	Missing/incomplete/invalid principal diagnosis.	CO or PI

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

Refers to	situations where additional data is needed from the	e billing provide	er for missing or invalid data on the submitted claim	m, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	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
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA65	Missing/incomplete/invalid admitting diagnosis.	CO or PI

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

	v e e e e e e e e e e e e e e e e e e e	•	olete Data from Submitted Claim	
Refers to	situations where additional data is needed from the CARC Description ⁴	RARC	er for missing or invalid data on the submitted of RARC Description ⁵	elaim, e.g., an 837 or D.0. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA66	Missing/incomplete/invalid principal procedure code.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA69	Missing/incomplete/invalid remarks.	CO or PI

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

D 6	v.	•	olete Data from Submitted Claim	
CARC	situations where additional data is needed from the CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA70	Missing/incomplete/invalid provider representative signature.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA71	Missing/incomplete/invalid provider representative signature date.	CO or PI

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

Refers to	Scenario #2: Missin	•	ete Data from Submitted Claim	im, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA75	Missing/incomplete/invalid patient or authorized representative signature.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA76	Missing/incomplete/invalid provider identifier for home health agency or hospice when physician is performing care plan oversight services.	CO or PI

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

	g 1 1/2 3 27 1	Table 3		
Defens to	Scenario #2: Missing. Situations where additional data is needed from the	•	lete Data from Submitted Claim	n a g an 827 an D A
CARC	CARC Description ⁴	RARC	RARC Description ⁵	ASC X12 CAG
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA81	Missing/incomplete/invalid provider/supplier signature.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA83	Did not indicate whether we are the primary or secondary payer.	CO or PI

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

Refers to	situations where additional data is needed from the	e billing provide	r for missing or invalid data on the submitted claim	m, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA88	Missing/incomplete/invalid insured's address and/or telephone number for the primary payer.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA89	Missing/incomplete/invalid patient's relationship to the insured for the primary payer.	CO or PI

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

D 4		•	lete Data from Submitted Claim	
CARC	situations where additional data is needed from the	e billing provide	r for missing or invalid data on the submitted clair	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA90	Missing/incomplete/invalid employment status code for the primary insured.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA92	Missing plan information for other insurance.	CO or PI

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

	Scenario #2: Missing/	/Invalid/Incomp	lete Data from Submitted Claim	
	situations where additional data is needed from the	e billing provide	r for missing or invalid data on the submitted clain	n, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	ASC X12 CAGO
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	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
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA96	Claim rejected. Coded as a Medicare Managed Care Demonstration but patient is not enrolled in a Medicare managed care plan.	CO or PI

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

Refers to	Scenario #2: Missing/ situations where additional data is needed from the	•	lete Data from Submitted Claim r for missing or invalid data on the submitted cl	aim, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA97	Missing/incomplete/invalid Medicare Managed Care Demonstration contract number or clinical trial registry number.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA99	Missing/incomplete/invalid Medigap information.	CO or PI

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

Refers to	situations where additional data is needed from the	he billing provider	for missing or invalid data on the submitted clai	m, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA100	Missing/incomplete/invalid date of current illness or symptoms.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	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

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

	Scenario #2: Missing	/Invalid/Incompl	ete Data from Submitted Claim	
	situations where additional data is needed from the	e billing provider	for missing or invalid data on the submitted clair	n, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	ASC X12 CAGO
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA111	Missing/incomplete/invalid purchase price of the test(s) and/or the performing laboratory's name and address.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA112	Missing/incomplete/invalid group practice information.	CO or PI

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

Defere to	Scenario #2: Missing/ situations where additional data is needed from the	•	lete Data from Submitted Claim	n o g on 837 or D 0
CARC	CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	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
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA114	Missing/incomplete/invalid information on where the services were furnished.	CO or PI

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

D 6	- Carlotte and the Carlotte	•	elete Data from Submitted Claim	02 5 D.0
CARC	situations where additional data is needed from the CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	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
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	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

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

	Scenario #2: Missing	/Invalid/Incomp	elete Data from Submitted Claim	
	situations where additional data is needed from the			
CARC	CARC Description ⁴	RARC	RARC Description ⁵	ASC X12 CAGO
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA120	Missing/incomplete/invalid CLIA certification number.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA121	Missing/incomplete/invalid x-ray date.	CO or PI

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

	e de la companya de	•	ete Data from Submitted Claim	
Refers to	situations where additional data is needed from the CARC Description ⁴	e billing provider	r for missing or invalid data on the submitted clain RARC Description ⁵	m, e.g., an 837 or D.0. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA122	Missing/incomplete/invalid initial treatment date.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA128	Missing/incomplete/invalid FDA approval number.	CO or PI

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

Refers to	situations where additional data is needed from the	•	lete Data from Submitted Claim r for missing or invalid data on the submitted clain	m, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	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
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA134	Missing/incomplete/invalid provider number of the facility where the patient resides.	CO or PI

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

CARC	CARC Description ⁴	RARC	r for missing or invalid data on the submitted claim RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N4	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	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

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

Refers to	Scenario #2: Missing situations where additional data is needed from the	•	lete Data from Submitted Claim r for missing or invalid data on the submitted c	laim, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N20	Service not payable with other service rendered on the same date.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N27	Missing/incomplete/invalid treatment number.	CO or PI

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

Refers to	Scenario #2: Missing. situations where additional data is needed from the	•	lete Data from Submitted Claim r for missing or invalid data on the submitted clai	m, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N31	Missing/incomplete/invalid prescribing provider identifier.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N32	Claim must be submitted by the provider who rendered the service.	CO or PI

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

T	v.	•	elete Data from Submitted Claim	02 5 D.0
CARC	situations where additional data is needed from the CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N34	Incorrect claim form/format for this service.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N37	Missing/incomplete/invalid tooth number/letter.	CO or PI

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

	situations where additional data is needed from th	e billing provide	r for missing or invalid data on the submitted claim	m, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N39	Procedure code is not compatible with tooth number/letter.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N46	Missing/incomplete/invalid admission hour.	CO or PI

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

	<u> </u>	•	lete Data from Submitted Claim	
Refers to	situations where additional data is needed from the CARC Description ⁴	e billing provide	r for missing or invalid data on the submitted cla RARC Description ⁵	im, e.g., an 837 or D.0. ASC X12 CAGO
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N48	Claim information does not agree with information received from other insurance carrier.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N50	Missing/incomplete/invalid discharge information.	CO or PI

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

	situations where additional data is needed from the			
16	CARC Description ⁴ 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N53	Missing/incomplete/invalid point of pick-up address.	ASC X12 CAGO
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N54	Claim information is inconsistent with precertified/authorized services.	CO or PI

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

	v.	•	olete Data from Submitted Claim	
Refers to	situations where additional data is needed from the CARC Description ⁴	RARC	er for missing or invalid data on the submitted clair RARC Description ⁵	n, e.g., an 837 or D.0. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N57	Missing/incomplete/invalid prescribing date.	CO or PI

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

	v.	•	lete Data from Submitted Claim	
Refers to CARC	situations where additional data is needed from the CARC Description ⁴	e billing provide	er for missing or invalid data on the submitted clai	m, e.g., an 837 or D.0. ASC X12 CAGO
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N58	Missing/incomplete/invalid patient liability amount.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N62	Dates of service span multiple rate periods. Resubmit separate claims.	CO or PI

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

	v e e e e e e e e e e e e e e e e e e e	•	olete Data from Submitted Claim	
Refers to	situations where additional data is needed from the CARC Description ⁴	RARC	er for missing or invalid data on the submitted clair RARC Description ⁵	m, e.g., an 837 or D.0. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N63	Rebill services on separate claim lines.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N64	The "from" and "to" dates must be different.	CO or PI

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

Refers to	Scenario #2: Missing/ situations where additional data is needed from the	•	lete Data from Submitted Claim r for missing or invalid data on the submitted clai	m, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N65	Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N75	Missing/incomplete/invalid tooth surface information.	CO or PI

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

Refers to	situations where additional data is needed from the	•	lete Data from Submitted Claim r for missing or invalid data on the submitted clair	n, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N76	Missing/incomplete/invalid number of riders.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N77	Missing/incomplete/invalid designated provider number.	CO or PI

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

	Scenario #2: Missing/	/Invalid/Incomp	lete Data from Submitted Claim	
Refers to	Situations where additional data is needed from the CARC Description ⁴	e billing provide	er for missing or invalid data on the submitted clain RARC Description ⁵	n, e.g., an 837 or D.0. ASC X12 CAGO
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N80	Missing/incomplete/invalid prenatal screening information.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	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

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

Refers to	situations where additional data is needed from th	e billing provide	r for missing or invalid data on the submitted cla	im, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N148	Missing/incomplete/invalid date of last menstrual period.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N150	Missing/incomplete/invalid model number.	CO or PI

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

Refers to	situations where additional data is needed from the	•	elete Data from Submitted Claim or for missing or invalid data on the submitted clai	m, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N152	Missing/incomplete/invalid replacement claim information.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N153	Missing/incomplete/invalid room and board rate.	CO or PI

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

Refers to	situations where additional data is needed from the	•	lete Data from Submitted Claim r for missing or invalid data on the submitted clair	n, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	ASC X12 CAGO
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N161	This drug/service/supply is covered only when the associated service is covered.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N182	This claim/service must be billed according to the schedule for this plan.	CO or PI

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

Refers to	e de la companya de	•	olete Data from Submitted Claim er for missing or invalid data on the submitted clair	n, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N188	The approved level of care does not match the procedure code submitted.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N190	Missing contract indicator.	CO or PI

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

	v.	•	olete Data from Submitted Claim	
Refers to	situations where additional data is needed from the CARC Description ⁴	RARC	er for missing or invalid data on the submitted cl RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N203	Missing/incomplete/invalid anesthesia time/units.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N207	Missing/incomplete/invalid weight.	CO or PI

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

	Scenario #2: Missing	/Invalid/Incomp	elete Data from Submitted Claim	
	situations where additional data is needed from the	e billing provide	r for missing or invalid data on the submitted cl	aim, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	ASC X12 CAGO
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N208	Missing/incomplete/invalid DRG code.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N209	Missing/incomplete/invalid taxpayer identification number (TIN).	CO or PI

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

Refere to	Scenario #2: Missing situations where additional data is needed from the	•	ete Data from Submitted Claim	im a g an 837 or D o
CARC	CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N213	Missing/incomplete/invalid facility/discrete unit DRG/DRG exempt status information.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N229	Incomplete/invalid contract indicator.	CO or PI

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

	Scenario #2: Missing/	/Invalid/Incomp	elete Data from Submitted Claim	
	situations where additional data is needed from the	e billing provide	er for missing or invalid data on the submitted clair	n, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	ASC X12 CAGO
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N230	Incomplete/invalid indication of whether the patient owns the equipment that requires the part or supply.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N245	Incomplete/invalid plan information for other insurance.	CO or PI

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

Refers to	Scenario #2: Missing situations where additional data is needed from the	•	lete Data from Submitted Claim r for missing or invalid data on the submitted clain	n, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N247	Missing/incomplete/invalid assistant surgeon taxonomy.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N248	Missing/incomplete/invalid assistant surgeon name.	CO or PI

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

Refers to	Scenario #2: Missing situations where additional data is needed from the	•	lete Data from Submitted Claim r for missing or invalid data on the submitted clair	n, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N249	Missing/incomplete/invalid assistant surgeon primary identifier.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N250	Missing/incomplete/invalid assistant surgeon secondary identifier.	CO or PI

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

D 6	v.	•	olete Data from Submitted Claim	
Refers to	situations where additional data is needed from the CARC Description ⁴	RARC	er for missing or invalid data on the submitted c	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N251	Missing/incomplete/invalid attending provider taxonomy.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N252	Missing/incomplete/invalid attending provider name.	CO or PI

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

Refers to	situations where additional data is needed from the	e billing provide	er for missing or invalid data on the submitted o	laim, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N253	Missing/incomplete/invalid attending provider primary identifier.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N254	Missing/incomplete/invalid attending provider secondary identifier.	CO or PI

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

Refers to	situations where additional data is needed from the	e billing provide	er for missing or invalid data on the submitted clai	m, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	ASC X12 CAGO
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N255	Missing/incomplete/invalid billing provider taxonomy.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N256	Missing/incomplete/invalid billing provider/supplier name.	CO or PI

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

	Scenario #2: Missing/	/Invalid/Incomp	lete Data from Submitted Claim	
Refers to	situations where additional data is needed from the	e billing provide	er 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 CAGO
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N257	Missing/incomplete/invalid billing provider/supplier primary identifier.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N258	Missing/incomplete/invalid billing provider/supplier address.	CO or PI

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

	v.	•	olete Data from Submitted Claim	
Refers to	situations where additional data is needed from the CARC Description ⁴	RARC	er for missing or invalid data on the submitted c RARC Description ⁵	laim, e.g., an 837 or D.0. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N259	Missing/incomplete/invalid billing provider/supplier secondary identifier.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N260	Missing/incomplete/invalid billing provider/supplier contact information.	CO or PI

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

Refers to	Scenario #2: Missing situations where additional data is needed from the	•	lete Data from Submitted Claim r for missing or invalid data on the submitted c	laim, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N261	Missing/incomplete/invalid operating provider name.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N262	Missing/incomplete/invalid operating provider primary identifier.	CO or PI

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

D 6	v.	•	elete Data from Submitted Claim	02 5 D.0
CARC	situations where additional data is needed from the CARC Description ⁴	RARC	er for missing or invalid data on the submitted clair RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N263	Missing/incomplete/invalid operating provider secondary identifier.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N264	Missing/incomplete/invalid ordering provider name.	CO or PI

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

Refers to	situations where additional data is needed from th	e billing provide	r for missing or invalid data on the submitted clain	n, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N265	Missing/incomplete/invalid ordering provider primary identifier.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N266	Missing/incomplete/invalid ordering provider address.	CO or PI

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

D 6	v.	•	elete Data from Submitted Claim	02 5 D.0
Refers to CARC	situations where additional data is needed from the CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N267	Missing/incomplete/invalid ordering provider secondary identifier.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N268	Missing/incomplete/invalid ordering provider contact information.	CO or PI

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

Refers to	Scenario #2: Missing situations where additional data is needed from the	•	lete Data from Submitted Claim r for missing or invalid data on the submitted cla	im, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N269	Missing/incomplete/invalid other provider name.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N270	Missing/incomplete/invalid other provider primary identifier.	CO or PI

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

	v.	•	elete Data from Submitted Claim	
Refers to	situations where additional data is needed from the CARC Description ⁴	e billing provide	er for missing or invalid data on the submitted class	im, e.g., an 837 or D.0. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N271	Missing/incomplete/invalid other provider secondary identifier.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N272	Missing/incomplete/invalid other payer attending provider identifier.	CO or PI

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

D 0	v.	•	elete Data from Submitted Claim	02 5 D.0
CARC	situations where additional data is needed from the CARC Description ⁴	RARC	er for missing or invalid data on the submitted clair RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N273	Missing/incomplete/invalid other payer operating provider identifier.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N274	Missing/incomplete/invalid other payer other provider identifier.	CO or PI

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

	Scenario #2: Missing/	/Invalid/Incomp	lete Data from Submitted Claim	
Refers to	situations where additional data is needed from the	e billing provide	r for missing or invalid data on the submitted cl	aim, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	ASC X12 CAGO
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N275	Missing/incomplete/invalid other payer purchased service provider identifier.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N276	Missing/incomplete/invalid other payer referring provider identifier.	CO or PI

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

Refers to	Scenario #2: Missing	•	lete Data from Submitted Claim r for missing or invalid data on the submitted cl	aim, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N277	Missing/incomplete/invalid other payer rendering provider identifier.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N278	Missing/incomplete/invalid other payer service facility provider identifier.	CO or PI

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

	Scenario #2: Missing/	Table 3 Invalid/Incomp	olete Data from Submitted Claim	
Refers to	situations where additional data is needed from the	billing provide	er for missing or invalid data on the submitted claim	m, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N279	Missing/incomplete/invalid pay-to provider name.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N280	Missing/incomplete/invalid pay-to provider primary identifier.	CO or PI

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

Refers to	Scenario #2: Missing situations where additional data is needed from the	•	lete Data from Submitted Claim r for missing or invalid data on the submitted clai	im, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N281	Missing/incomplete/invalid pay-to provider address.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N282	Missing/incomplete/invalid pay-to provider secondary identifier.	CO or PI

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

Refers to	situations where additional data is needed from th	ne billing provide	r for missing or invalid data on the submitted claim	m, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N283	Missing/incomplete/invalid purchased service provider identifier.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N284	Missing/incomplete/invalid referring provider taxonomy.	CO or PI

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

	- The state of the	•	lete Data from Submitted Claim	
Refers to	situations where additional data is needed from the CARC Description ⁴	e billing provide	er for missing or invalid data on the submitted claim RARC Description ⁵	n, e.g., an 837 or D.0. ASC X12 CAGO
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N285	Missing/incomplete/invalid referring provider name.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N286	Missing/incomplete/invalid referring provider primary identifier.	CO or PI

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

Refers to	Scenario #2: Missing	•	lete Data from Submitted Claim r for missing or invalid data on the submitted clair	n, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N287	Missing/incomplete/invalid referring provider secondary identifier.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N288	Missing/incomplete/invalid rendering provider taxonomy.	CO or PI

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

	situations where additional data is needed from the			-
CARC	CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N289	Missing/incomplete/invalid rendering provider name.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N290	Missing/incomplete/invalid rendering provider primary identifier.	CO or PI

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

Refers to	Scenario #2: Missin situations where additional data is needed from t		ete Data from Submitted Claim for missing or invalid data on the submitted cla	im, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N291	Missing/incomplete/invalid rendering provider secondary identifier.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N292	Missing/incomplete/invalid service facility name.	CO or PI

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

	Scenario #2: Missing/	/Invalid/Incomp	elete Data from Submitted Claim	
	situations where additional data is needed from the			
CARC	CARC Description ⁴	RARC	RARC Description ⁵	ASC X12 CAGO
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N293	Missing/incomplete/invalid service facility primary identifier.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N294	Missing/incomplete/invalid service facility primary address.	CO or PI

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

D 0	v.	•	elete Data from Submitted Claim	
CARC	situations where additional data is needed from the CARC Description ⁴	RARC	er for missing or invalid data on the submitted clair	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N295	Missing/incomplete/invalid service facility secondary identifier.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N296	Missing/incomplete/invalid supervising provider name.	CO or PI

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

.	v.	•	olete Data from Submitted Claim	
Refers to	situations where additional data is needed from the CARC Description ⁴	RARC	er for missing or invalid data on the submitted cla RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N297	Missing/incomplete/invalid supervising provider primary identifier.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N298	Missing/incomplete/invalid supervising provider secondary identifier.	CO or PI

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

Refers to	Scenario #2: Missing situations where additional data is needed from the	•	lete Data from Submitted Claim r for missing or invalid data on the submitted clai	im, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N299	Missing/incomplete/invalid occurrence date(s).	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N300	Missing/incomplete/invalid occurrence span date(s).	CO or PI

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

- ·	v.	•	lete Data from Submitted Claim	
Refers to CARC	situations where additional data is needed from the CARC Description ⁴	RARC	r for missing or invalid data on the submitted clain RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N301	Missing/incomplete/invalid procedure date(s).	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N302	Missing/incomplete/invalid other procedure date(s).	CO or PI

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

	Scenario #2: Missing/	/Invalid/Incomp	elete Data from Submitted Claim	
	situations where additional data is needed from the	e billing provide		im, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	ASC X12 CAGO
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N303	Missing/incomplete/invalid principal procedure date.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N304	Missing/incomplete/invalid dispensed date.	CO or PI

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

Refers to	Scenario #2: Missing situations where additional data is needed from the	•	lete Data from Submitted Claim r for missing or invalid data on the submitted cla	nim, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N305	Missing/incomplete/invalid accident date.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N306	Missing/incomplete/invalid acute manifestation date.	CO or PI

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

Refers to	situations where additional data is needed from the	•	olete Data from Submitted Claim er for missing or invalid data on the submitted clai	im, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N307	Missing/incomplete/invalid adjudication or payment date.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N308	Missing/incomplete/invalid appliance placement date.	CO or PI

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

Refers to	Scenario #2: Missing situations where additional data is needed from the	•	ete Data from Submitted Claim r for missing or invalid data on the submitted clai	m, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N309	Missing/incomplete/invalid assessment date.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N310	Missing/incomplete/invalid assumed or relinquished care date.	CO or PI

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

Refers to	Scenario #2: Missing situations where additional data is needed from the	•	lete Data from Submitted Claim r for missing or invalid data on the submitted cla	im, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N312	Missing/incomplete/invalid begin therapy date.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N313	Missing/incomplete/invalid certification revision date.	CO or PI

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

	- Carlotte and the Carlotte	•	olete Data from Submitted Claim	
Refers to	situations where additional data is needed from the CARC Description ⁴	RARC	er for missing or invalid data on the submitted clai	m, e.g., an 837 or D.0. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N314	Missing/incomplete/invalid diagnosis date.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N317	Missing/incomplete/invalid discharge hour.	CO or PI

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

	Scenario #2: Missing/	/Invalid/Incomp	lete Data from Submitted Claim	
Refers to	situations where additional data is needed from the CARC Description ⁴	e billing provide	r for missing or invalid data on the submitted clair RARC Description ⁵	n, e.g., an 837 or D.0. ASC X12 CAGO
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N318	Missing/incomplete/invalid discharge or end of care date.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N319	Missing/incomplete/invalid hearing or vision prescription date.	CO or PI

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

Refers to	Scenario #2: Missing situations where additional data is needed from the	•	lete Data from Submitted Claim	aim, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N320	Missing/incomplete/invalid Home Health Certification Period.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N321	Missing/incomplete/invalid last admission period.	CO or PI

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

Refers to	Scenario #2: Missing situations where additional data is needed from th	•	lete Data from Submitted Claim	m eg an 837 or D 0
CARC	CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N322	Missing/incomplete/invalid last certification date.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N323	Missing/incomplete/invalid last contact date.	CO or PI

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

Refers to	Scenario #2: Missing situations where additional data is needed from the	•	lete Data from Submitted Claim r for missing or invalid data on the submitted clai	im, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N324	Missing/incomplete/invalid last seen/visit date.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N325	Missing/incomplete/invalid last worked date.	CO or PI

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

	v.	•	olete Data from Submitted Claim	
Refers to	situations where additional data is needed from the CARC Description ⁴	RARC	er for missing or invalid data on the submitted clair	im, e.g., an 837 or D.0. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N326	Missing/incomplete/invalid last x-ray date.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N327	Missing/incomplete/invalid other insured birth date.	CO or PI

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

Refers to	Scenario #2: Missing situations where additional data is needed from the	•	lete Data from Submitted Claim	im eg an 837 or D 0
CARC	CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N328	Missing/incomplete/invalid Oxygen Saturation Test date.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N329	Missing/incomplete/invalid patient birth date.	CO or PI

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

Refers to	Scenario #2: Missing situations where additional data is needed from the	•	lete Data from Submitted Claim	im, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N330	Missing/incomplete/invalid patient death date.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N331	Missing/incomplete/invalid physician order date.	CO or PI

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

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CARC	situations where additional data is needed from the CARC Description ⁴	RARC	er for missing or invalid data on the submitted clair RARC Description ⁵	m, e.g., an 837 or D.0. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N332	Missing/incomplete/invalid prior hospital discharge date.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N333	Missing/incomplete/invalid prior placement date.	CO or PI

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

Refers to	Scenario #2: Missing situations where additional data is needed from the	•	lete Data from Submitted Claim r for missing or invalid data on the submitted cla	aim, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N334	Missing/incomplete/invalid re-evaluation date.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N335	Missing/incomplete/invalid referral date.	CO or PI

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

Refers to	Scenario #2: Missing situations where additional data is needed from the	•	lete Data from Submitted Claim r for missing or invalid data on the submitted clair	n, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N336	Missing/incomplete/invalid replacement date.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N337	Missing/incomplete/invalid secondary diagnosis date.	CO or PI

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

	Scenario #2: Missing.	/Invalid/Incomp	lete Data from Submitted Claim	
	situations where additional data is needed from the	e billing provide	er for missing or invalid data on the submitted claim	n, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	ASC X12 CAGO
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N338	Missing/incomplete/invalid shipped date.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N339	Missing/incomplete/invalid similar illness or symptom date.	CO or PI

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

	v e e e e e e e e e e e e e e e e e e e	•	olete Data from Submitted Claim	
Refers to	situations where additional data is needed from the CARC Description ⁴	e billing provide	er for missing or invalid data on the submitted clain RARC Description ⁵	m, e.g., an 837 or D.0. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N340	Missing/incomplete/invalid subscriber birth date.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N341	Missing/incomplete/invalid surgery date.	CO or PI

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

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CARC	situations where additional data is needed from the CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N342	Missing/incomplete/invalid test performed date.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N343	Missing/incomplete/invalid Transcutaneous Electrical Nerve Stimulator (TENS) trial start date.	CO or PI

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

Refers to	Scenario #2: Missing/ situations where additional data is needed from the	•	lete Data from Submitted Claim r for missing or invalid data on the submitted clair	m, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N344	Missing/incomplete/invalid Transcutaneous Electrical Nerve Stimulator (TENS) trial end date.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N345	Date range not valid with units submitted.	CO or PI

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

Refers to	situations where additional data is needed from the	e billing provide	er for missing or invalid data on the submitted clair	n, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	ASC X12 CAGO
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N346	Missing/incomplete/invalid oral cavity designation code.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N349	The administration method and drug must be reported to adjudicate this service.	CO or PI

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

Refers to		•	olete Data from Submitted Claim er for missing or invalid data on the submitted clain	n, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N350	Missing/incomplete/invalid description of service for a Not Otherwise Classified (NOC) code or for an Unlisted/By Report procedure.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N359	Missing/incomplete/invalid height.	CO or PI

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

Refers to	Scenario #2: Missing situations where additional data is needed from the	•	lete Data from Submitted Claim r for missing or invalid data on the submitted clai	im, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N378	Missing/incomplete/invalid prescription quantity.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N382	Missing/incomplete/invalid patient identifier.	CO or PI

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

- ·	v e e e e e e e e e e e e e e e e e e e	•	olete Data from Submitted Claim	
Refers to	situations where additional data is needed from the CARC Description ⁴	RARC	er for missing or invalid data on the submitted cla RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N388	Missing/incomplete/invalid prescription number.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N418	Misrouted claim. See the payer's claim submission instructions.	CO or PI

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

Refers to	Scenario #2: Missing	•	ete Data from Submitted Claim	m, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N433	Resubmit this claim using only your National Provider Identifier (NPI).	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N434	Missing/Incomplete/Invalid Present on Admission indicator.	CO or PI

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

Refers to	Scenario #2: Missing situations where additional data is needed from the	•	lete Data from Submitted Claim r for missing or invalid data on the submitted clai	im, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N439	Missing anesthesia physical status report/indicators.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N440	Incomplete/invalid anesthesia physical status report/indicators.	CO or PI

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

	v.	•	olete Data from Submitted Claim	
Refers to	situations where additional data is needed from the CARC Description ⁴	RARC	er for missing or invalid data on the submitted cla RARC Description ⁵	aim, e.g., an 837 or D.0. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N443	Missing/incomplete/invalid total time or begin/end time.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N471	Missing/incomplete/invalid HIPPS Rate Code.	CO or PI

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

.	, and the second se	•	olete Data from Submitted Claim	
Refers to	situations where additional data is needed from the CARC Description ⁴	RARC	er for missing or invalid data on the submitted clai	im, e.g., an 837 or D.0. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N479	Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N480	Incomplete/invalid Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).	CO or PI

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

Refers to	Scenario #2: Missing/ situations where additional data is needed from the	•	lete Data from Submitted Claim r for missing or invalid data on the submitted cla	im, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N521	Mismatch between the submitted provider information and the provider information stored in our system.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N547	A refund request (Frequency Type Code 8) was processed previously.	CO or PI

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

D - 6 4-	, and the second se	•	olete Data from Submitted Claim	
CARC	situations where additional data is needed from the CARC Description ⁴	RARC	RARC Description ⁵	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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N554	Missing/Incomplete/Invalid Family Planning Indicator.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N562	The provider number of your incoming claim does not match the provider number on the processed Notice of Admission (NOA) for this bundled payment.	CO or PI

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

	, and the second se	•	olete Data from Submitted Claim	
Refers to	situations where additional data is needed from the CARC Description ⁴	RARC	er for missing or invalid data on the submitted clair RARC Description ⁵	m, e.g., an 837 or D.0. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N575	Mismatch between the submitted ordering/referring provider name and the ordering/referring provider name stored in our records.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N595	Records reflect the injured party did not complete an Assignment of Benefits for this loss.	CO or PI

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

	, and the second se	•	olete Data from Submitted Claim	
Refers to	situations where additional data is needed from the CARC Description ⁴	RARC	er for missing or invalid data on the submitted cla RARC Description ⁵	im, e.g., an 837 or D.0. 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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N596	Records reflect the injured party did not complete a Medical Authorization for this loss.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N625	Missing/Incomplete/Invalid Workers' Compensation Claim Number.	CO or PI

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

	Sagnaria #2: Missing	Table 3	elete Data from Submitted Claim	
Refers to	situations where additional data is needed from the			uim eg an 837 or D 0
CARC	CARC Description ⁴	RARC	RARC Description ⁵	ASC X12 CAGO
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N653	The date of injury does not match the reported date of loss.	CO or PI
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.) This change effective 11/1/2013: Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N657	This should be billed with the appropriate code for these services.	CO or PI
18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	N522	Duplicate of a claim processed, or to be processed, as a crossover claim.	OA or CO
69	Day outlier amount.		†	CO or PI
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.	N622	Not covered based on the date of injury/accident.	CO or PI

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

		Table	3-1	
	Scenario #2: Missing	/Invalid/Incom	plete Data from Submitted Claim	
Refers to	situations where additional data is needed from th	e billing provid	er for missing or invalid data on the submitted claim	n, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	ASC X12 CAGO
129	Prior processing information appears	MA36	Missing/incomplete/invalid patient name.	CO or PI
	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.)			
129	Prior processing information appears	N48	Claim information does not agree with	CO or PI
	incorrect. At least one Remark Code must be		information received from other insurance	
	provided (may be comprised of either the		carrier.	
	NCPDP Reject Reason Code, or Remittance			
	Advice Remark Code that is not an ALERT.)			
140	Patient/Insured health identification number		1	CO or PI
	and name do not match.			
146	Diagnosis was invalid for the date(s) of service reported.	M64	Missing/incomplete/invalid other diagnosis.	CO or PI
146	Diagnosis was invalid for the date(s) of service reported.	M76	Missing/incomplete/invalid diagnosis or condition.	CO or PI
146	Diagnosis was invalid for the date(s) of	MA63	Missing/incomplete/invalid principal	CO or PI
	service reported.		diagnosis.	
146	Diagnosis was invalid for the date(s) of	MA65	Missing/incomplete/invalid admitting	CO or PI
	service reported.		diagnosis.	
146	Diagnosis was invalid for the date(s) of	N517	Resubmit a new claim with the requested	CO or PI
	service reported.		information.	
146	Diagnosis was invalid for the date(s) of	N657	This should be billed with the appropriate	CO or PI
175	service reported. Prescription is incomplete.	N592	code for these services. Adjusted because this is not the initial	CO or PI
175	rescription is incomplete.	11372	prescription or exceeds the amount allowed	CO 0111
			for the initial prescription.	
175	Prescription is incomplete.	N668	Incomplete/invalid prescription	CO or PI
181	Procedure code was invalid on the date of	M20	Missing/incomplete/invalid HCPCS.	CO or PI
101	service.	1.120	missing meomplete, invalid from est.	00 0111
181	Procedure code was invalid on the date of	N517	Resubmit a new claim with the requested	CO or PI
	service.		information.	
181	Procedure code was invalid on the date of	N657	This should be billed with the appropriate	CO or PI
	service.		code for these services.	
182	Procedure modifier was invalid on the date of	N517	Resubmit a new claim with the requested	CO or PI
102	service.	Nota	information.	CO N
182	Procedure modifier was invalid on the date of service.	N657	This should be billed with the appropriate code for these services.	CO or PI
183	The referring provider is not eligible to refer	N574	Our records indicate the ordering/referring	CO or PI
-	the service billed. Note: Refer to the 835		provider is of a type/specialty that cannot	
	Healthcare Policy Identification Segment		order or refer. Please verify that the claim	
	(loop 2110 Service Payment Information		ordering/referring provider information is	
	REF), if present.		accurate or contact the ordering/referring	
			provider.	
183	The referring provider is not eligible to refer	N630	Referral not authorized by attending physician	CO, PI or PR
	the service billed. Note: Refer to the 835		, a gr ,	,
	Healthcare Policy Identification Segment			
	(loop 2110 Service Payment Information			
	REF), if present.			

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

		Table :		
			elete Data from Submitted Claim	
			er for missing or invalid data on the submitted clair	
CARC	CARC Description ⁴	RARC	RARC Description ⁵	ASC X12 CAGO
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.	N574	Our records indicate the ordering/referring provider is of a type/specialty that cannot order or refer. Please verify that the claim ordering/referring provider information is accurate or contact the ordering/referring provider.	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
189	'Not otherwise classified' or 'unlisted' procedure code (CPT/HCPCS) was billed when there is a specific procedure code for this procedure/service.	N657	This should be billed with the appropriate code for these services.	CO or PI
199	Revenue code and Procedure code do not match.	N657	This should be billed with the appropriate code for these services.	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
207	National Provider identifier - Invalid format.	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 or workers compensation state regulations/ fee schedule requirements.	N644	Reimbursement has been made according to the bilateral procedure rule.	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 or workers compensation state regulations/ fee schedule requirements.	N657	This should be billed with the appropriate code for these services.	CO or PI
240	The diagnosis is inconsistent with the patient's birth weight. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M76	Missing/incomplete/invalid diagnosis or condition.	CO or PI
240	The diagnosis is inconsistent with the patient's birth weight. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA63	Missing/incomplete/invalid principal diagnosis.	CO or PI

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

		Table	3-1				
Refers to	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			
240	The diagnosis is inconsistent with the patient's birth weight. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N207	Missing/incomplete/invalid weight.	CO or PI			
240	The diagnosis is inconsistent with the patient's birth weight. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N657	This should be billed with the appropriate code for these services.	CO or PI			
A8	Ungroupable DRG.	N647	Adjusted based on diagnosis-related group (DRG).	CO or PI			
A8	Ungroupable DRG.	N657	This should be billed with the appropriate code for these services.	CO or PI			

⁴Washington Publishing Company: http://www.wpc-edi.com/reference/

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⁵Washington Publishing Company: http://www.wpc-edi.com/reference/

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

		Table	4-1	
	Scenario #3: B	illed Service No	ot Covered by Health Plan	
	Refers to situations wher	e the billed serv	rice 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
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.	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
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.	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
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.	N129	Not eligible due to the patient's age.	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.	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
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.	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

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

		Table		
			ot Covered by Health Plan	
G1.F.~			rice is not covered by the health plan.	
CARC	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGO
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.	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
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.	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
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.	N598	Health care policy coverage is primary.	CO, PI or PR
23	The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)			OA
26	Expenses incurred prior to coverage.	N30	Patient ineligible for this service.	CO, PI or PR
26	Expenses incurred prior to coverage.	N52	Patient not enrolled in the billing provider's managed care plan on the date of service.	CO, PI or PR
26	Expenses incurred prior to coverage.	N128	This amount represents the prior to coverage portion of the allowance.	CO, PI or PR
26	Expenses incurred prior to coverage.	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
26	Expenses incurred prior to coverage.	N622	Not covered based on the date of injury/accident.	CO, PI or PR
26	Expenses incurred prior to coverage.	N650	This policy was not in effect for this date of loss. No coverage is available.	CO, PI or PR
26	Expenses incurred prior to coverage.	N652	The date of service is before the date of loss.	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
27	Expenses incurred after coverage terminated.	N30	Patient ineligible for this service.	CO, PI or PR
27	Expenses incurred after coverage terminated.	N45	Payment based on authorized amount.	CO, PI or PR

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

		Table	4-1	
	Scenario #3: B	Billed Service No	ot Covered by Health Plan	
	Refers to situations when	e the billed serv	ice is not covered by the health plan.	
CARC	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGC
27	Expenses incurred after coverage terminated.	N52	Patient not enrolled in the billing provider's managed care plan on the date of service.	CO, PI or PR
27	Expenses incurred after coverage terminated.	N381	Consult our contractual agreement for restrictions/billing/payment information related to these charges.	CO, PI or PR
27	Expenses incurred after coverage terminated.	N418	Misrouted claim. See the payer's claim submission instructions.	CO, PI or PR
27	Expenses incurred after coverage terminated.	N619	Coverage terminated for non-payment of premium.	CO, PI or PR
27	Expenses incurred after coverage terminated.	N622	Not covered based on the date of injury/accident.	CO, PI or PR
27	Expenses incurred after coverage terminated.	N650	This policy was not in effect for this date of loss. No coverage is available.	CO, PI or PR
29	The time limit for filing has expired.	N30	Patient ineligible for this service.	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
32	Our records indicate that this dependent is not an eligible dependent as defined.	N52	Patient not enrolled in the billing provider's managed care plan on the date of service.	CO, PI or PR
32	Our records indicate that this dependent is not an eligible dependent as defined.	N129	Not eligible due to the patient's age.	CO, PI or PR
33	Insured has no dependent coverage.	N578	Coverages do not apply to this loss.	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
35	Lifetime benefit maximum has been reached.	N587	Policy benefits have been exhausted.	CO, PI or PR
39	Services denied at the time authorization/pre- certification was requested.	N627	Service not payable per managed care contract.	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.	N627	Service not payable per managed care contract.	CO, PI or PR

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Tab 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	
		ere the billed servi	ce is not covered by the health plan.	
CARC	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGC
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. This change effective 11/1/2013: This is a non-covered service because it is a routine/preventive exam or a diagnostic/screening procedure done in conjunction with a routine/preventive exam. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO 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. This change effective 11/1/2013: This is a non-covered service because it is a routine/preventive exam or a diagnostic/screening procedure done in conjunction with a routine/preventive exam. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	CO 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. This change effective 11/1/2013: This is a non-covered service because it is a routine/preventive exam or a diagnostic/screening procedure done in conjunction with a routine/preventive exam. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N390	This service/report cannot be billed separately.	CO or PR

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Tab 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 who	ere the billed servi	ce is not covered by the health plan.	
CARC	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGC
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. This change effective 11/1/2013: This is a non-covered service because it is a routine/preventive exam or a diagnostic/screening procedure done in conjunction with a routine/preventive exam. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N427	Payment for eyeglasses or contact lenses can be made only after cataract surgery.	CO 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. This change effective 11/1/2013: This is a non-covered service because it is a routine/preventive exam or a diagnostic/screening procedure done in conjunction with a routine/preventive exam. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N429	Not covered when considered routine.	CO 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. This change effective 11/1/2013: This is a non-covered service because it is a routine/preventive exam or a diagnostic/screening procedure done in conjunction with a routine/preventive exam. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N567	Not covered when considered preventative.	CO, PI or PR

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

		Table 4	4-1	
	Scenario #3: B	Billed Service No	ot Covered by Health Plan	
	Refers to situations wher	e the billed serv	ice is not covered by the health plan.	
CARC	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGC
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. This change effective 11/1/2013: This is a non-covered service because it is a routine/preventive exam or a diagnostic/screening procedure done in conjunction with a routine/preventive exam. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N627	Service not payable per managed care contract.	CO, PI 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
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.	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
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.	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
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.	M64	Missing/incomplete/invalid other diagnosis.	CO, PI or PR

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

		Table 4	4-1	
	Scenario #3:	Billed Service No	ot Covered by Health Plan	
			ice is not covered by the health plan.	
CARC	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGC
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.	M76	Missing/incomplete/invalid diagnosis or condition.	CO, PI 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.	M85	Subjected to review of physician evaluation and management services.	CO, PI 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.	MA46	The new information was considered but additional payment will not be issued.	CO, PI 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.	MA91	This determination is the result of the appeal you filed.	CO, PI 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.	MA126	Pancreas transplant not covered unless kidney transplant performed.	CO, PI 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.	N10	Payment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	CO, PI 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.	N45	Payment based on authorized amount.	CO, PI 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.	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
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	N109	This claim/service was chosen for complex review and was denied after reviewing the medical records.	CO, PI or PR

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

		Table 4-1		
	Scenario #3	: Billed Service Not C	Covered by Health Plan	
	Refers to situations wh	ere the billed service	is not covered by the health plan.	
CARC	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGC
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.	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
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.	N129	Not eligible due to the patient's age.	CO, PI 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.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	CO, PI 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.	N161	This drug/service/supply is covered only when the associated service is covered.	CO, PI 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.	N163	Medical record does not support code billed per the code definition.	CO, PI 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.	N180	This item or service does not meet the criteria for the category under which it was billed.	CO, PI 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.	N206	The supporting documentation does not match the information sent on the claim.	CO, PI 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.	N225	Incomplete/invalid documentation/orders/notes/summary/report/c hart.	CO, PI 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.	N229	Incomplete/invalid contract indicator.	CO, PI or PR

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

		Table	4-1	
	Scenario #3: B	illed Service No	ot Covered by Health Plan	
	Refers to situations wher	e the billed serv	rice is not covered by the health plan.	
CARC	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGO
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.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO, PI 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.	N372	Only reasonable and necessary maintenance/service charges are covered.	CO, PI 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.	N383	Not covered when deemed cosmetic.	CO, PI 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.	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
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.	N607	Service provided for non-compensable condition(s).	CO, PI 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.	N627	Service not payable per managed care contract.	CO, PI 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.	N658	Services by an unlicensed provider are not reimbursable.	CO, PI 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.	N661	Documentation does not support that the services rendered were medically necessary.	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 advisor/dental advisor/peer review.	CO or PR

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Tab 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 who	ere the billed service	is not covered by the health plan.	
CARC	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGC
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.	N29	Missing documentation/orders/notes/summary/report/c hart.	CO 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.	N45	Payment based on authorized amount.	CO 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.	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
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.	N204	Services under review for possible pre- existing condition. Send medical records for prior 12 months.	CO 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.	N607	Service provided for non-compensable condition(s).	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.	N646	Reimbursement has been adjusted based on the guidelines for an assistant.	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 present.	M49	Missing/incomplete/invalid value code(s) or amount(s).	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 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
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 present.	N563	Missing required provider/supplier issuance of advance patient notice of non-coverage. The patient is not liable for payment for this service.	CO, PI or PR

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

		Table 4	-1	
	Scenario #3:	Billed Service No	t Covered by Health Plan	
	Refers to situations who	ere the billed servi	ice is not covered by the health plan.	
CARC	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGO
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 present.	N623	Not covered when deemed unscientific/unproven/outmoded/experimenta l/excessive/inappropriate.	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.	N563	Missing required provider/supplier issuance of advance patient notice of non-coverage. The patient is not liable for payment for this service.	CO or PI
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.	N623	Not covered when deemed unscientific/unproven/outmoded/experimenta l/excessive/inappropriate.	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.	N563	Missing required provider/supplier issuance of advance patient notice of non-coverage. The patient is not liable for payment for this service.	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.	N633	Additional anesthesia time units are not allowed.	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.	N644	Reimbursement has been made according to the bilateral procedure rule.	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.	N670	This service code has been identified as the primary procedure code subject to the Medicare Multiple Procedure Payment Reduction (MPPR) rule.	CO or PI
60	Charges for outpatient services are not covered when performed within a period of time prior to or after inpatient services.	N627	Service not payable per managed care contract.	CO, PI or PR
60	Charges for outpatient services are not covered when performed within a period of time prior to or after inpatient services.	N676	Service does not qualify for payment under the Outpatient Facility Fee Schedule.	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			CO or PI

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

		Table	4-1	
			ot Covered by Health Plan	
CARC			rice is not covered by the health plan.	100711201
	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGC
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.	N584	Not covered based on the insured's noncompliance with policy or statutory conditions.	CO, PI or PR
95	Plan procedures not followed.	N593	Not covered based on failure to attend a scheduled Independent Medical Exam (IME).	CO, PI or PR
95	Plan procedures not followed.	N594	Records reflect the injured party did not complete an Application for Benefits for this loss.	CO, PI or PR
95	Plan procedures not followed.	N595	Records reflect the injured party did not complete an Assignment of Benefits for this loss.	CO, PI or PR
95	Plan procedures not followed.	N596	Records reflect the injured party did not complete a Medical Authorization for this loss.	CO, PI or PR
95	Plan procedures not followed.	N627	Service not payable per managed care contract.	CO, PI or PR
95	Plan procedures not followed.	N630	Referral not authorized by attending physician).	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 ALERT.) 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
96	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 ALERT.) 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
96	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 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

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

		Table 4	4-1	
	Scenario #3: I	Billed Service No	t Covered by Health Plan	
	Refers to situations when	e the billed serv	ice is not covered by the health plan.	
CARC	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGC
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M13	Only one initial visit is covered per specialty per medical group.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	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
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	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
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M28	This does not qualify for payment under Part B when Part A coverage is exhausted or not otherwise available.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M37	Not covered when the patient is under age 35.	CO, PI or PR

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

		Table	4-1	
	Scenario #3: B	illed Service No	ot Covered by Health Plan	
	Refers to situations when	e the billed serv	rice is not covered by the health plan.	
CARC	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGC
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	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
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M41	We do not pay for this as the patient has no legal obligation to pay for this.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M49	Missing/incomplete/invalid value code(s) or amount(s).	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	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
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M61	We cannot pay for this as the approval period for the FDA clinical trial has expired.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO, PI or PR

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

		Table -	4-1	
	Scenario #3: B	Billed Service No	ot Covered by Health Plan	
	Refers to situations when	e the billed serv	rice is not covered by the health plan.	
CARC	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGC
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M82	Service is not covered when patient is under age 50.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M83	Service is not covered unless the patient is classified as at high risk.	CO, PI or PR
96	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 ALERT.) 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, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M87	Claim/service(s) subjected to CFO-CAP prepayment review.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M89	Not covered more than once under age 40.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M90	Not covered more than once in a 12 month period.	CO, PI or PR

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

		Table -	4-1	
	Scenario #3: B	Billed Service No	ot Covered by Health Plan	
	Refers to situations wher	e the billed serv	rice is not covered by the health plan.	
CARC	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGC
96	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 ALERT.) 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
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	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
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M111	We do not pay for chiropractic manipulative treatment when the patient refuses to have an x-ray taken.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	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
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M117	Not covered unless submitted via electronic claim.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M121	We pay for this service only when performed with a covered cryosurgical ablation.	CO, PI or PR

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

		Table -	4-1	
	Scenario #3: B	Billed Service No	ot Covered by Health Plan	
	Refers to situations wher	e the billed serv	rice is not covered by the health plan.	
CARC	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGC
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M134	Performed by a facility/supplier in which the provider has a financial interest.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	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
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M139	Denied services exceed the coverage limit for the demonstration.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	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
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA24	Christian Science Sanitarium/ Skilled Nursing Facility (SNF) bill in the same benefit period.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA25	A patient may not elect to change a hospice provider more than once in a benefit period.	CO, PI or PR

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

		Table	4-1	
	Scenario #3: B	illed Service No	ot Covered by Health Plan	
	Refers to situations wher	e the billed serv	ice is not covered by the health plan.	
CARC	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGC
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	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
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA54	Physician certification or election consent for hospice care not received timely.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	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
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	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
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA57	Patient submitted written request to revoke his/her election for religious non-medical health care services.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA67	Correction to a prior claim.	CO, PI or PR

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

		Table 4	4-1	
	Scenario #3: B	silled Service No	ot Covered by Health Plan	
	Refers to situations wher	e the billed serv	ice is not covered by the health plan.	
CARC	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGC
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	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
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	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
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	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
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA123	Your center was not selected to participate in this study, therefore, we cannot pay for these services.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	MA126	Pancreas transplant not covered unless kidney transplant performed.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	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

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

		Table -	4-1	
	Scenario #3: B	Billed Service No	ot Covered by Health Plan	
	Refers to situations when	e the billed serv	rice is not covered by the health plan.	
CARC	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGC
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	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
96	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 ALERT.) 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 advisor/dental advisor/peer review.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	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
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N15	Services for a newborn must be billed separately.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N16	Family/member Out-of-Pocket maximum has been met. Payment based on a higher percentage.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N20	Service not payable with other service rendered on the same date.	CO, PI or PR

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

		Table	4-1	
	Scenario #3: B	Billed Service No	ot Covered by Health Plan	
	Refers to situations when	e the billed serv	rice is not covered by the health plan.	
CARC	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGC
96	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 ALERT.) 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
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N32	Claim must be submitted by the provider who rendered the service.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N35	Program integrity/utilization review decision.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N43	Bed hold or leave days exceeded.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N45	Payment based on authorized amount.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N52	Patient not enrolled in the billing provider's managed care plan on the date of service.	CO, PI or PR

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

		Table -	4-1	
	Scenario #3: B	illed Service No	ot Covered by Health Plan	
	Refers to situations wher	e the billed serv	rice is not covered by the health plan.	
CARC	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGC
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N54	Claim information is inconsistent with precertified/authorized services.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N55	Procedures for billing with group/referring/performing providers were not followed.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N59	Please refer to your provider manual for additional program and provider information.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N61	Rebill services on separate claims.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N70	Consolidated billing and payment applies.	CO, PI or PR

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

		Table -	4-1	
	Scenario #3: B	Billed Service No	ot Covered by Health Plan	
	Refers to situations when	e the billed serv	rice is not covered by the health plan.	
CARC	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGC
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N81	Procedure billed is not compatible with tooth surface code.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N83	No appeal rights. Adjudicative decision based on the provisions of a demonstration project.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	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
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N87	Home use of biofeedback therapy is not covered.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N90	Covered only when performed by the attending physician.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N92	This facility is not certified for digital mammography.	CO, PI or PR

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

		Table 4	4-1	
			t Covered by Health Plan	
CARC			ice is not covered by the health plan.	1.50 T14 G1 GG
96	CARC Description ⁶ 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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	RARC N95	RARC Description ⁷ This provider type/provider specialty may not bill this service.	ASC X12 CAGC CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	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
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	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
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	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 he or she is in a Federal facility, or while he or she is 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
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	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

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

		Table	4-1	
	Scenario #3: B	Billed Service No	ot Covered by Health Plan	
	Refers to situations when	e the billed serv	rice is not covered by the health plan.	
CARC	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGC
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N109	This claim/service was chosen for complex review and was denied after reviewing the medical records.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N110	This facility is not certified for film mammography.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N113	Only one initial visit is covered per physician, group practice or provider.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	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
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N117	This service is paid only once in a patient's lifetime.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N118	This service is not paid if billed more than once every 28 days.	CO, PI or PR

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

		Table 4-1		
			Covered by Health Plan	
	Refers to situations wh	here the billed service	e is not covered by the health plan.	
CARC	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGC
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	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
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	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
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	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
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	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
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N129	Not eligible due to the patient's age.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	CO, PI or PR

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

		Table -	4-1	
	Scenario #3: B	Billed Service No	ot Covered by Health Plan	
	Refers to situations when	e the billed serv	rice is not covered by the health plan.	
CARC	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGC
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	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
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N143	The patient was not in a hospice program during all or part of the service dates billed.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N157	Transportation to/from this destination is not covered.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N158	Transportation in a vehicle other than an ambulance is not covered.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N159	Payment denied/reduced because mileage is not covered when the patient is not in the ambulance.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N161	This drug/service/supply is covered only when the associated service is covered.	CO, PI or PR

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

		Table -	4-1	
	Scenario #3: B	illed Service No	ot Covered by Health Plan	
	Refers to situations wher	e the billed serv	rice is not covered by the health plan.	
CARC	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGC
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N163	Medical record does not support code billed per the code definition.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N167	Charges exceed the post-transplant coverage limit.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N171	Payment for repair or replacement is not covered or has exceeded the purchase price.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	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
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	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
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N180	This item or service does not meet the criteria for the category under which it was billed.	CO, PI or PR

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

		Table	4-1	
	Scenario #3: B	Billed Service No	ot Covered by Health Plan	
	Refers to situations when	e the billed serv	rice is not covered by the health plan.	
CARC	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGC
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N188	The approved level of care does not match the procedure code submitted.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N193	Specific Federal/state/local program may cover this service through another payer.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N194	Technical component not paid if provider does not own the equipment used.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N198	Rendering provider must be affiliated with the pay-to provider.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N202	Additional information/explanation will be sent separately.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	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

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

		Table -	4-1	
	Scenario #3: B	Billed Service No	ot Covered by Health Plan	
	Refers to situations when	e the billed serv	rice is not covered by the health plan.	
CARC	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGC
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N348	You chose that this service/supply/drug would be rendered/supplied and billed by a different practitioner/supplier.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N351	Service date outside of the approved treatment plan service dates.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N356	Not covered when performed with, or subsequent to, a non-covered service.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N365	This procedure code is not payable. It is for reporting/information purposes only.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N370	Billing exceeds the rental months covered/approved by the payer.	CO, PI or PR

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

		Table 4-1		
			Covered by Health Plan	
G170			e is not covered by the health plan.	
CARC	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGC
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N372	Only reasonable and necessary maintenance/service charges are covered.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N376	Subscriber/patient is assigned to active military duty, therefore primary coverage may be TRICARE.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N381	Consult our contractual agreement for restrictions/billing/payment information related to these charges.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N383	Not covered when deemed cosmetic.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	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
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N405	This service is only covered when the donor's insurer(s) do not provide coverage for the service.	CO, PI or PR

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

		Table	4-1	
	Scenario #3: B	Billed Service No	ot Covered by Health Plan	
	Refers to situations when	e the billed serv	rice is not covered by the health plan.	
CARC	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGC
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N406	This service is only covered when the recipient's insurer(s) do not provide coverage for the service.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N408	This payer does not cover deductibles assessed by a previous payer.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	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
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N410	Not covered unless the prescription changes.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N418	Misrouted claim. See the payer's claim submission instructions.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N424	Patient does not reside in the geographic area required for this type of payment.	CO, PI or PR

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

		Table 4	4-1	
	Scenario #3: B	Billed Service No	ot Covered by Health Plan	
	Refers to situations wher	e the billed serv	rice is not covered by the health plan.	
CARC	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGC
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N425	Statutorily excluded service(s).	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N426	No coverage when self-administered.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N428	Not covered when performed in this place of service.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N429	Not covered when considered routine.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N431	Not covered with this procedure.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N435	Exceeds number/frequency approved /allowed within time period without support documentation.	CO, PI or PR

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

		Table -	4-1	
	Scenario #3: B	Billed Service No	ot Covered by Health Plan	
	Refers to situations when	e the billed serv	rice is not covered by the health plan.	
CARC	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGC
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N441	This missed/cancelled appointment is not covered.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N442	Payment based on an alternate fee schedule.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N448	This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N450	Covered only when performed by the primary treating physician or the designee.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N507	Plan distance requirements have not been met.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N525	These services are not covered when performed within the global period of another service.	CO, PI or PR

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

		Table -	4-1	
	Scenario #3: B	Billed Service No	ot Covered by Health Plan	
	Refers to situations wher	e the billed serv	rice is not covered by the health plan.	
CARC	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGC
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N528	Patient is entitled to benefits for Institutional Services only.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N529	Patient is entitled to benefits for Professional Services only.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N563	Missing required provider/supplier issuance of advance patient notice of non-coverage. The patient is not liable for payment for this service.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N564	Patient did not meet the inclusion criteria for the demonstration project or pilot program.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N567	Not covered when considered preventative.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N569	Not covered when performed for the reported diagnosis.	CO, PI or PR

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

		Table -	4-1	
	Scenario #3: B	silled Service No	ot Covered by Health Plan	
	Refers to situations when	e the billed serv	rice is not covered by the health plan.	
CARC	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGC
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N576	Services not related to the specific incident/claim/accident/loss being reported.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N578	Coverages do not apply to this loss.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N584	Not covered based on the insured's noncompliance with policy or statutory conditions.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N588	The patient has instructed that medical claims/bills are not to be paid.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N589	Coverage is excluded to any person injured as a result of operating a motor vehicle while in an intoxicated condition or while the ability to operate such a vehicle is impaired by the use of a drug.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N590	Missing independent medical exam detailing the cause of injuries sustained and medical necessity of services rendered.	CO, PI or PR

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

		Table -	4-1	
	Scenario #3: B	Billed Service No	ot Covered by Health Plan	
	Refers to situations wher	e the billed serv	rice is not covered by the health plan.	
CARC	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGC
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N592	Adjusted because this is not the initial prescription or exceeds the amount allowed for the initial prescription.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N593	Not covered based on failure to attend a scheduled Independent Medical Exam (IME).	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N607	Service provided for non-compensable condition(s).	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N621	Charges for Jurisdiction required forms, reports, or chart notes are not payable.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N622	Not covered based on the date of injury/accident.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N624	The associated Workers' Compensation claim has been withdrawn.	CO, PI or PR

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

		Table	4-1	
	Scenario #3: B	Billed Service No	ot Covered by Health Plan	
	Refers to situations when	e the billed serv	vice is not covered by the health plan.	
CARC	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGC
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N628	Out-patient follow up visits on the same date of service as a scheduled test or treatment is disallowed.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N630	Referral not authorized by attending physician	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N633	Additional anesthesia time units are not allowed.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N636	Adjusted because this is reimbursable only once per injury.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N637	Consultations are not allowed once treatment has been rendered by the same provider.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N640	Exceeds number/frequency approved/allowed within time period.	CO, PI or PR

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

		Table	4-1	
	Scenario #3: B	illed Service No	ot Covered by Health Plan	
	Refers to situations wher	e the billed serv	rice is not covered by the health plan.	
CARC	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGC
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N643	The services billed are considered Not Covered or Non-Covered (NC) in the applicable state fee schedule.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N647	Adjusted based on diagnosis-related group (DRG).	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N651	No Personal Injury Protection/Medical Payments Coverage on the policy at the time of the loss.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N653	The date of injury does not match the reported date of loss.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N658	The billed service(s) are not considered medical expenses.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N665	Services by an unlicensed provider are not reimbursable.	CO, PI or PR

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Tab 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 wh	ere the billed service	e is not covered by the health plan.	
CARC	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGC
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N666	Only one evaluation and management code at this service level is covered during the course of care.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N676	Service does not qualify for payment under the Outpatient Facility Fee Schedule.	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
108	Rent/purchase guidelines were not met. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	CO, PI or PR
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	N36	Claim must meet primary payer's processing requirements before we can consider payment.	CO, PI or PR
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	CO, PI or PR
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	N193	Specific Federal/state/local program may cover this service through another payer.	CO, PI or PR
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	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
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	N381	Consult our contractual agreement for restrictions/billing/payment information related to these charges.	CO, PI or PR
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	N418	Misrouted claim. See the payer's claim submission instructions.	CO, PI or PR
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	N448	This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement.	CO, PI or PR

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

		Table 4	1-1	
	Scenario #3: E	Billed Service No	t Covered by Health Plan	
	Refers to situations when	e the billed serv	ice is not covered by the health plan.	
CARC	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGO
109	Claim/service not covered by this	N557	This claim/service is not payable under our	CO, PI or PR
	payer/contractor. You must send the		service area. The claim must be filed to the	
	claim/service to the correct payer/contractor.		Payer/Plan in whose service area the	
			specimen was collected.	
109	Claim/service not covered by this	N558	This claim/service is not payable under our	CO, PI or PR
	payer/contractor. You must send the		service area. The claim must be filed to the	
	claim/service to the correct payer/contractor.		Payer/Plan in whose service area the	
			equipment was received.	
109	Claim/service not covered by this	N559	This claim/service is not payable under our	CO, PI or PR
	payer/contractor. You must send the		service area. The claim must be filed to the	
	claim/service to the correct payer/contractor.		Payer/Plan in whose service area the Ordering	
			Physician is located.	
109	Claim/service not covered by this	N576	Services not related to the specific	CO, PI or PR
	payer/contractor. You must send the		incident/claim/accident/loss being reported.	
	claim/service to the correct payer/contractor.		1	
111	Not covered unless the provider accepts		†	CO, PI or PR
	assignment.			
114	Procedure/product not approved by the Food	N623	Not covered when deemed	CO, PI or PR
	and Drug Administration.		unscientific/unproven/outmoded/experimenta	
			l/excessive/inappropriate.	
115	Procedure postponed, canceled, or delayed.			CO, PI or PR
117	Transportation is only covered to the closest		 	CO, PI or PR
	facility that can provide the necessary care.			
119	Benefit maximum for this time period or	M38	The patient is liable for the charges for this	CO, PI or PR
	occurrence has been reached.		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.	
119	Benefit maximum for this time period or	M53	Missing/incomplete/invalid days or units of	CO, PI or PR
440	occurrence has been reached.	3.500	service.	
119	Benefit maximum for this time period or	M80	Not covered when performed during the same	CO, PI or PR
	occurrence has been reached.		session/date as a previously processed service	
110	Dona Citario di Control di Contro	1402	for the patient.	CO DI DD
119	Benefit maximum for this time period or	M83	Service is not covered unless the patient is	CO, PI or PR
110	occurrence has been reached. Benefit maximum for this time period or	Moe	classified as at high risk. Service denied because payment already	CO DI on DD
119	occurrence has been reached.	M86	made for same/similar procedure within set	CO, PI or PR
	occurrence has been reached.		time frame.	
119	Benefit maximum for this time period or	M89	Not covered more than once under age 40.	CO, PI or PR
11)	occurrence has been reached.	14107	1 to covered more than once under age 40.	CO, 11011K
119	Benefit maximum for this time period or	M90	Not covered more than once in a 12 month	CO, PI or PR
11)	occurrence has been reached.	14170	period.	CO, 11011K
119	Benefit maximum for this time period or	M139	Denied services exceed the coverage limit for	CO, PI or PR
117	occurrence has been reached.	141137	the demonstration.	CO, 11011K
119	Benefit maximum for this time period or	MA115	Missing/incomplete/invalid physical location	CO, PI or PR
11)	occurrence has been reached.	1411 111 13	(name and address, or PIN) where the	CO, 11011K
	occurrence has been reached.		service(s) were rendered in a Health	
			Professional Shortage Area (HPSA).	
			i iorossionai biiorage Area (III BA).	

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

		Table 4		
	Scenario #3: B	illed Service No	ot Covered by Health Plan	
	Refers to situations wher	e the billed serv	ice is not covered by the health plan.	
CARC	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGC
119	Benefit maximum for this time period or occurrence has been reached.	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
119	Benefit maximum for this time period or occurrence has been reached.	N45	Payment based on authorized amount.	CO, PI or PR
119	Benefit maximum for this time period or occurrence has been reached.	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
119	Benefit maximum for this time period or occurrence has been reached.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	CO, PI or PR
119	Benefit maximum for this time period or occurrence has been reached.	N357	Time frame requirements between this service/procedure/supply and a related service/procedure/supply have not been met.	CO, PI or PR
119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO, PI or PR
119	Benefit maximum for this time period or occurrence has been reached.	N381	Consult our contractual agreement for restrictions/billing/payment information related to these charges.	CO, PI or PR
119	Benefit maximum for this time period or occurrence has been reached.	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
119	Benefit maximum for this time period or occurrence has been reached.	N418	Misrouted claim. See the payer's claim submission instructions.	CO, PI or PR
119	Benefit maximum for this time period or occurrence has been reached.	N435	Exceeds number/frequency approved /allowed within time period without support documentation.	CO, PI or PR
119	Benefit maximum for this time period or occurrence has been reached.	N587	Policy benefits have been exhausted.	CO, PI or PR
119	Benefit maximum for this time period or occurrence has been reached.	N636	Adjusted because this is reimbursable only once per injury.	CO, PI or PR
119	Benefit maximum for this time period or occurrence has been reached.	N640	Exceeds number/frequency approved/allowed within time period.	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.	N584	Not covered based on the insured's noncompliance with policy or statutory conditions.	CO, PI or PR
149	Lifetime benefit maximum has been reached for this service/benefit category.	N587	Policy benefits have been exhausted.	CO, PI or PR
150	Payer deems the information submitted does not support this level of service.	N640	Exceeds number/frequency approved/allowed within time period.	CO, PI or PR

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

		Table		
	Scenario #3: 1	Billed Service No	ot Covered by Health Plan	
	Refers to situations when	re the billed serv	ice is not covered by the health plan.	
CARC	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGO
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.	N640	Exceeds number/frequency approved/allowed within time period.	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
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
160	Injury/illness was the result of an activity that is a benefit exclusion.	N167	Charges exceed the post-transplant coverage limit.	CO, PI or PR
160	Injury/illness was the result of an activity that is a benefit exclusion.	N356	Not covered when performed with, or subsequent to, a non-covered service.	CO, PI or PR
160	Injury/illness was the result of an activity that is a benefit exclusion.	N607	Service provided for non-compensable condition(s).	CO, PI or PR
160	Injury/illness was the result of an activity that is a benefit exclusion.	N622	Not covered based on the date of injury/accident.	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
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.	N607	Service provided for non-compensable condition(s).	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.	N647	Adjusted based on diagnosis-related group (DRG).	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

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Tab 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 wh	ere the billed service	is not covered by the health plan.	
CARC	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGC
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.	N90	Covered only when performed by the attending physician.	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.	N95	This provider type/provider specialty may not bill 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.	N348	You chose that this service/supply/drug would be rendered/supplied and billed by a different practitioner/supplier.	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.	N665	Services by an unlicensed provider are not reimbursable.	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
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.	N92	This facility is not certified for digital mammography.	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.	N110	This facility is not certified for film mammography.	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.	N428	Not covered when performed in this place of service.	CO, PI or PR
173	Service was not prescribed by a physician. This change effective 07/01/2013: Service/equipment was not prescribed by a physician.	N667	Missing prescription	CO, PI or PR

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

		Table 4-1		
	Scenario #3:	Billed Service Not C	Covered by Health Plan	
	Refers to situations who	ere the billed service	is not covered by the health plan.	
CARC	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGO
173	Service was not prescribed by a physician. This change effective 07/01/2013: Service/equipment was not prescribed by a physician.	N668	Incomplete/invalid prescription	CO, PI or PR
174	Service was not prescribed prior to delivery.	N627	Service not payable per managed care contract.	CO, PI or PR
174	Service was not prescribed prior to delivery.	N667	Missing prescription	CO, PI or PR
174	Service was not prescribed prior to delivery.	N668	Incomplete/invalid prescription	CO, PI or PR
176	Prescription is not current.	N592	Adjusted because this is not the initial prescription or exceeds the amount allowed for the initial prescription.	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
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
198	Precertification/authorization exceeded.	N54	Claim information is inconsistent with pre- certified/authorized services.	CO, PI or PR
198	Precertification/authorization exceeded.	N351	Service date outside of the approved treatment plan service dates.	CO, PI or PR
200	Expenses incurred during lapse in coverage.	N619	Coverage terminated for non-payment of premium.	CO, PI or PR
200	Expenses incurred during lapse in coverage.	N650	This policy was not in effect for this date of loss. No coverage is available.	CO, PI or PR
202	Non-covered personal comfort or convenience services.	N658	The billed service(s) are not considered medical expenses.	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
204	This service/equipment/drug is not covered under the patient's current benefit plan.	N448	This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement.	CO, PI or PR
204	This service/equipment/drug is not covered under the patient's current benefit plan.	N567	Not covered when considered preventative.	CO, PI or PR
204	This service/equipment/drug is not covered under the patient's current benefit plan.	N569	Not covered when performed for the reported diagnosis.	CO, PI or PR

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

		Table 4-1		
	Scenario #3: I	Billed Service Not C	Covered by Health Plan	
	Refers to situations when	re the billed service	is not covered by the health plan.	
CARC	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGO
204	This service/equipment/drug is not covered under the patient's current benefit plan.	N651	No Personal Injury Protection/Medical Payments Coverage on the policy at the time of the loss.	CO, PI or PR
204	This service/equipment/drug is not covered under the patient's current benefit plan.	N658	The billed service(s) are not considered medical expenses.	CO, PI or PR
204	This service/equipment/drug is not covered under the patient's current benefit plan.	N666	Only one evaluation and management code at this service level is covered during the course of care.	CO, PI or PR
212	Administrative surcharges are not covered.	N658	The billed service(s) are not considered medical expenses.	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.	N587	Policy benefits have been exhausted.	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.	N627	Service not payable per managed care contract.	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.	N633	Additional anesthesia time units are not allowed.	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.	N640	Exceeds number/frequency approved/allowed within time period.	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.	N555	Missing medication list.	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.	N556	Incomplete/invalid medication list.	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.	N628	Out-patient follow up visits on the same date of service as a scheduled test or treatment is disallowed.	CO, PI or PR
233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.	N627	Service not payable per managed care contract.	CO, PI or PR

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

		Table	4-1	
	Scenario #3: B	Billed Service No	ot Covered by Health Plan	
	Refers to situations when	e the billed serv	rice is not covered by the health plan.	
CARC	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGO
238	Claim spans eligible and ineligible periods of coverage, this is the reduction for the ineligible period (use Group Code PR). This change effective 7/1/2013: Claim spans eligible and ineligible periods of coverage, this is the reduction for the ineligible period. (Use only with Group Code PR)			PR
239	Claim spans eligible and ineligible periods of coverage. Rebill separate claims.			CO, PI or PR
242	Services not provided by network/primary care providers. Notes: This code replaces deactivated code 38	M115	This item is denied when provided to this patient by a non-contract or non-demonstration supplier.	CO, PI or PR
242	Services not provided by network/primary care providers. Notes: This code replaces deactivated code 38	N95	This provider type/provider specialty may not bill this service.	CO, PI or PR
242	Services not provided by network/primary care providers. Notes: This code replaces deactivated code 38	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	CO, PI or PR
242	Services not provided by network/primary care providers. Notes: This code replaces deactivated code 38	N202	Additional information/explanation will be sent separately.	CO, PI or PR
242	Services not provided by network/primary care providers. Notes: This code replaces deactivated code 38	N450	Covered only when performed by the primary treating physician or the designee.	CO, PI or PR
243	Services not authorized by network/primary care providers. Notes: This code replaces deactivated code 38	M115	This item is denied when provided to this patient by a non-contract or non-demonstration supplier.	CO, PI or PR
243	Services not authorized by network/primary care providers. Notes: This code replaces deactivated code 38	N95	This provider type/provider specialty may not bill this service.	CO, PI or PR
243	Services not authorized by network/primary care providers. Notes: This code replaces deactivated code 38	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	CO, PI or PR
243	Services not authorized by network/primary care providers. Notes: This code replaces deactivated code 38	N202	Additional information/explanation will be sent separately.	CO, PI or PR
243	Services not authorized by network/primary care providers. Notes: This code replaces deactivated code 38	N450	Covered only when performed by the primary treating physician or the designee.	CO, PI or PR
243	Services not authorized by network/primary care providers. Notes: This code replaces deactivated code 38	N630	Referral not authorized by attending physician).	CO, PI or PR
246	This non-payable code is for required reporting only.	N572	This procedure is not payable unless non- payable reporting codes and appropriate modifiers are submitted.	CO, PI or PR
249	This claim has been identified as a readmission. (Use only with Group Code CO)	N627	Service not payable per managed care contract.	СО
254	Claim received by the dental plan, but benefits not available under this plan. Submit these services to the patient's medical plan for further consideration.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	CO, PI or PR

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

		Table 4	4-1	
	Scenario #3: B	Billed Service No	ot Covered by Health Plan	
			ice is not covered by the health plan.	
CARC	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGC
254	Claim received by the dental plan, but benefits not available under this plan. Submit these services to the patient's medical plan for further consideration.	N202	Additional information/explanation will be sent separately	CO, PI or PR
256	Service not payable per managed care contract.	M14	No separate payment for an injection administered during an office visit, and no payment for a full office visit if the patient only received an injection.	CO, PI or PR
256	Service not payable per managed care contract.	M37	Not covered when the patient is under age 35.	CO, PI or PR
256	Service not payable per managed care contract.	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
256	Service not payable per managed care contract.	M39	The patient is not liable for payment for this service as the advance notice of non-coverage you provided the patient did not comply with program requirements.	CO, PI or PR
256	Service not payable per managed care contract.	M61	We cannot pay for this as the approval period for the FDA clinical trial has expired.	CO, PI or PR
256	Service not payable per managed care contract.	M81	You are required to code to the highest level of specificity.	CO, PI or PR
256	Service not payable per managed care contract.	M82	Service is not covered when patient is under age 50.	CO, PI or PR
256	Service not payable per managed care contract.	M89	Not covered more than once under age 40.	CO, PI or PR
256	Service not payable per managed care contract.	M90	Not covered more than once in a 12 month period.	CO, PI or PR
256	Service not payable per managed care contract.	M96	The technical component of a service furnished to an inpatient may only be billed by that inpatient facility. You must contact the inpatient facility for technical component reimbursement. If not already billed, you should bill us for the professional component only.	CO, PI or PR
256	Service not payable per managed care contract.	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
256	Service not payable per managed care contract.	M139	Denied services exceed the coverage limit for the demonstration.	CO, PI or PR
256	Service not payable per managed care contract.	MA16	The patient is covered by the Black Lung Program. Send this claim to the Department of Labor, Federal Black Lung Program, P.O. Box 828, Lanham-Seabrook MD 20703.	CO, PI or PR
256	Service not payable per managed care contract.	N52	Patient not enrolled in the billing provider's managed care plan on the date of service.	CO, PI or PR
256	Service not payable per managed care contract.	N95	This provider type/provider specialty may not bill this service.	CO, PI or PR

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

		Table		
			ot Covered by Health Plan	
CARC			ice is not covered by the health plan.	
CARC	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGO
256	Service not payable per managed care contract.	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 he or she is in a Federal facility, or while he or she is 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
256	Service not payable per managed care contract.	N117	This service is paid only once in a patient's lifetime.	CO, PI or PR
256	Service not payable per managed care contract.	N118	This service is not paid if billed more than once every 28 days.	CO, PI or PR
256	Service not payable per managed care contract.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	CO, PI or PR
256	Service not payable per managed care contract.	N202	Additional information/explanation will be sent separately	CO, PI or PR
256	Service not payable per managed care contract.	N246	State regulated patient payment limitations apply to this service.	CO, PI or PR
256	Service not payable per managed care contract.	N365	This procedure code is not payable. It is for reporting/information purposes only.	CO, PI or PR
256	Service not payable per managed care contract.	N428	Not covered when performed in this place of service.	CO, PI or PR
256	Service not payable per managed care contract.	N448	This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement	CO, PI or PR
256	Service not payable per managed care contract.	N623	Not covered when deemed unscientific/unproven/outmoded/experimenta l/excessive/inappropriate.	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
B1	Non-covered visits.	N628	Out-patient follow up visits on the same date of service as a scheduled test or treatment is disallowed.	CO, PI or PR
B5	Coverage/program guidelines were not met or were exceeded.	N584	Not covered based on the insured's noncompliance with policy or statutory conditions.	CO, PI or PR
B5	Coverage/program guidelines were not met or were exceeded.	N593	Not covered based on failure to attend a scheduled Independent Medical Exam (IME).	CO, PI or PR
В5	Coverage/program guidelines were not met or were exceeded.	N630	Referral not authorized by attending physician	CO, PI or PR
B5	Coverage/program guidelines were not met or were exceeded.	N640	Exceeds number/frequency approved/allowed within time period.	CO, PI or PR
В7	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	N570	Missing/incomplete/invalid credentialing data	CO, PI or PR

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

		Table	4-1	
	Scenario #3: B	Billed Service No	ot Covered by Health Plan	
	Refers to situations when	e the billed serv	rice is not covered by the health plan.	
CARC	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGO
В7	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.	N612	Medical provider not authorized/certified to provide treatment to injured workers in this jurisdiction.	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.	N665	Services by an unlicensed provider are not reimbursable.	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
В9	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
B11	The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.	N381	Consult our contractual agreement for restrictions/billing/payment information related to these charges.	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.	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
B14	Only one visit or consultation per physician per day is covered.	N2	This allowance has been made in accordance with the most appropriate course of treatment provision of the plan.	CO, PI or PR
B14	Only one visit or consultation per physician per day is covered.	N628	Out-patient follow up visits on the same date of service as a scheduled test or treatment is disallowed.	CO, PI or PR
B14	Only one visit or consultation per physician per day is covered.	N637	Consultations are not allowed once treatment has been rendered by the same provider.	CO, PI or PR
B14	Only one visit or consultation per physician per day is covered.	N666	Only one evaluation and management code at this service level is covered during the course of care.	CO, PI or PR

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

		Table 4	4-1	
	Scenario #3: I	Billed Service No	t Covered by Health Plan	
	Refers to situations when	re the billed serv	ice is not covered by the health plan.	
CARC	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGC
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
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.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	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.	N20	Service not payable with other service rendered on the same date.	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.	N674	Not covered unless a pre-requisite procedure/service has been provided.	CO, PI or PR
B16	'New Patient' qualifications were not met.			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
W5	Medical provider not authorized/certified to provide treatment to injured workers in this jurisdiction. (Use with Group Code CO or OA)			CO or OA
W6	Referral not authorized by attending physician per regulatory requirement.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	CO, PI or PR
W9	Service not paid under jurisdiction allowed outpatient facility fee schedule.	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
W9	Service not paid under jurisdiction allowed outpatient facility fee schedule.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	CO, PI or PR

⁶Washington Publishing Company: http://www.wpc-edi.com/reference/

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⁷Washington Publishing Company: http://www.wpc-edi.com/reference/

Tab 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	

⁸CARC 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

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

		Table		
	Scenario #4: Ben	efit for Billed Se	rvice Not Separately Payable	
	Refers to situations where the billed	d service or bene	fit 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			CO, PI or PR
	agreement/managed care plan.			
97	The benefit for this service is included in the	M2	Not paid separately when the patient is an	CO, PI or PR
	payment/allowance for another		inpatient.	
	service/procedure that has already been			
	adjudicated. Note: Refer to the 835			
	Healthcare Policy Identification Segment			
	(loop 2110 Service Payment Information REF), if present.			
97	The benefit for this service is included in the	M15	Separately billed services/tests have been	CO, PI or PR
91	payment/allowance for another	WIIJ	bundled as they are considered components of	CO, FIOIFK
	service/procedure that has already been		the same procedure. Separate payment is not	
	adjudicated. Note: Refer to the 835		allowed.	
	Healthcare Policy Identification Segment			
	(loop 2110 Service Payment Information			
	REF), if present.			
97	The benefit for this service is included in the	M80	Not covered when performed during the same	CO, PI or PR
	payment/allowance for another		session/date as a previously processed service	
	service/procedure that has already been		for the patient.	
	adjudicated. Note: Refer to the 835			
	Healthcare Policy Identification Segment			
	(loop 2110 Service Payment Information REF), if present.			
97	The benefit for this service is included in the	M86	Camina daniad hassaysa mayumant almaada	CO, PI or PR
91	payment/allowance for another	MISO	Service denied because payment already made for same/similar procedure within set	CO, PI OF PR
	service/procedure that has already been		time frame.	
	adjudicated. Note: Refer to the 835		came realise	
	Healthcare Policy Identification Segment			
	(loop 2110 Service Payment Information			
	REF), if present.			
97	The benefit for this service is included in the	M97	Not paid to practitioner when provided to	CO, PI or PR
	payment/allowance for another		patient in this place of service. Payment	
	service/procedure that has already been		included in the reimbursement issued the	
	adjudicated. Note: Refer to the 835		facility.	
	Healthcare Policy Identification Segment (loop 2110 Service Payment Information			
	REF), if present.			
97	The benefit for this service is included in the	M144	Pre-/post-operative care payment is included	CO, PI or PR
	payment/allowance for another	1,11	in the allowance for the surgery/procedure.	00,110111
	service/procedure that has already been			
	adjudicated. Note: Refer to the 835			
	Healthcare Policy Identification Segment			
	(loop 2110 Service Payment Information			
	REF), if present.	27		
97	The benefit for this service is included in the	N19	Procedure code incidental to primary	CO, PI or PR
	payment/allowance for another		procedure.	
	service/procedure that has already been			
	adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment			
	(loop 2110 Service Payment Information			
	REF), if present.			

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

	Campuia #A. Dan	Table	ervice Not Separately Payable	
			efit is not separately Payable by the health plan.	
0.7				GO DI DD
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.	N20	Service not payable with other service rendered on the same date.	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.	N22	This procedure code was added/changed because it more accurately describes the services rendered.	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.	N45	Payment based on authorized amount.	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.	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	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.	N63	Rebill services on separate claim lines.	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.	N70	Consolidated billing and payment applies.	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.	NIII	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
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.	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

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

		Table	5-1	
	Scenario #4: Ben	efit for Billed Se	ervice Not Separately Payable	
	Refers to situations where the billed		efit is not separately payable by the health plan.	
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.	N122	Add-on code cannot be billed by itself.	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.	N123	This is a split service and represents a portion of the units from the originally submitted service.	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.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	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.	N202	Additional information/explanation will be sent separately.	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.	N365	This procedure code is not payable. It is for reporting/information purposes only.	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.	N370	Billing exceeds the rental months covered/approved by the payer.	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.	N390	This service/report cannot be billed separately.	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.	N432	Adjustment based on a Recovery Audit.	CO, PI or PR

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

		Table		
			rvice Not Separately Payable	
	Refers to situations where the billed	d service or bene	efit is not separately payable by the health plan.	
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.	N525	These services are not covered when performed within the global period of another service.	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.	N626	New or established patient E/M codes are not payable with chiropractic care codes.	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.	N628	Out-patient follow up visits on the same date of service as a scheduled test or treatment is disallowed.	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.	N637	Consultations are not allowed once treatment has been rendered by the same provider.	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.	N646	Reimbursement has been adjusted based on the guidelines for an assistant.	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.	N666	Only one evaluation and management code at this service level is covered during the course of care.	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
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.)	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO, PI or PR

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

		Table	5-1	
	Scenario #4: Bene	efit for Billed Se	ervice Not Separately Payable	
	Refers to situations where the billed	l service or ben	efit is not separately payable by the health plan.	
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.)	N626	New or established patient E/M codes are not payable with chiropractic care codes.	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.)	N628	Out-patient follow up visits on the same date of service as a scheduled test or treatment is disallowed.	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.)	N676	Service does not qualify for payment under the Outpatient Facility Fee Schedule.	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
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.	M144	Pre-/post-operative care payment is included in the allowance for the surgery/procedure.	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.	N22	This procedure code was added/changed because it more accurately describes the services rendered.	CO, PI or PR
W8	Procedure has a relative value of zero in the jurisdiction fee schedule, therefore no payment is due.			CO, PI or PR

⁹Washington Publishing Company: http://www.wpc-edi.com/reference/

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¹⁰Washington Publishing Company: http://www.wpc-edi.com/reference/

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 docu	umentation is needed fr	om the billing provider or an ERA from a prior	payer.			
	Scenario #2: Missi	ng/Invalid/Incomplet	e Data from Submitted Claim				
Refers	to situations where additional data is needed from	n the billing provider fo	or missing or invalid data on the submitted claim	n, e.g., an 837 or D.0.			
	Scenario #3	3: Billed Service Not C	Covered by Health Plan				
	Refers to situations v	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).	**	For retail pharmacy the NCPDP External Code List must be used. 13	CO or PI			

¹¹Washington Publishing Company: http://www.wpc-edi.com/reference/

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¹²Washington Publishing Company: http://www.wpc-edi.com/reference/

¹³http://www.ncpdp.org/members/members_download.aspx. NCPDP Reject Codes are in Appendix A

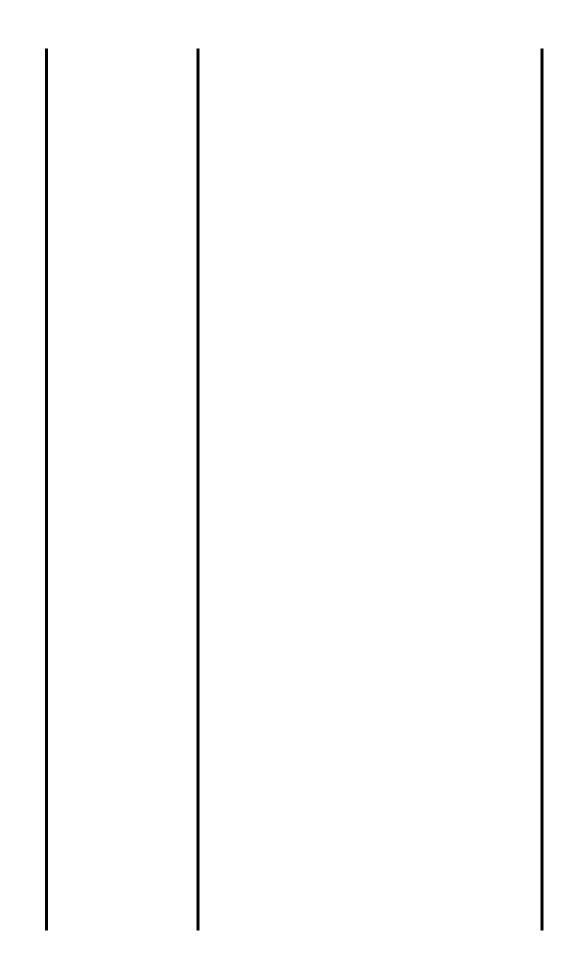
Change Log for CORE-required Code Combinations for CORE-defined B

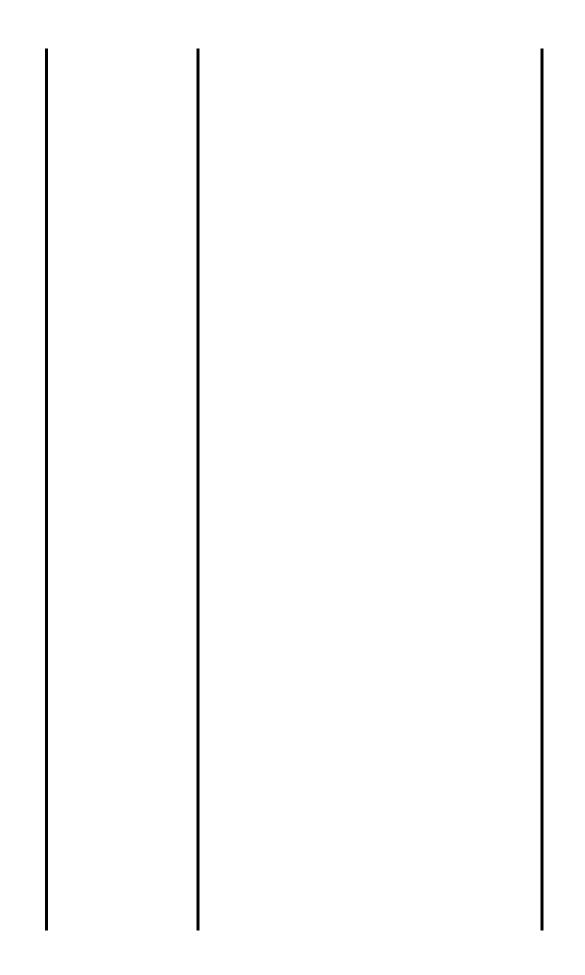
Version	Description
3.0.0	CORE-required Code Combinations for CORE-defined Business Scenarios for the Phase III CORE 360 Uniform Use of Claim Adjustment Reason Codes and Remittance Advice Remark Codes (835) based on published CARC & RARC lists as of June 2011, balloted and approved by CORE members
3.0.1	Compliance-based adjustments as part of the CAQH CORE Code Combinations Maintenance Process based on published CARC & RARC lists as of November 2011
3.0.2	Compliance-based adjustments as part of the CAQH CORE Code Combinations Maintenance Process based on published CARC & RARC lists as of March 2013
3.0.3	Compliance-based adjustments as part of the CAQH CORE Code Combinations Maintenance Process based on published CARC & RARC lists as of July 2013

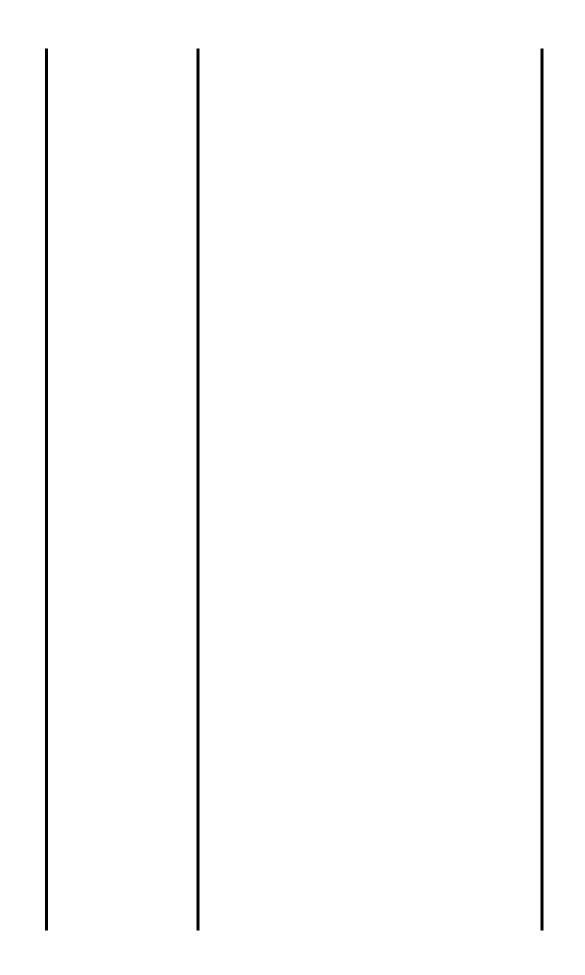
Detailed Description of Updates for the October 2013 v3.0.3 CORE Code Con				
Scenario	Adjustment			
Business Scenario #1 – Additional Information Required – Missing/Invalid/Incomplete Documentation	S CARC descriptions modified 18 RARCs added			

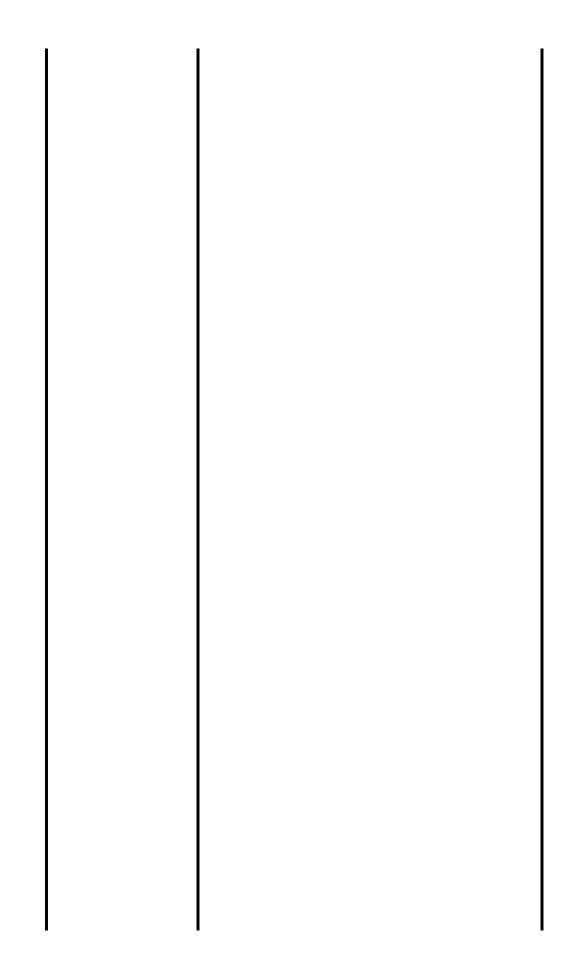
Business Scenario #2 –	· 3 CARC descriptions modified
Additional Information	
Required – Missing/Invalid/Incomplete	
Data from Submitted Claim	
	· 29 RARCs added

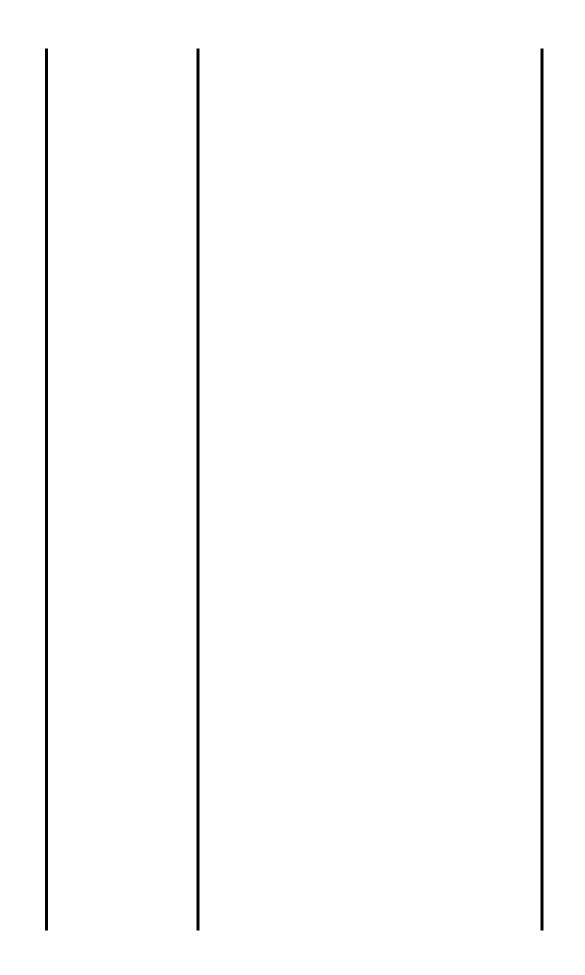
Rusiness Scenario #3 – Billed	· 1 code combination removed
Service Not Covered by Health Plan	r code comonidaton removed
	· 2 RARC descriptions modified
	· 4 CARC descriptions modified
	· 5 CARCs added
	· 134 RARCs added
I	

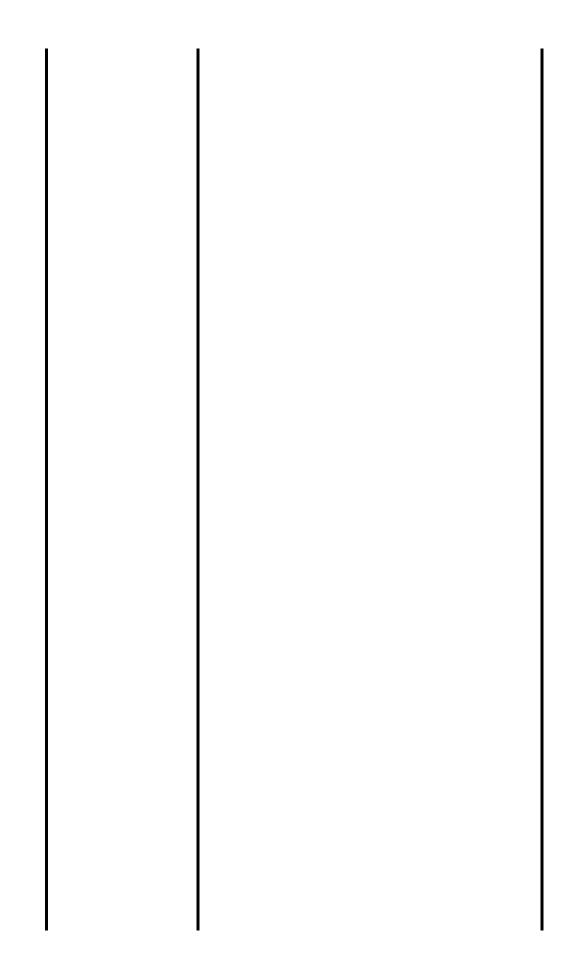












_		_
Business Scenario #4 –	· 1 CARC added	
Benefit for Billed Service Not	· 8 RARCs added	
Separately Payable	o RARCS auutu	

ge (CORE) **35) Rule Scenarios**

usiness Scenarios
Publication Date
06/01/2012
01/31/2013
05/24/2013
10/01/2013
inations Betaneu Description of Adjustment
Description of CARC 163 was modified Description of CARC 164 was modified

· Description of CARC 250 was modified

· Description of CARC 251 was modified

· Description of CARC 252 was modified

· RARC N590 was associated with CARC 251

· RARC N590 was associated with CARC 252

· RARC N594 was associated with CARC 250

· RARC N594 was associated with CARC 251

· RARC N594 was associated with CARC 252

· RARC N595 was associated with CARC 250

- · RARC N595 was associated with CARC 251
- · RARC N595 was associated with CARC 252
- · RARC N596 was associated with CARC 250
- · RARC N596 was associated with CARC 251
- · RARC N596 was associated with CARC 252
- · RARC N630 was associated with CARC 165
- · RARC N667 was associated with CARC 250
- · RARC N667 was associated with CARC 251
- · RARC N667 was associated with CARC 252
- · RARC N668 was associated with CARC 250
- · RARC N668 was associated with CARC 251
- · RARC N668 was associated with CARC 252
- · Description of CARC 16 was modified
- · Description of CARC 18 was modified
- · Description of CARC 236 was modified
- · RARC N574 was associated with CARC 183
- · RARC N574 was associated with CARC 184
- · RARC N575 was associated with CARC 16
- · RARC N592 was associated with CARC 175
- · RARC N595 was associated with CARC 16

- · RARC N596 was associated with CARC 15
- · RARC N596 was associated with CARC 16
- · RARC N622 was associated with CARC 110
- · RARC N625 was associated with CARC 16
- · RARC N630 was associated with CARC 183
- · RARC N644 was associated with CARC 4
- · RARC N644 was associated with CARC 236
- · RARC N647 was associated with CARC A8
- · RARC N653 was associated with CARC 16
- · RARC N657 was associated with CARC 10
- · RARC N657 was associated with CARC 11
- · RARC N657 was associated with CARC 12
- · RARC N657 was associated with CARC 146
- · RARC N657 was associated with CARC 16
- · RARC N657 was associated with CARC 181
- · RARC N657 was associated with CARC 182
- · RARC N657 was associated with CARC 189
- · RARC N657 was associated with CARC 199
- · RARC N657 was associated with CARC 236

- · RARC N657 was associated with CARC 240
- · RARC N657 was associated with CARC 4
- · RARC N657 was associated with CARC 9
- · RARC N657 was associated with CARC A8
- · RARC N668 was associated with CARC 175
- · RARC N7 was removed from combination with CARC 96 due to modification of RARC description
- · Description of CARC N10 was modified
- · Description of CARC N441 was modified
- · Description of CARC 173 was modified
- · Description of CARC 238 was modified
- \cdot Description of CARC 242 was modified
- · Description of CARC 243 was modified
- · CARC 254 was added
- · CARC 256 was added
- · CARC W5 was added
- · CARC W6 was added
- · CARC W9 was added
- · RARC M139 was associated with CARC 256
- · RARC M14 was associated with CARC 256
- · RARC M37 was associated with CARC 256
- · RARC M38 was associated with CARC 256
- · RARC M39 was associated with CARC 256
- · RARC M61 was associated with CARC 256
- · RARC M81 was associated with CARC 256

- · RARC M82 was associated with CARC 256
- · RARC M89 was associated with CARC 256
- · RARC M90 was associated with CARC 256
- · RARC M96 was associated with CARC 256
- · RARC M97 was associated with CARC 256
- · RARC MA16 was associated with CARC 256
- · RARC N103 was associated with CARC 256
- · RARC N104 was associated with CARC W9
- · RARC N117 was associated with CARC 256
- · RARC N118 was associated with CARC 256
- · RARC N130 was associated with CARC 254
- · RARC N130 was associated with CARC 256
- · RARC N130 was associated with CARC W6
- · RARC N130 was associated with CARC W9
- · RARC N202 was associated with CARC 254
- · RARC N202 was associated with CARC 256
- · RARC N246 was associated with CARC 256
- · RARC N365 was associated with CARC 256
- · RARC N428 was associated with CARC 256

- · RARC N448 was associated with CARC 256
- · RARC N52 was associated with CARC 256
- · RARC N576 was associated with CARC 109
- · RARC N576 was associated with CARC 96
- · RARC N578 was associated with CARC 33
- · RARC N578 was associated with CARC 96
- · RARC N584 was associated with CARC 138
- · RARC N584 was associated with CARC 95
- · RARC N584 was associated with CARC 96
- · RARC N584 was associated with CARC B5
- · RARC N587 was associated with CARC 119
- · RARC N587 was associated with CARC 149
- · RARC N587 was associated with CARC 222
- · RARC N587 was associated with CARC 35
- · RARC N588 was associated with CARC 96
- · RARC N589 was associated with CARC 96
- · RARC N590 was associated with CARC 96
- · RARC N592 was associated with CARC 176
- · RARC N592 was associated with CARC 96

- · RARC N593 was associated with CARC 95
- · RARC N593 was associated with CARC 96
- · RARC N593 was associated with CARC B5
- · RARC N594 was associated with CARC 95
- · RARC N595 was associated with CARC 95
- · RARC N596 was associated with CARC 95
- · RARC N598 was associated with CARC 22
- · RARC N607 was associated with CARC 160
- · RARC N607 was associated with CARC 167
- · RARC N607 was associated with CARC 50
- · RARC N607 was associated with CARC 51
- · RARC N607 was associated with CARC 96
- · RARC N612 was associated with CARC B7
- · RARC N619 was associated with CARC 200
- · RARC N619 was associated with CARC 27
- · RARC N621 was associated with CARC 96
- · RARC N622 was associated with CARC 160
- · RARC N622 was associated with CARC 26
- · RARC N622 was associated with CARC 27

- · RARC N622 was associated with CARC 96
- · RARC N623 was associated with CARC 114
- · RARC N623 was associated with CARC 256
- · RARC N623 was associated with CARC 55
- · RARC N623 was associated with CARC 56
- · RARC N624 was associated with CARC 96
- · RARC N627 was associated with CARC 174
- · RARC N627 was associated with CARC 222
- · RARC N627 was associated with CARC 233
- · RARC N627 was associated with CARC 249
- · RARC N627 was associated with CARC 39
- · RARC N627 was associated with CARC 40
- · RARC N627 was associated with CARC 49
- · RARC N627 was associated with CARC 50
- · RARC N627 was associated with CARC 60
- · RARC N627 was associated with CARC 95
- · RARC N628 was associated with CARC 231
- · RARC N628 was associated with CARC 96
- · RARC N628 was associated with CARC B1

- · RARC N628 was associated with CARC B14
- · RARC N630 was associated with CARC 243
- · RARC N630 was associated with CARC 95
- · RARC N630 was associated with CARC 96
- · RARC N630 was associated with CARC B5
- · RARC N633 was associated with CARC 222
- · RARC N633 was associated with CARC 59
- · RARC N633 was associated with CARC 96
- · RARC N636 was associated with CARC 119
- · RARC N636 was associated with CARC 96
- · RARC N637 was associated with CARC 96
- · RARC N637 was associated with CARC B14
- · RARC N640 was associated with CARC 119
- · RARC N640 was associated with CARC 150
- · RARC N640 was associated with CARC 152
- · RARC N640 was associated with CARC 222
- · RARC N640 was associated with CARC 96
- · RARC N640 was associated with CARC B5
- · RARC N643 was associated with CARC 96

- · RARC N644 was associated with CARC 59
- · RARC N646 was associated with CARC 54
- · RARC N647 was associated with CARC 167
- · RARC N647 was associated with CARC 96
- · RARC N650 was associated with CARC 200
- · RARC N650 was associated with CARC 26
- · RARC N650 was associated with CARC 27
- · RARC N651 was associated with CARC 204
- · RARC N651 was associated with CARC 96
- · RARC N652 was associated with CARC 26
- · RARC N653 was associated with CARC 96
- · RARC N658 was associated with CARC 202
- · RARC N658 was associated with CARC 204
- · RARC N658 was associated with CARC 212
- · RARC N658 was associated with CARC 50
- · RARC N658 was associated with CARC 96
- · RARC N661 was associated with CARC 50
- · RARC N665 was associated with CARC 170
- · RARC N665 was associated with CARC 96

- · RARC N665 was associated with CARC B7
- · RARC N666 was associated with CARC 204
- · RARC N666 was associated with CARC 96
- · RARC N666 was associated with CARC B14
- · RARC N667 was associated with CARC 173
- · RARC N667 was associated with CARC 174
- · RARC N668 was associated with CARC 173
- · RARC N668 was associated with CARC 174
- · RARC N670 was associated with CARC 59
- · RARC N674 was associated with CARC B15
- · RARC N676 was associated with CARC 60
- · RARC N676 was associated with CARC 96
- · RARC N95 was associated with CARC 256
- · CARC W8 was added
- · RARC N626 was added to CARC 97
- · RARC N626 was associated with CARC 234
- · RARC N628 was associated with CARC 234
- · RARC N628 was associated with CARC 97
- · RARC N637 was associated with CARC 97
- · RARC N646 was associated with CARC 97

- · RARC N666 was associated with CARC 97
- · RARC N676 was associated with CARC 234

Change Log for CORE-required Code Combinations for CORE-defined Business Scenarios

Version	Description	Publication Date
3.0.0	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) based on published CARC & RARC lists as of June 2011, balloted and approved by CORE members	06/01/2012
3.0.1	Compliance-based adjustments as part of the CAQH CORE Code Combinations Maintenance Process based on published CARC & RARC lists as of November 2011	01/31/2013

3.0.2	Compliance-based adjustments as part of the CAQH CORE Code Combinations Maintenance Process based on published CARC & RARC lists as of March 2013	05/24/2013
3.0.3	Compliance-based adjustments as part of the CAQH CORE Code Combinations Maintenance Process based on published CARC & RARC lists as of July 2013	10/01/2013
3.0.4	Compliance-based adjustments as part of the CAQH CORE Code Combinations Maintenance Process based on published CARC & RARC lists as of November 2013	02/01/2014

Detailed Description of Updates for the February 2014 v3.0.4 CORE Code Combinations		
CORE-defined Business Scenario	Adjustment	Detailed Description of Adjustment
Business Scenario #1 – Additional Information Required – Missing/Invalid/Incomplete Documentation	·3 RARC descriptions modified	Description of RARC N102 was modified Description of RARC N178 was modified
	· 40 RARCs added	Description of RARC N244 was modified RARC N678 was associated
	· 40 KARCs audeu	with CARC 163 RARC N679 was associated with CARC 163 RARC N680 was associated with CARC 163 RARC N680 was associated with CARC 163 RARC N681 was associated
		with CARC 163 RARC N682 was associated with CARC 163 RARC N683 was associated with CARC 163
		RARC N685 was associated with CARC 163 RARC N686 was associated with CARC 163 RARC N678 was associated
		with CARC 164 · RARC N679 was associated with CARC 164 · RARC N680 was associated with CARC 164
		 RARC N681 was associated with CARC 164 RARC N682 was associated with CARC 164 RARC N683 was associated
		with CARC 164 • RARC N685 was associated with CARC 164 • RARC N686 was associated
		with CARC 164

		with CARC 16 RARC N684 was associated
Missing/Invalid/Incomplete Data From Submitted Claim	· 1 CARC added · 4 RARCs added	· CARC P7 was added · RARC N685 was associated
nformation Required –	_	modified
Business Scenario #2 – Additional	· 1 CARC description modified	Description of CARC 16 wa
		CARC 165 with RARC N630
	· 1 CAGC corrected	· CAGC PR was removed from
		with CARC 252
		with CARC 252 · RARC N686 was associated
		· RARC N685 was associated
		with CARC 252
		with CARC 252 • RARC N683 was associated
		· RARC N682 was associated
		with CARC 252
		· RARC N681 was associated
		with CARC 252
		with CARC 252 · RARC N680 was associated
		· RARC N679 was associated
		with CARC 252
		· RARC N678 was associated
		with CARC 251
		with CARC 251 · RARC N686 was associated
		· RARC N685 was associated
		with CARC 251
		· RARC N683 was associated
		with CARC 251
		with CARC 251 • RARC N682 was associated
		· RARC N681 was associated
		with CARC 251
		· RARC N680 was associated
		 RARC N679 was associated with CARC 251
		with CARC 251
		· RARC N678 was associated
		with CARC 250
		with CARC 250 · RARC N686 was associated
		· RARC N685 was associated
		with CARC 250
		· RARC N683 was associated
		 RARC N682 was associated with CARC 250
		with CARC 250
		· RARC N681 was associated
		with CARC 250
		· RARC N680 was associated
		 RARC N679 was associated with CARC 250
		with CARC 250

	1 CAGC corrected 1 RARC corrected in Marked-up version, Master tab	· RARC M51 was associated with CARC P7 · RARC M119 was associated with CARC P7 · CAGC PR was removed from CARC 183 with RARC N630 · In the master tab in v3.0.3 RARC N644, and not RARC N664, should have been associated with CARC 236. RARC N644 appeared correctly in the v3.0.3 tab for BS#2.
Business Scenario #3 – Billed Service Not Covered by Health Plan	· 1 CARC description modified · 2 RARC descriptions modified	Description of CARC 49 was modified Description of RARC N102 was modified Description of RARC N103 was modified
	· 16 code combinations removed	CARC W5 was removed due to deactivation of CARC CARC W6 with RARC N130 was removed due to deactivation of CARC CARC W9 with RARCs N104 and N130 was removed due to deactivation of CARC RARC N627 was removed from association with CARC 39 due to deactivation of RARC RARC N627 was removed from association with CARC 40 due to deactivation of RARC RARC N627 was removed from association with CARC 49 due to deactivation of RARC RARC N627 was removed from association with CARC 49 due to deactivation of RARC RARC N627 was removed from association with CARC 50 due to deactivation of RARC RARC N627 was removed from association with CARC 60 due to deactivation of RARC RARC N627 was removed from association with CARC 95 due to deactivation of RARC RARC N365 was removed from association with CARC 96 due to deactivation of RARC

-	
	· RARC N627 was removed
	from association with CARC
	174 due to deactivation of
	RARC
	· RARC N627 was removed
	from association with CARC
	222 due to deactivation of
	RARC
	 RARC N627 was removed from association with CARC
	233 due to deactivation of
	RARC
	· RARC N627 was removed
	from association with CARC
	249 due to deactivation of
	RARC
	· RARC N365 was removed
	from association with CARC
	256 due to deactivation of
	RARC
· 8 CARCs added	· CARC 258 was added
	· CARC P2 was added
	· CARC P3 was added
	· CARC P4 was added
	· CARC P16 was added
	· CARC P17 was added
	· CARC P20 was added
	· CARC P21 was added
· 47 RARCs added	· RARC N684 was associated
	with CARC 8
	· RARC N30 was associated
	with CARC 258
	· RARC N103 was associated
	with CARC 258
	· RARC N193 was associated with CARC 258
	· RARC N612 was associated
	with CARC P4
	With CARC 14
1	 RARC M80 was associated
	· RARC M80 was associated with CARC P21
	with CARC P21
	with CARC P21
	with CARC P21 RARC MA04 was associated
	with CARC P21 • RARC MA04 was associated with CARC P21
	with CARC P21 · RARC MA04 was associated with CARC P21 · RARC N10 was associated
	with CARC P21 RARC MA04 was associated with CARC P21 RARC N10 was associated with CARC P21
	with CARC P21 RARC MA04 was associated with CARC P21 RARC N10 was associated with CARC P21 RARC N36 was associated
	with CARC P21 RARC MA04 was associated with CARC P21 RARC N10 was associated with CARC P21 RARC N36 was associated with CARC P21
	with CARC P21 RARC MA04 was associated with CARC P21 RARC N10 was associated with CARC P21 RARC N36 was associated with CARC P21 RARC N36 was associated with CARC P21 RARC N95 was associated
	with CARC P21 RARC MA04 was associated with CARC P21 RARC N10 was associated with CARC P21 RARC N36 was associated with CARC P21 RARC N36 was associated with CARC P21 RARC N95 was associated with CARC P21
	with CARC P21 RARC MA04 was associated with CARC P21 RARC N10 was associated with CARC P21 RARC N36 was associated with CARC P21 RARC N95 was associated with CARC P21 RARC N95 was associated with CARC P21 RARC N158 was associated
	with CARC P21 RARC MA04 was associated with CARC P21 RARC N10 was associated with CARC P21 RARC N36 was associated with CARC P21 RARC N95 was associated with CARC P21 RARC N95 was associated with CARC P21 RARC N158 was associated with CARC P21
	with CARC P21 RARC MA04 was associated with CARC P21 RARC N10 was associated with CARC P21 RARC N36 was associated with CARC P21 RARC N95 was associated with CARC P21 RARC N158 was associated with CARC P21 RARC N158 was associated with CARC P21 RARC N409 was associated
	with CARC P21 RARC MA04 was associated with CARC P21 RARC N10 was associated with CARC P21 RARC N36 was associated with CARC P21 RARC N95 was associated with CARC P21 RARC N158 was associated with CARC P21 RARC N158 was associated with CARC P21 RARC N409 was associated with CARC P21
	with CARC P21 RARC MA04 was associated with CARC P21 RARC N10 was associated with CARC P21 RARC N36 was associated with CARC P21 RARC N95 was associated with CARC P21 RARC N158 was associated with CARC P21 RARC N158 was associated with CARC P21 RARC N409 was associated with CARC P21 RARC N409 was associated with CARC P21 RARC N479 was associated

· RARC N577 was associated
with CARC P21
· RARC N578 was associated
with CARC P21 RARC N579 was associated
with CARC P21
· RARC N580 was associated
with CARC P21
· RARC N582 was associated
with CARC P21
· RARC N583 was associated
with CARC P21
· RARC N584 was associated
with CARC P21
· RARC N585 was associated
with CARC P21 RARC N586 was associated
with CARC P21
· RARC N587 was associated
with CARC P21
· RARC N588 was associated
with CARC P21
· RARC N589 was associated
with CARC P21
· RARC N590 was associated
with CARC P21
· RARC N593 was associated
with CARC P21
· RARC N594 was associated with CARC P21
· RARC N595 was associated
with CARC P21
· RARC N596 was associated
with CARC P21
· RARC N598 was associated
with CARC P21
· RARC N607 was associated
with CARC P21
· RARC N611 was associated
with CARC P21
· RARC N621 was associated with CARC P21
· RARC N622 was associated
with CARC P21
· RARC N650 was associated
with CARC P21
· RARC N651 was associated
with CARC P21
· RARC N652 was associated
with CARC P21
 RARC N653 was associated with CARC P21
· RARC N657 was associated
with CARC P21
· RARC N658 was associated
with CARC P21
· RARC N661 was associated
with CARC P21

Business Scenario #4 – Benefit for Billed Service Not Separately Payable	· 2 code combinations removed	· RARC N665 was associated with CARC P21 · RARC N666 was associated with CARC P21 · RARC N667 was associated with CARC P21 · RARC N668 was associated with CARC P21 · CARC W8 was removed due to deactivation of CARC · RARC N365 was removed from combination with CARC 97 due to deactivation of RARC
	· 2 CARCs added	· CARC P14 was added · CARC P19 was added
	· 13 RARCs added	RARC M2 was associated with CARC P14 RARC M15 was associated with CARC P14 RARC M75 was associated with CARC P14 RARC M80 was associated with CARC P14 RARC M86 was associated with CARC P14 RARC M97 was associated with CARC P14 RARC M97 was associated with CARC P14 RARC M144 was associated with CARC P14 RARC N19 was associated with CARC P14 RARC N20 was associated with CARC P14 RARC N67 was associated with CARC P14 RARC N111 was associated with CARC P14 RARC N111 was associated with CARC P14 RARC N390 was associated with CARC P14 RARC N390 was associated with CARC P14 RARC N525 was associated with CARC P14

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 version 3.0.4 February 1, 2014

Change Log for CORE-required Code Combinations for CORE-defined Business Scenarios

Version	Description	Publication Date
3.0.0	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) based on published CARC & RARC lists as of June 2011, balloted and approved by CORE members	06/01/2012
3.0.1	Compliance-based adjustments as part of the CAQH CORE Code Combinations Maintenance Process based on published CARC & RARC lists as of November 2011	01/31/2013
3.0.2	Compliance-based adjustments as part of the CAQH CORE Code Combinations Maintenance Process based on published CARC & RARC lists as of March 2013	05/24/2013
3.0.3	Compliance-based adjustments as part of the CAQH CORE Code Combinations Maintenance Process based on published CARC & RARC lists as of July 2013	10/01/2013
3.0.4	Compliance-based adjustments as part of the CAQH CORE Code Combinations Maintenance Process based on published CARC & RARC lists as of November 2013	02/01/2014

Detailed Description of Updates for the February 2014 v3.0.4 CORE Code Combinations		
CORE-defined Business Scenario	Adjustment	Detailed Description of Adjustment
Business Scenario #1 – Additional	·3 RARC descriptions modified	· Description of RARC N102 was modified
nformation Required –		· Description of RARC N178 was modified
fissing/Invalid/Incomplete Documentation		· Description of RARC N244 was modified
	· 40 RARCs added	· RARC N678 was associated with CARC 163
		· RARC N679 was associated with CARC 163
		· RARC N680 was associated with CARC 163
		· RARC N681 was associated with CARC 163
		· RARC N682 was associated with CARC 163
		· RARC N683 was associated with CARC 163
		· RARC N685 was associated with CARC 163
		· RARC N686 was associated with CARC 163
		· RARC N678 was associated with CARC 164
		· RARC N679 was associated with CARC 164
		· RARC N680 was associated with CARC 164
		· RARC N681 was associated with CARC 164
		· RARC N682 was associated with CARC 164
		· RARC N683 was associated with CARC 164
		· RARC N685 was associated with CARC 164
		· RARC N686 was associated with CARC 164
		· RARC N678 was associated with CARC 250
		· RARC N679 was associated with CARC 250
		· RARC N680 was associated with CARC 250
		· RARC N681 was associated with CARC 250
		· RARC N682 was associated with CARC 250
		· RARC N683 was associated with CARC 250
		· RARC N685 was associated with CARC 250
		· RARC N686 was associated with CARC 250
		· RARC N678 was associated with CARC 251
		· RARC N679 was associated with CARC 251
		· RARC N680 was associated with CARC 251

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	•	
		· RARC N681 was associated with CARC 251
		· RARC N682 was associated with CARC 251
		· RARC N683 was associated with CARC 251
		· RARC N685 was associated with CARC 251
		· RARC N686 was associated with CARC 251
		· RARC N678 was associated with CARC 252
		· RARC N679 was associated with CARC 252
		· RARC N680 was associated with CARC 252
		· RARC N681 was associated with CARC 252
		· RARC N682 was associated with CARC 252
		· RARC N683 was associated with CARC 252
		· RARC N685 was associated with CARC 252
		· RARC N686 was associated with CARC 252
	· 1 CAGC corrected	· CAGC PR was removed from CARC 165 with RARC N630
	· I CAGC confected	· CAGC FR was fellioved from CARC 103 with RARC 1030
Business Scenario #2 – Additional	· 1 CARC description modified	· Description of CARC 16 was modified
Information Required –	· 1 CARC added	· CARC P7 was added
Missing/Invalid/Incomplete Data from	· 4 RARCs added	· RARC N685 was associated with CARC 16
Submitted Claim		· RARC N684 was associated with CARC 185
		· RARC M51 was associated with CARC P7
		· RARC M119 was associated with CARC P7
	· 1 CAGC corrected	· CAGC PR was removed from CARC 183 with RARC N630
	· 1 CAGC confected	· CAGC I K was fellioved from CARC 185 with RARC 1850
	· 1 RARC corrected in Marked-up version, Master tab	· In the master tab in v3.0.3 RARC N644, and not RARC
		N664, should have been associated with CARC 236. RARC
		N644 appeared correctly in the v3.0.3 tab for BS#2.
Business Scenario #3 – Billed Service Not	· 1 CARC description modified	· Description of CARC 49 was modified
Covered by Health Plan	· 2 RARC descriptions modified	· Description of RARC N102 was modified
	· 2 KARC descriptions mounted	Description of RARC N102 was modified Description of RARC N103 was modified
	· 16 code combinations removed	CARC W5 was removed due to deactivation of CARC
	· 16 code combinations removed	
		 CARC W6 with RARC N130 was removed due to deactivation of CARC
		· CARC W9 with RARCs N104 and N130 was removed due to
		deactivation of CARC
		· RARC N627 was removed from association with CARC 39
		due to deactivation of RARC
		• RARC N627 was removed from association with CARC 40
		due to deactivation of RARC RARC N627 was removed from association with CARC 49
		due to deactivation of RARC
		· RARC N627 was removed from association with CARC 50
		due to deactivation of RARC
		• RARC N627 was removed from association with CARC 60
		due to deactivation of RARC RARC N627 was removed from association with CARC 95
		due to deactivation of RARC
		RARC N365 was removed from association with CARC 96
		due to deactivation of RARC
		· RARC N627 was removed from association with CARC 174
		due to deactivation of RARC
		• RARC N627 was removed from association with CARC 222
		due to deactivation of RARC RARC N627 was removed from association with CARC 233
		due to deactivation of RARC
		· RARC N627 was removed from association with CARC 249
		due to deactivation of RARC
		• RARC N365 was removed from association with CARC 256
	. 8 CARCs added	due to deactivation of RARC · CARC 258 was added
	· 8 CARCs added	
		· CARC P2 was added
		· CARC P3 was added
		· CARC P4 was added
		· CARC P16 was added
	•	

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	1	· CARC P17 was added
		· CARC P20 was added
		· CARC P21 was added
	· 47 RARCs added	· RARC N684 was associated with CARC 8
		• RARC N30 was associated with CARC 258
		· RARC N103 was associated with CARC 258
		· RARC N193 was associated with CARC 258
		• RARC N612 was associated with CARC P4
		• RARC M80 was associated with CARC P21
		• RARC MA04 was associated with CARC P21
		• RARC N10 was associated with CARC P21
		• RARC N36 was associated with CARC P21
		RARC N95 was associated with CARC P21
		RARC N158 was associated with CARC P21
		RARC N409 was associated with CARC P21
		RARC N409 was associated with CARC F21 RARC N479 was associated with CARC P21
		RARC N576 was associated with CARC P21
		RARC N577 was associated with CARC P21
		RARC N578 was associated with CARC P21
		· RARC N579 was associated with CARC P21
		· RARC N580 was associated with CARC P21
		· RARC N582 was associated with CARC P21
		· RARC N583 was associated with CARC P21
		· RARC N584 was associated with CARC P21
		· RARC N585 was associated with CARC P21
		· RARC N586 was associated with CARC P21
		· RARC N587 was associated with CARC P21
		· RARC N588 was associated with CARC P21
		· RARC N589 was associated with CARC P21
		· RARC N590 was associated with CARC P21
		· RARC N593 was associated with CARC P21
		· RARC N594 was associated with CARC P21
		· RARC N595 was associated with CARC P21
		· RARC N596 was associated with CARC P21
		· RARC N598 was associated with CARC P21
		· RARC N607 was associated with CARC P21
		· RARC N611 was associated with CARC P21
		· RARC N621 was associated with CARC P21
		· RARC N622 was associated with CARC P21
		· RARC N650 was associated with CARC P21
		· RARC N651 was associated with CARC P21
		· RARC N652 was associated with CARC P21
		· RARC N653 was associated with CARC P21
		· RARC N657 was associated with CARC P21
		· RARC N658 was associated with CARC P21
		RARC N661 was associated with CARC P21
		RARC N665 was associated with CARC P21
		RARC N666 was associated with CARC P21
		RARC N667 was associated with CARC P21
		• RARC N667 was associated with CARC 121
usiness Scenario #4 – Benefit for Billed	. 2 code combinations removed	CARC W8 was removed due to deactivation of CARC
usiness Scenario #4 – Benefit for Billed ervice Not Separately Payable	· 2 code combinations removed	CARC W8 was removed due to deactivation of CARC RARC N365 was removed from combination with CARC 97
or the separately Layable		due to deactivation of RARC
	· 2 CARCs added	· CARC P14 was added
		· CARC P19 was added
1	· 13 RARCs added	• RARC M2 was associated with CARC P14
		TO THE WAS ASSOCIATED WITH CARC I 17
	13 To INOS daded	· RARC M15 was associated with CARC P14

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Code Combinations for Business Scenario #3: Billed Service Not Covered by Health Plan	BS #3
Code Combinations for Business Scenario #4: Benefit for Billed Service Not Separately Payable	BS #4
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Code Combinations for Business Scenarios #1, #2, #3 and #4	Master

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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/CAGC¹ 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
- 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, 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 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

 $http://www.ncpdp.org/members_download.aspx.\ NCPDP\ Reject\ Codes\ are\ in\ Appendix\ A.$

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

	G	Table		
			- Missing/Invalid/Incomplete Documentation	
			d from the billing provider or an ERA from a prior	
CARC	CARC Description ²	RARC	RARC Description ³	ASC X12 CAGO
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.	N563	Missing required provider/supplier issuance of advance patient notice of non-coverage. The patient is not liable for payment for this service.	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/c hart.	CO or PI
163	Attachment/other documentation referenced on the claim was not received.	N678	Missing post-operative images/visual field results.	CO or PI
163	Attachment/other documentation referenced on the claim was not received.	N679	Incomplete/Invalid post-operative images/visual field results.	CO or PI
163	Attachment/other documentation referenced on the claim was not received.	N680	Missing/Incomplete/Invalid date of previous dental extractions.	CO or PI
163	Attachment/other documentation referenced on the claim was not received.	N681	Missing/Incomplete/Invalid full arch series.	CO or PI
163	Attachment/other documentation referenced on the claim was not received.	N682	Missing/Incomplete/Invalid history of prior periodontal therapy/maintenance.	CO or PI
163	Attachment/other documentation referenced on the claim was not received.	N683	Missing/Incomplete/Invalid prior treatment documentation.	CO or PI
163	Attachment/other documentation referenced on the claim was not received.	N685	Missing/Incomplete/Invalid Prosthesis, Crown or Inlay Code.	CO or PI
163	Attachment/other documentation referenced on the claim was not received.	N686	Missing/incomplete/Invalid questionnaire needed to complete payment determination.	CO or PI
164	Attachment/other documentation referenced on the claim was not received in a timely fashion.	N678	Missing post-operative images/visual field results.	CO or PI
164	Attachment/other documentation referenced on the claim was not received in a timely fashion.	N679	Incomplete/Invalid post-operative images/visual field results.	CO or PI
164	Attachment/other documentation referenced on the claim was not received in a timely fashion.	N680	Missing/Incomplete/Invalid date of previous dental extractions.	CO or PI
164	Attachment/other documentation referenced on the claim was not received in a timely fashion.	N681	Missing/Incomplete/Invalid full arch series.	CO or PI
164	Attachment/other documentation referenced on the claim was not received in a timely fashion.	N682	Missing/Incomplete/Invalid history of prior periodontal therapy/maintenance.	CO or PI
164	Attachment/other documentation referenced on the claim was not received in a timely fashion.	N683	Missing/Incomplete/Invalid prior treatment documentation.	CO or PI
164	Attachment/other documentation referenced on the claim was not received in a timely fashion.	N685	Missing/Incomplete/Invalid Prosthesis, Crown or Inlay Code.	CO or PI
164	Attachment/other documentation referenced on the claim was not received in a timely fashion.	N686	Missing/incomplete/Invalid questionnaire needed to complete payment determination.	CO or PI
165	Referral absent or exceeded.	N630	Referral not authorized by attending physician).	CO or PI

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

	Scenario #1: Additional Informa	tion Required -	Missing/Invalid/Incomplete Documentation	
	Refers to situations where additional documer	tation is needed	l from the billing provider or an ERA from a prior	payer.
CARC	CARC Description ²	RARC	RARC Description ³	ASC X12 CAGO
197	Precertification/authorization/notification absent.			CO or PI
250	The attachment/other documentation content received is inconsistent with the expected content.	N555	Missing medication list.	CO or PI
250	The attachment/other documentation content received is inconsistent with the expected content.	N556	Incomplete/invalid medication list.	CO or PI
250	The attachment/other documentation content received is inconsistent with the expected content.	N594	Records reflect the injured party did not complete an Application for Benefits for this loss.	CO or PI
250	The attachment/other documentation content received is inconsistent with the expected content.	N595	Records reflect the injured party did not complete an Assignment of Benefits for this loss.	CO or PI
250	The attachment/other documentation content received is inconsistent with the expected content.	N596	Records reflect the injured party did not complete a Medical Authorization for this loss.	CO or PI
250	The attachment/other documentation content received is inconsistent with the expected content.	N667	Missing prescription	CO or PI
250	The attachment/other documentation content received is inconsistent with the expected content.	N668	Incomplete/invalid prescription	CO or PI
250	The attachment/other documentation content received is inconsistent with the expected content.	N678	Missing post-operative images/visual field results.	CO or PI
250	The attachment/other documentation content received is inconsistent with the expected content.	N679	Incomplete/Invalid post-operative images/visual field results.	CO or PI
250	The attachment/other documentation content received is inconsistent with the expected content.	N680	Missing/Incomplete/Invalid date of previous dental extractions.	CO or PI
250	The attachment/other documentation content received is inconsistent with the expected content.	N681	Missing/Incomplete/Invalid full arch series.	CO or PI
250	The attachment/other documentation content received is inconsistent with the expected content.	N682	Missing/Incomplete/Invalid history of prior periodontal therapy/maintenance.	CO or PI
250	The attachment/other documentation content received is inconsistent with the expected content.	N683	Missing/Incomplete/Invalid prior treatment documentation.	CO or PI
250	The attachment/other documentation content received is inconsistent with the expected content.	N685	Missing/Incomplete/Invalid Prosthesis, Crown or Inlay Code.	CO or PI
250	The attachment/other documentation content received is inconsistent with the expected content.	N686	Missing/incomplete/Invalid questionnaire needed to complete payment determination.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	M1	X-ray not taken within the past 12 months or near enough to the start of treatment.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	M19	Missing oxygen certification/re-certification.	CO or PI

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

		Table 2		
			Missing/Invalid/Incomplete Documentation	
	Refers to situations where additional documen	ntation is needed	from the billing provider or an ERA from a prior	payer.
CARC	CARC Description ²	RARC	RARC Description ³	ASC X12 CAGO
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	M21	Missing/incomplete/invalid place of residence for this service/item provided in a home.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	M23	Missing invoice.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	M29	Missing operative note/report.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	M30	Missing pathology report.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	M31	Missing radiology report.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	M42	The medical necessity form must be personally signed by the attending physician.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	M47	Missing/incomplete/invalid internal or document control number.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	M51	Missing/incomplete/invalid procedure code(s).	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	M60	Missing Certificate of Medical Necessity.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	M64	Missing/incomplete/invalid other diagnosis.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	M127	Missing patient medical record for this service.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	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
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	M131	Missing physician financial relationship form.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	M132	Missing pacemaker registration form.	CO or PI

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

	G ' #4 A 1144' 1 T 6	Table		
		_	Missing/Invalid/Incomplete Documentation	navan
a			from the billing provider or an ERA from a prior	
CARC	CARC Description ²	RARC	RARC Description ³	ASC X12 CAGC
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	M135	Missing/incomplete/invalid plan of treatment.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	M141	Missing physician certified plan of care.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	M142	Missing American Diabetes Association Certificate of Recognition.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	M143	The provider must update license information with the payer.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	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
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	MA27	Missing/incomplete/invalid entitlement number or name shown on the claim.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	MA61	Missing/incomplete/invalid social security number or health insurance claim number.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	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
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	MA75	Missing/incomplete/invalid patient or authorized representative signature.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	MA76	Missing/incomplete/invalid provider identifier for home health agency or hospice when physician is performing care plan oversight services.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	MA81	Missing/incomplete/invalid provider/supplier signature.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	MA83	Did not indicate whether we are the primary or secondary payer.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	MA88	Missing/incomplete/invalid insured's address and/or telephone number for the primary payer.	CO or PI

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

		Table 2		
	Scenario #1: Additional Informa	ation Required –	Missing/Invalid/Incomplete Documentation	
	Refers to situations where additional docume	ntation is needed	from the billing provider or an ERA from a prior	payer.
CARC	CARC Description ²	RARC	RARC Description ³	ASC X12 CAGO
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	MA92	Missing plan information for other insurance.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	MA96	Claim rejected. Coded as a Medicare Managed Care Demonstration but patient is not enrolled in a Medicare managed care plan.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	MA111	Missing/incomplete/invalid purchase price of the test(s) and/or the performing laboratory's name and address.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	MA112	Missing/incomplete/invalid group practice information.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	MA114	Missing/incomplete/invalid information on where the services were furnished.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	MA122	Missing/incomplete/invalid initial treatment date.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	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
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N3	Missing consent form.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N4	Missing/incomplete/invalid prior insurance carrier EOB.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N26	Missing itemized bill/statement	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N28	Consent form requirements not fulfilled.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N29	Missing documentation/orders/notes/summary/report/c hart.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N40	Missing radiology film(s)/image(s).	CO or PI

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

	Scenario #1 · Additional Informa	Table	- Missing/Invalid/Incomplete Documentation	
		_	- Missing/Invalid/Incomplete Documentation d from the billing provider or an ERA from a prior	paver.
CARC	CARC Description ²	RARC	RARC Description ³	ASC X12 CAGC
251	The attachment/other documentation content	N42	No record of mental health assessment.	CO or PI
	received did not contain the content required to process this claim or service.			
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N59	Please refer to your provider manual for additional program and provider information.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N80	Missing/incomplete/invalid prenatal screening information.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N102	This claim has been denied without reviewing the medical/dental record because the requested records were not received or were not received timely.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N146	Missing screening document.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N175	Missing review organization approval.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N178	Missing pre-operative images/visual field results.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N179	Additional information has been requested from the member. The charges will be reconsidered upon receipt of that information.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N186	Non-Availability Statement (NAS) required for this service. Contact the nearest Military Treatment Facility (MTF) for assistance.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N191	The provider must update insurance information directly with payer.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N197	The subscriber must update insurance information directly with payer.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N202	Additional information/explanation will be sent separately.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N204	Services under review for possible pre- existing condition. Send medical records for prior 12 months.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N205	Information provided was illegible.	CO or PI

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

	Scanario #1. Additional Informa	Table	- Missing/Invalid/Incomplete Documentation	
			d from the billing provider or an ERA from a prior	paver.
CARC	CARC Description ²	RARC	RARC Description ³	ASC X12 CAGO
251	The attachment/other documentation content	N206	The supporting documentation does not	CO or PI
231	received did not contain the content required to process this claim or service.	11200	match the claim.	CO W 11
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N214	Missing/incomplete/invalid history of the related initial surgical procedure(s).	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N221	Missing Admitting History and Physical report.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N222	Incomplete/invalid Admitting History and Physical report.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N223	Missing documentation of benefit to the patient during initial treatment period.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N224	Incomplete/invalid documentation of benefit to the patient during initial treatment period.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N225	Incomplete/invalid documentation/orders/notes/summary/report/c hart.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N227	Incomplete/invalid Certificate of Medical Necessity.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N228	Incomplete/invalid consent form.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	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
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N232	Incomplete/invalid itemized bill/statement.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N233	Incomplete/invalid operative note/report.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N234	Incomplete/invalid oxygen certification/re-certification.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N235	Incomplete/invalid pacemaker registration form.	CO or PI

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

	Cooperis #1. Additional T. C.	tion Docuined	Missing/Involid/Incomplete Descriptories	
		•	- Missing/Invalid/Incomplete Documentation d from the billing provider or an ERA from a prior	naver
CARC	CARC Description ²	RARC	RARC Description ³	ASC X12 CAGO
251	The attachment/other documentation content	N236	Incomplete/invalid pathology report.	CO or PI
	received did not contain the content required to process this claim or service.			
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N237	Incomplete/invalid patient medical record for this service.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N238	Incomplete/invalid physician certified plan of care.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N239	Incomplete/invalid physician financial relationship form.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N240	Incomplete/invalid radiology report.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N241	Incomplete/invalid review organization approval.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N242	Incomplete/invalid radiology film(s)/image(s).	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N243	Incomplete/invalid/not approved screening document.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N244	Incomplete/Invalid pre-operative images/visual field results.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N245	Incomplete/invalid plan information for other insurance	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N286	Missing/incomplete/invalid referring provider primary identifier.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N331	Missing/incomplete/invalid physician order date.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N350	Missing/incomplete/invalid description of service for a Not Otherwise Classified (NOC) code or for an Unlisted/By Report procedure.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N354	Incomplete/invalid invoice.	CO or PI

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

		Table		
	Scenario #1: Additional Informa	tion Required -	Missing/Invalid/Incomplete Documentation	
	Refers to situations where additional document	ntation is needed	l from the billing provider or an ERA from a prior	payer.
CARC	CARC Description ²	RARC	RARC Description ³	ASC X12 CAGC
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	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
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N375	Missing/incomplete/invalid questionnaire/information required to determine dependent eligibility.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N391	Missing emergency department records.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N392	Incomplete/invalid emergency department records.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N393	Missing progress notes/report.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N394	Incomplete/invalid progress notes/report.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N395	Missing laboratory report.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N396	Incomplete/invalid laboratory report.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N398	Missing elective consent form.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N399	Incomplete/invalid elective consent form.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N401	Missing periodontal charting.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N402	Incomplete/invalid periodontal charting.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N403	Missing facility certification.	CO or PI

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

		Table		
			Missing/Invalid/Incomplete Documentation	
	Refers to situations where additional documen	ntation is needed	l from the billing provider or an ERA from a prior	payer.
CARC	CARC Description ²	RARC	RARC Description ³	ASC X12 CAGO
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N404	Incomplete/invalid facility certification.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N439	Missing anesthesia physical status report/indicators.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N440	Incomplete/invalid anesthesia physical status report/indicators.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N445	Missing document for actual cost or paid amount.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N446	Incomplete/invalid document for actual cost or paid amount.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N451	Missing Admission Summary Report.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N452	Incomplete/invalid Admission Summary Report.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N453	Missing Consultation Report.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N454	Incomplete/invalid Consultation Report.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N455	Missing Physician Order.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N456	Incomplete/invalid Physician Order.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N457	Missing Diagnostic Report.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N458	Incomplete/invalid Diagnostic Report.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N459	Missing Discharge Summary.	CO or PI

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

251 The a receive to process to p	CARC Description ² Ittachment/other documentation content yed did not contain the content required occess this claim or service. Ittachment/other documentation content yed did not contain the content required occess this claim or service. Ittachment/other documentation content yed did not contain the content required occess this claim or service. Ittachment/other documentation content yed did not contain the content required occess this claim or service. Ittachment/other documentation content yed did not contain the content required occess this claim or service. Ittachment/other documentation content yed did not contain the content required occess this claim or service.		- Missing/Invalid/Incomplete Documentation d from the billing provider or an ERA from a prior RARC Description ³ Incomplete/invalid Discharge Summary. Missing Nursing Notes. Incomplete/invalid Nursing Notes. Missing support data for claim.	ASC X12 CAGO CO or PI CO or PI CO or PI
251 The a receive to process to p	CARC Description ² Ittachment/other documentation content yed did not contain the content required occess this claim or service. Ittachment/other documentation content yed did not contain the content required occess this claim or service. Ittachment/other documentation content yed did not contain the content required occess this claim or service. Ittachment/other documentation content yed did not contain the content required occess this claim or service. Ittachment/other documentation content yed did not contain the content required occess this claim or service.	N460 N461 N462	RARC Description ³ Incomplete/invalid Discharge Summary. Missing Nursing Notes. Incomplete/invalid Nursing Notes.	ASC X12 CAGO CO or PI CO or PI
251 The a receive to proceed to p	attachment/other documentation content yed did not contain the content required occess this claim or service. attachment/other documentation content yed did not contain the content required occess this claim or service. attachment/other documentation content yed did not contain the content required occess this claim or service. attachment/other documentation content yed did not contain the content required occess this claim or service. attachment/other documentation content yed did not contain the content required occess this claim or service.	N460 N461 N462	Incomplete/invalid Discharge Summary. Missing Nursing Notes. Incomplete/invalid Nursing Notes.	CO or PI
receive to proceed to	ditachment/other documentation content required occss this claim or service. ditachment/other documentation content red did not contain the content required occss this claim or service. ditachment/other documentation content red did not contain the content required occss this claim or service. ditachment/other documentation content red did not contain the content required occss this claim or service.	N461 N462	Missing Nursing Notes. Incomplete/invalid Nursing Notes.	CO or PI
to pro 251 The a receive to pro	attachment/other documentation content ved did not contain the content required occess this claim or service. attachment/other documentation content ved did not contain the content required occess this claim or service. attachment/other documentation content ved did not contain the content required occess this claim or service. attachment/other documentation content ved did not contain the content required occess this claim or service.	N462	Incomplete/invalid Nursing Notes.	
receive to proceed to	deed did not contain the content required occess this claim or service. Attachment/other documentation content red did not contain the content required occess this claim or service. Attachment/other documentation content red did not contain the content required occess this claim or service. Attachment/other documentation content red did not contain the content required occess this claim or service.	N462	Incomplete/invalid Nursing Notes.	
to pro 251 The a receive to pro	attachment/other documentation content ved did not contain the content required occss this claim or service. attachment/other documentation content ved did not contain the content required did not contain the content required occss this claim or service.			CO or PI
251 The a receive to process to p	attachment/other documentation content yed did not contain the content required occess this claim or service. attachment/other documentation content yed did not contain the content required occess this claim or service.			CO or PI
receive to proceed to	yed did not contain the content required occss this claim or service. Attachment/other documentation content yed did not contain the content required occss this claim or service. Attachment/other documentation content			CO or PI
to pro 251 The a receive to pro	attachment/other documentation content ved did not contain the content required occss this claim or service.	N463	Missing support data for claim.	
251 The a receive to process to p	attachment/other documentation content yed did not contain the content required occss this claim or service.	N463	Missing support data for claim.	
receive to produce to	yed did not contain the content required occess this claim or service.	N463	Missing support data for claim.	
to pro 251 The a receive to pro	ocess this claim or service. ttachment/other documentation content			CO or PI
251 The a receive to proceed to p	attachment/other documentation content		•	
receive to process to				
to pro 251 The a receive to pro		N464	Incomplete/invalid support data for claim.	CO or PI
251 The a receive to process to p	ved did not contain the content required			
receive to proceed to	ocess this claim or service.			
to pro 251 The a receive to pro	ttachment/other documentation content	N465	Missing Physical Therapy Notes/Report.	CO or PI
251 The a receive to proceed to p	ved did not contain the content required			
receive to process to	ocess this claim or service.			
to pro 251 The a receive to pro	attachment/other documentation content	N466	Incomplete/invalid Physical Therapy	CO or PI
251 The a receive to proceed to p	ved did not contain the content required		Notes/Report.	
receive to process to	ocess this claim or service.			
to pro 251 The a receive to pro	attachment/other documentation content	N467	Missing Report of Tests and Analysis Report.	CO or PI
251 The a receive to proceed to p	ved did not contain the content required			
receive to produce to	ocess this claim or service.			
to pro 251 The a receive to pro 251 The a receive to pro 251 The a receive to pro-	attachment/other documentation content	N468	Incomplete/invalid Report of Tests and	CO or PI
251 The a receive to process to p	ved did not contain the content required		Analysis Report.	
receive to pro	ocess this claim or service.			
to pro The a	ttachment/other documentation content	N473	Missing certification.	CO or PI
251 The a	ved did not contain the content required			
receiv	ocess this claim or service.			
	attachment/other documentation content	N474	Incomplete/invalid certification.	CO or PI
to pro	ved did not contain the content required			
	ocess this claim or service.			
	<u> </u>	N475	Missing completed referral form.	CO or PI
	ttachment/other documentation content			
to pro	ved did not contain the content required			
		N476	Incomplete/invalid completed referral form.	CO or PI
	ved did not contain the content required occss this claim or service.			
to pro	ved did not contain the content required occss this claim or service. uttachment/other documentation content ved did not contain the content required			
251 The a	ved did not contain the content required occss this claim or service.		Ţ l	CO or PI
receiv to pro	ved did not contain the content required occss this claim or service. uttachment/other documentation content ved did not contain the content required	N477	Missing Dental Models.	

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

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	1	RARC		
251	CARC Description ² The attachment/other documentation content	N478	RARC Description ³ Incomplete/invalid Dental Models.	ASC X12 CAGO
231	received did not contain the content required to process this claim or service.	11476	meompiete/invalid Bental Models.	COULT
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N479	Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N480	Incomplete/invalid Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N481	Missing Models.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N482	Incomplete/invalid Models.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N483	Missing Periodontal Charts.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N484	Incomplete/invalid Periodontal Charts.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N485	Missing Physical Therapy Certification.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N486	Incomplete/invalid Physical Therapy Certification.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N487	Missing Prosthetics or Orthotics Certification.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N488	Incomplete/invalid Prosthetics or Orthotics Certification.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N489	Missing referral form.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N490	Incomplete/invalid referral form.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N491	Missing/Incomplete/Invalid Exclusionary Rider Condition.	CO or PI

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

Table 2-1						
Scenario #1: Additional Information Required – Missing/Invalid/Incomplete Documentation						
a. 5 a	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 CAGO		
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N493	Missing Doctor First Report of Injury.	CO or PI		
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N494	Incomplete/invalid Doctor First Report of Injury.	CO or PI		
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N495	Missing Supplemental Medical Report.	CO or PI		
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N496	Incomplete/invalid Supplemental Medical Report.	CO or PI		
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N497	Missing Medical Permanent Impairment or Disability Report.	CO or PI		
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N498	Incomplete/invalid Medical Permanent Impairment or Disability Report.	CO or PI		
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N499	Missing Medical Legal Report.	CO or PI		
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N500	Incomplete/invalid Medical Legal Report.	CO or PI		
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N542	Missing income verification.	CO or PI		
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N543	Incomplete/invalid income verification.	CO or PI		
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N555	Missing medication list.	CO or PI		
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N556	Incomplete/invalid medication list.	CO or PI		
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N563	Missing required provider/supplier issuance of advance patient notice of non-coverage. The patient is not liable for payment for this service.	CO or PI		
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N590	Missing independent medical exam detailing the cause of injuries sustained and medical necessity of services rendered.	CO or PI		

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

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 CAGO
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N594	Records reflect the injured party did not complete an Application for Benefits for this loss.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N595	Records reflect the injured party did not complete an Assignment of Benefits for this loss.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N596	Records reflect the injured party did not complete a Medical Authorization for this loss.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N667	Missing prescription	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N668	Incomplete/invalid prescription	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N678	Missing post-operative images/visual field results.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N679	Incomplete/Invalid post-operative images/visual field results.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N680	Missing/Incomplete/Invalid date of previous dental extractions.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N681	Missing/Incomplete/Invalid full arch series.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N682	Missing/Incomplete/Invalid history of prior periodontal therapy/maintenance.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N683	Missing/Incomplete/Invalid prior treatment documentation.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N685	Missing/Incomplete/Invalid Prosthesis, Crown or Inlay Code.	CO or PI
251	The attachment/other documentation content received did not contain the content required to process this claim or service.	N686	Missing/incomplete/Invalid questionnaire needed to complete payment determination.	CO or PI

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

Table 2-1 Scenario #1: Additional Information Required – Missing/Invalid/Incomplete Documentation						
		•	•	navar		
CARC			d from the billing provider or an ERA from a prior			
252	CARC Description ² An attachment/other documentation is	RARC M1	RARC Description ³ X-ray not taken within the past 12 months or	CO or PI		
252	required to adjudicate this claim/service. At	WH	near enough to the start of treatment.	COOLE		
	least one Remark Code must be provided					
	(may be comprised of either the NCPDP					
	Reject Reason Code, or Remittance Advice					
	Remark Code that is not an ALERT).					
252	An attachment/other documentation is	M19	Missing oxygen certification/re-certification.	CO or PI		
	required to adjudicate this claim/service. At					
	least one Remark Code must be provided					
	(may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice					
	Remark Code that is not an ALERT).					
252	An attachment/other documentation is	M21	Missing/incomplete/invalid place of residence	CO or PI		
202	required to adjudicate this claim/service. At	1,121	for this service/item provided in a home.	20 01 11		
	least one Remark Code must be provided		,			
	(may be comprised of either the NCPDP					
	Reject Reason Code, or Remittance Advice					
	Remark Code that is not an ALERT).					
252	An attachment/other documentation is	M23	Missing invoice.	CO or PI		
	required to adjudicate this claim/service. At least one Remark Code must be provided					
252	An attachment/other documentation is	M29	Missing operative note/report.	CO or PI		
202	required to adjudicate this claim/service. At	1,12)	operative note/report	00 0111		
	least one Remark Code must be provided					
252	An attachment/other documentation is	M30	Missing pathology report.	CO or PI		
	required to adjudicate this claim/service. At					
252	least one Remark Code must be provided An attachment/other documentation is	M31	Missing radiology report.	CO or PI		
202	required to adjudicate this claim/service. At	1,101	inisong radiology reports	00 0111		
	least one Remark Code must be provided					
252	An attachment/other documentation is	M42	The medical necessity form must be	CO or PI		
	required to adjudicate this claim/service. At least one Remark Code must be provided		personally signed by the attending physician.			
252	An attachment/other documentation is	M47	Missing/incomplete/invalid internal or	CO or PI		
	required to adjudicate this claim/service. At		document control number.			
252	least one Remark Code must be provided	1.471	Mining Community Com 111	GO DY		
252	An attachment/other documentation is required to adjudicate this claim/service. At	M51	Missing/incomplete/invalid procedure code(s).	CO or PI		
	least one Remark Code must be provided		couc(s).			
252	An attachment/other documentation is	M60	Missing Certificate of Medical Necessity.	CO or PI		
	required to adjudicate this claim/service. At					
	least one Remark Code must be provided					
252	An attachment/other documentation is	M64	Missing/incomplete/invalid other diagnosis.	CO or PI		
	required to adjudicate this claim/service. At least one Remark Code must be provided					
252	An attachment/other documentation is	M127	Missing patient medical record for this	CO or PI		
	required to adjudicate this claim/service. At		service.			

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

		Table		
		•	- Missing/Invalid/Incomplete Documentation	
	Refers to situations where additional docume	ntation is needed	d from the billing provider or an ERA from a prior	payer.
CARC	CARC Description ²	RARC	RARC Description ³	ASC X12 CAGO
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	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
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	M131	Missing physician financial relationship form.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	M132	Missing pacemaker registration form.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	M135	Missing/incomplete/invalid plan of treatment.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	M141	Missing physician certified plan of care.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	M142	Missing American Diabetes Association Certificate of Recognition.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	M143	The provider must update license information with the payer.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice	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
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	MA27	Missing/incomplete/invalid entitlement number or name shown on the claim.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	MA61	Missing/incomplete/invalid social security number or health insurance claim number.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not as ALEPT)	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
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	MA75	Missing/incomplete/invalid patient or authorized representative signature.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP	MA76	Missing/incomplete/invalid provider identifier for home health agency or hospice when physician is performing care plan oversight services.	CO or PI

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

	0 1 1/4 1 3 3 1/4 2 7 2	Table		
			Missing/Invalid/Incomplete Documentation	navan
G. D.G			from the billing provider or an ERA from a prior	
CARC	CARC Description ²	RARC	RARC Description ³	ASC X12 CAGO
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	MA81	Missing/incomplete/invalid provider/supplier signature.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	MA83	Did not indicate whether we are the primary or secondary payer.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	MA88	Missing/incomplete/invalid insured's address and/or telephone number for the primary payer.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	MA92	Missing plan information for other insurance.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP	MA96	Claim rejected. Coded as a Medicare Managed Care Demonstration but patient is not enrolled in a Medicare managed care plan.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	MA111	Missing/incomplete/invalid purchase price of the test(s) and/or the performing laboratory's name and address.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	MA112	Missing/incomplete/invalid group practice information.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDR	MA114	Missing/incomplete/invalid information on where the services were furnished.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	MA122	Missing/incomplete/invalid initial treatment date.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice	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
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N3	Missing consent form.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N4	Missing/incomplete/invalid prior insurance carrier EOB.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N26	Missing itemized bill/statement	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N28	Consent form requirements not fulfilled.	CO or PI

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

		Table		
			- Missing/Invalid/Incomplete Documentation	
		entation is needed	d from the billing provider or an ERA from a prior	payer.
CARC	CARC Description ²	RARC	RARC Description ³	ASC X12 CAGO
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N29	Missing documentation/orders/notes/summary/report/c hart.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N40	Missing radiology film(s)/image(s).	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N42	No record of mental health assessment.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N50	Missing/incomplete/invalid discharge information.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N59	Please refer to your provider manual for additional program and provider information.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N80	Missing/incomplete/invalid prenatal screening information.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP	N102	This claim has been denied without reviewing the medical/dental record because the requested records were not received or were not received timely.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N146	Missing screening document.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N170	A new/revised/renewed certificate of medical necessity is needed.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N175	Missing review organization approval.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N178	Missing pre-operative images/visual field results.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP	N179	Additional information has been requested from the member. The charges will be reconsidered upon receipt of that information.	CO or PI

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

		Table		
			Missing/Invalid/Incomplete Documentation	
			from the billing provider or an ERA from a prior	
CARC	CARC Description ²	RARC	RARC Description ³	ASC X12 CAGO
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N186	Non-Availability Statement (NAS) required for this service. Contact the nearest Military Treatment Facility (MTF) for assistance.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N191	The provider must update insurance information directly with payer.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N197	The subscriber must update insurance information directly with payer.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N202	Additional information/explanation will be sent separately.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP)	N204	Services under review for possible pre- existing condition. Send medical records for prior 12 months.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N205	Information provided was illegible.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N206	The supporting documentation does not match the claim.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N214	Missing/incomplete/invalid history of the related initial surgical procedure(s).	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N221	Missing Admitting History and Physical report.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N222	Incomplete/invalid Admitting History and Physical report.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N223	Missing documentation of benefit to the patient during initial treatment period.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N224	Incomplete/invalid documentation of benefit to the patient during initial treatment period.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N225	Incomplete/invalid documentation/orders/notes/summary/report/c hart.	CO or PI

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

	Coongris #1. Additional Information	Table	- Missing/Invalid/Incomplete Documentation	
		•	Missing/invalid/incomplete Documentation I from the billing provider or an ERA from a prior	naver
CARC	CARC Description ²	RARC	RARC Description ³	ASC X12 CAGO
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N227	Incomplete/invalid Certificate of Medical Necessity.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N228	Incomplete/invalid consent form.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice	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
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N232	Incomplete/invalid itemized bill/statement.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N233	Incomplete/invalid operative note/report.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N234	Incomplete/invalid oxygen certification/re-certification.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N235	Incomplete/invalid pacemaker registration form.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N236	Incomplete/invalid pathology report.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N237	Incomplete/invalid patient medical record for this service.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N238	Incomplete/invalid physician certified plan of care	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N239	Incomplete/invalid physician financial relationship form.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP	N240	Incomplete/invalid radiology report.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N241	Incomplete/invalid review organization approval.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N242	Incomplete/invalid radiology film(s)/image(s).	CO or PI

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

		Table		
		•	Missing/Invalid/Incomplete Documentation	
			from the billing provider or an ERA from a prior	
CARC	CARC Description ²	RARC	RARC Description ³	ASC X12 CAGO
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N243	Incomplete/invalid/not approved screening document.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N244	Incomplete/Invalid pre-operative images/visual field results.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N245	Incomplete/invalid plan information for other insurance	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N286	Missing/incomplete/invalid referring provider primary identifier.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N331	Missing/incomplete/invalid physician order date.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP	N350	Missing/incomplete/invalid description of service for a Not Otherwise Classified (NOC) code or for an Unlisted/By Report procedure.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N354	Incomplete/invalid invoice.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	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
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N375	Missing/incomplete/invalid questionnaire/information required to determine dependent eligibility.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N391	Missing emergency department records.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N392	Incomplete/invalid emergency department records.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N393	Missing progress notes/report.	CO or PI

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

	6 14 1710 17 2	Table :		
			Missing/Invalid/Incomplete Documentation	
			from the billing provider or an ERA from a prior	
CARC	CARC Description ²	RARC	RARC Description ³	ASC X12 CAGO
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N394	Incomplete/invalid progress notes/report.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N395	Missing laboratory report.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N396	Incomplete/invalid laboratory report.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N398	Missing elective consent form.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N399	Incomplete/invalid elective consent form.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N401	Missing periodontal charting.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N402	Incomplete/invalid periodontal charting.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N403	Missing facility certification.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N404	Incomplete/invalid facility certification.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N439	Missing anesthesia physical status report/indicators.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N440	Incomplete/invalid anesthesia physical status report/indicators.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N445	Missing document for actual cost or paid amount.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N446	Incomplete/invalid document for actual cost or paid amount.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N451	Missing Admission Summary Report.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N452	Incomplete/invalid Admission Summary Report.	CO or PI

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

		Table 2		
		_	Missing/Invalid/Incomplete Documentation	
	Refers to situations where additional docume	ntation is needed	from the billing provider or an ERA from a prior	payer.
CARC	CARC Description ²	RARC	RARC Description ³	ASC X12 CAGO
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N453	Missing Consultation Report.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N454	Incomplete/invalid Consultation Report.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N455	Missing Physician Order.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N456	Incomplete/invalid Physician Order.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N457	Missing Diagnostic Report.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N458	Incomplete/invalid Diagnostic Report.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N459	Missing Discharge Summary.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N460	Incomplete/invalid Discharge Summary.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N461	Missing Nursing Notes.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N462	Incomplete/invalid Nursing Notes.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N463	Missing support data for claim.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N464	Incomplete/invalid support data for claim.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N465	Missing Physical Therapy Notes/Report.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N466	Incomplete/invalid Physical Therapy Notes/Report.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N467	Missing Report of Tests and Analysis Report.	CO or PI

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

	Seenarie #1. Additional Inform	Table		
			- Missing/Invalid/Incomplete Documentation d from the billing provider or an ERA from a prior	r naver
CARC	CARC Description ²	RARC	RARC Description ³	ASC X12 CAGO
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N468	Incomplete/invalid Report of Tests and Analysis Report.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N473	Missing certification.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N474	Incomplete/invalid certification.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N475	Missing completed referral form.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N476	Incomplete/invalid completed referral form.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N477	Missing Dental Models.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N478	Incomplete/invalid Dental Models.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N479	Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N480	Incomplete/invalid Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N481	Missing Models.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N482	Incomplete/invalid Models.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N483	Missing Periodontal Charts.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N484	Incomplete/invalid Periodontal Charts.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N485	Missing Physical Therapy Certification.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N486	Incomplete/invalid Physical Therapy Certification.	CO or PI

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

	Comoni- #1. A 3.3/41 T. C	Table		
			- Missing/Invalid/Incomplete Documentation d from the billing provider or an ERA from a prio	r novor
G. D.G				
CARC	CARC Description ²	RARC	RARC Description ³	ASC X12 CAGO
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N487	Missing Prosthetics or Orthotics Certification.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N488	Incomplete/invalid Prosthetics or Orthotics Certification.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N489	Missing referral form.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N490	Incomplete/invalid referral form.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N491	Missing/Incomplete/Invalid Exclusionary Rider Condition.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At	N493	Missing Doctor First Report of Injury.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N494	Incomplete/invalid Doctor First Report of Injury.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N495	Missing Supplemental Medical Report.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N496	Incomplete/invalid Supplemental Medical Report.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N497	Missing Medical Permanent Impairment or Disability Report.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N498	Incomplete/invalid Medical Permanent Impairment or Disability Report.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N499	Missing Medical Legal Report.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N500	Incomplete/invalid Medical Legal Report.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N542	Missing income verification.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N543	Incomplete/invalid income verification.	CO or PI

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

	Soonaria #1. Additional Information	Table 2		
			Missing/Invalid/Incomplete Documentation I from the billing provider or an ERA from a prior	naver.
CARC	CARC Description ²	RARC	RARC Description ³	ASC X12 CAGO
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N555	Missing medication list.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N556	Incomplete/invalid medication list.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP	N563	Missing required provider/supplier issuance of advance patient notice of non-coverage. The patient is not liable for payment for this service.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP)	N590	Missing independent medical exam detailing the cause of injuries sustained and medical necessity of services rendered.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N594	Records reflect the injured party did not complete an Application for Benefits for this loss.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N595	Records reflect the injured party did not complete an Assignment of Benefits for this loss.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N596	Records reflect the injured party did not complete a Medical Authorization for this loss.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N667	Missing prescription	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N668	Incomplete/invalid prescription	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N678	Missing post-operative images/visual field results.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N679	Incomplete/Invalid post-operative images/visual field results.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N680	Missing/Incomplete/Invalid date of previous dental extractions.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N681	Missing/Incomplete/Invalid full arch series.	CO or PI

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

		Table :	2-1	
		•	Missing/Invalid/Incomplete Documentation I from the billing provider or an ERA from a prio	or payer.
CARC	CARC Description ²	RARC	RARC Description ³	ASC X12 CAGC
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT).	N682	Missing/Incomplete/Invalid history of prior periodontal therapy/maintenance.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N683	Missing/Incomplete/Invalid prior treatment documentation.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N685	Missing/incomplete/Invalid questionnaire needed to complete payment determination.	CO or PI
252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided	N686	Missing/incomplete/Invalid questionnaire needed to complete payment determination.	CO or PI

²Washington Publishing Company: http://www.wpc-edi.com/reference/

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³Washington Publishing Company: http://www.wpc-edi.com/reference/

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

	Conquia #2: Missing	Table // Table	3-1 Delete Data from Submitted Claim	
Refere to	o de la companya de	•	otete Data from Submitted Claim er for missing or invalid data on the submitted clair	m a 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
4	The procedure code is inconsistent with the modifier used or a required modifier is	N519	Invalid combination of HCPCS modifiers.	CO or PI
4	The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare	N572	This procedure is not payable unless non- payable reporting codes and appropriate modifiers are submitted.	CO or PI
4	The procedure code is inconsistent with the modifier used or a required modifier is	N644	Reimbursement has been made according to the bilateral procedure rule.	CO or PI
4	The procedure code is inconsistent with the modifier used or a required modifier is	N657	This should be billed with the appropriate code for these services.	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
9	The diagnosis is inconsistent with the patient's age. Note: Refer to the 835	N657	This should be billed with the appropriate code for these services.	CO or PI
10	The diagnosis is inconsistent with the patient's gender. Note: Refer to the 835	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	N657	This should be billed with the appropriate code for these services.	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.	N657	This should be billed with the appropriate code for these services.	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.	N657	This should be billed with the appropriate code for these services.	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
15	The authorization number is missing, invalid, or does not apply to the billed services or provider.	N596	Records reflect the injured party did not complete a Medical Authorization for this loss.	CO or PI

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

	G	Table		
Dofore 4			olete Data from Submitted Claim	
CARC		RARC	er for missing or invalid data on the submitted claim	ASC X12 CAG
	CARC Description ⁴		RARC Description ⁵	
16	Claim/service lacks information or has submission/billing error(s) which is needed	M20	Missing/incomplete/invalid HCPCS.	CO or PI
	for adjudication. Do not use this code for			
	claims attachment(s)/other documentation. At			
	least one Remark Code must be provided			
	(may be comprised of either the NCPDP			
	Reject Reason Code, or Remittance Advice			
	Remark Code that is not an ALERT.) Note:			
	Refer to the 835 Healthcare Policy			
	Identification Segment (loop 2110 Service			
	Payment Information REF), if present.			
	1 ayment information KE1/), it present.			
16	Claim/service lacks information or has	M21	Missing/incomplete/invalid place of residence	CO or PI
	submission/billing error(s) which is needed		for this service/item provided in a home.	
16	Claim/service lacks information or has	M22	Missing/incomplete/invalid number of miles	CO or PI
	submission/billing error(s) which is needed		traveled.	
16	Claim/service lacks information or has	M24	Missing/incomplete/invalid number of doses	CO or PI
	submission/billing error(s) which is needed		per vial.	
16	Claim/service lacks information or has	M44	Missing/incomplete/invalid condition code.	CO or PI
	submission/billing error(s) which is needed			
16	Claim/service lacks information or has	M45	Missing/incomplete/invalid occurrence	CO or PI
	submission/billing error(s) which is needed		code(s).	
16	Claim/service lacks information or has	M46	Missing/incomplete/invalid occurrence span	CO or PI
	submission/billing error(s) which is needed		code(s).	
16	Claim/service lacks information or has	M47	Missing/incomplete/invalid internal or	CO or PI
	submission/billing error(s) which is needed		document control number.	
	for adjudication. Do not use this code for	3.540		
16	Claim/service lacks information or has	M49	Missing/incomplete/invalid value code(s) or	CO or PI
	submission/billing error(s) which is needed		amount(s).	
16	Claim/service lacks information or has	M50	Missing/incomplete/invalid revenue code(s).	CO or PI
	submission/billing error(s) which is needed			
16	Claim/service lacks information or has	M51	Missing/incomplete/invalid procedure	CO or PI
	submission/billing error(s) which is needed		code(s).	
16	Claim/service lacks information or has	M52	Missing/incomplete/invalid "from" date(s) of	CO or PI
	submission/billing error(s) which is needed		service.	
16	Claim/service lacks information or has	M53	Missing/incomplete/invalid days or units of	CO or PI
	submission/billing error(s) which is needed	3.55.1	service.	GO 77
16	Claim/service lacks information or has	M54	Missing/incomplete/invalid total charges.	CO or PI
16	submission/billing error(s) which is needed	1456	Mining fine and the fine 111 11 CC	CO DI
16	Claim/service lacks information or has	M56	Missing/incomplete/invalid payer identifier.	CO or PI
16	submission/billing error(s) which is needed	Mso	Missing/imagementate/inv-1: 4 Healt detects of	CO DI
16	Claim/service lacks information or has	M59	Missing/incomplete/invalid "to" date(s) of	CO or PI
16	submission/billing error(s) which is needed Claim/service lacks information or has	M60	Service.	CO or PI
10		MOO	Missing Certificate of Medical Necessity.	CO or PI
16	submission/billing error(s) which is needed Claim/service lacks information or has	M62	Missing/incomplete/invalid treatment	CO or PI
10	submission/billing error(s) which is needed	10102	authorization code.	COOFFI
16	Claim/service lacks information or has	M64	Missing/incomplete/invalid other diagnosis.	CO or PI
10	submission/billing error(s) which is needed	10104	wissing/incomplete/invalid other diagnosts.	CO of PI
16	Claim/service lacks information or has	M67	Missing/incomplete/invalid other procedure	CO or PI
10	submission/billing error(s) which is needed	1710/	code(s).	COOFFI
16	Claim/service lacks information or has	M76	Missing/incomplete/invalid diagnosis or	CO or PI
10	submission/billing error(s) which is needed	171 / U	condition.	COOLFI
16	Claim/service lacks information or has	M77	Missing/incomplete/invalid place of service.	CO or PI
10	submission/billing error(s) which is needed	IVI / /	wissing/incomplete/invalid place of service.	CO of PI

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

		Table	3-1	
	Scenario #2: Missing	/Invalid/Incomp	plete Data from Submitted Claim	
Refers to	situations where additional data is needed from th	e billing provide	er for missing or invalid data on the submitted claim	n, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	ASC X12 CAGO
16	Claim/service lacks information or has	M79	Missing/incomplete/invalid charge.	CO or PI
	submission/billing error(s) which is needed			
16	Claim/service lacks information or has	M81	You are required to code to the highest level	CO or PI
	submission/billing error(s) which is needed		of specificity.	
16	Claim/service lacks information or has	M99	Missing/incomplete/invalid Universal	CO or PI
16	submission/billing error(s) which is needed Claim/service lacks information or has	M119	Product Number/Serial Number. Missing/incomplete/invalid/	CO or PI
16	submission/billing error(s) which is needed	WIII9	deactivated/withdrawn National Drug Code	COOLFI
16	Claim/service lacks information or has	M122	Missing/incomplete/invalid level of	CO or PI
	submission/billing error(s) which is needed		subluxation.	
16	Claim/service lacks information or has	M123	Missing/incomplete/invalid name, strength, or	CO or PI
	submission/billing error(s) which is needed		dosage of the drug furnished.	
16	Claim/service lacks information or has	M124	Missing indication of whether the patient	CO or PI
	submission/billing error(s) which is needed		owns the equipment that requires the part or	
16	for adjudication. Do not use this code for Claim/service lacks information or has	M125	supply. Missing/incomplete/invalid information on	CO or PI
10	submission/billing error(s) which is needed	W1123	the period of time for which the	COOFFI
	for adjudication. Do not use this code for		service/supply/equipment will be needed.	
16	Claim/service lacks information or has	M126	Missing/incomplete/invalid individual lab	CO or PI
	submission/billing error(s) which is needed		codes included in the test.	
16	Claim/service lacks information or has	M129	Missing/incomplete/invalid indicator of x-ray	CO or PI
	submission/billing error(s) which is needed		availability for review.	
16	Claim/service lacks information or has	M133	Claim did not identify who performed the	CO or PI
	submission/billing error(s) which is needed		purchased diagnostic test or the amount you	
16	for adjudication. Do not use this code for Claim/service lacks information or has	M136	were charged for the test.	CO or PI
10	submission/billing error(s) which is needed	W1130	Missing/incomplete/invalid indication that the service was supervised or evaluated by a	CO or PI
	for adjudication. Do not use this code for		physician.	
16	Claim/service lacks information or has	MA04	Secondary payment cannot be considered	CO or PI
	submission/billing error(s) which is needed		without the identity of or payment	
16	Claim/service lacks information or has	MA27	Missing/incomplete/invalid entitlement	CO or PI
	submission/billing error(s) which is needed		number or name shown on the claim.	
16	Claim/service lacks information or has	MA30	Missing/incomplete/invalid type of bill.	CO or PI
	submission/billing error(s) which is needed			
16	Claim/service lacks information or has	MA31	Missing/incomplete/invalid beginning and	CO or PI
16	submission/billing error(s) which is needed Claim/service lacks information or has	34422	ending dates of the period billed.	CO - DI
16	submission/billing error(s) which is needed	MA32	Missing/incomplete/invalid number of covered days during the billing period.	CO or PI
16	Claim/service lacks information or has	MA33	Missing/incomplete/invalid noncovered days	CO or PI
	submission/billing error(s) which is needed		during the billing period.	20 0111
16	Claim/service lacks information or has	MA34	Missing/incomplete/invalid number of	CO or PI
	submission/billing error(s) which is needed		coinsurance days during the billing period.	
16	Claim/service lacks information or has	MA35	Missing/incomplete/invalid number of	CO or PI
	submission/billing error(s) which is needed	37102	lifetime reserve days.	G0 T1
16	Claim/service lacks information or has	MA36	Missing/incomplete/invalid patient name.	CO or PI
16	submission/billing error(s) which is needed Claim/service lacks information or has	MA37	Missing/incomplete/invalid patient's address.	CO or PI
10	submission/billing error(s) which is needed	WA3/	wissing/incomplete/invalid patient's address.	COOFFI
16	Claim/service lacks information or has	MA39	Missing/incomplete/invalid gender.	CO or PI
	submission/billing error(s) which is needed		S r S	
16	Claim/service lacks information or has	MA40	Missing/incomplete/invalid admission date.	CO or PI
	submission/billing error(s) which is needed			
16	Claim/service lacks information or has	MA41	Missing/incomplete/invalid admission type.	CO or PI
	submission/billing error(s) which is needed			a
16	Claim/service lacks information or has submission/billing error(s) which is needed	MA42	Missing/incomplete/invalid admission source.	CO or PI

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

	Scenario #2: Missing	g/Invalid/Incomp	olete Data from Submitted Claim	
Refers to s			er for missing or invalid data on the submitted clair	n, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	ASC X12 CAGC
16	Claim/service lacks information or has	MA43	Missing/incomplete/invalid patient status.	CO or PI
	submission/billing error(s) which is needed			
16	Claim/service lacks information or has	MA48	Missing/incomplete/invalid name or address	CO or PI
	submission/billing error(s) which is needed		of responsible party or primary payer.	
16	Claim/service lacks information or has	MA50	Missing/incomplete/invalid Investigational	CO or PI
	submission/billing error(s) which is needed	3.51.50	Device Exemption number for FDA-approved	
16	Claim/service lacks information or has	MA53	Missing/incomplete/invalid Competitive	CO or PI
1.6	submission/billing error(s) which is needed	MA50	Bidding Demonstration Project identification. Missing/incomplete/invalid release of	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	MA58	Missing/incomplete/invalid release of information indicator.	CO or PI
16	Claim/service lacks information or has	MA60	Missing/incomplete/invalid patient	CO or PI
10	submission/billing error(s) which is needed	MAOO	relationship to insured.	COOLL
16	Claim/service lacks information or has	MA61	Missing/incomplete/invalid social security	CO or PI
10	submission/billing error(s) which is needed	IVIAUI	number or health insurance claim number.	CO 01 11
16	Claim/service lacks information or has	MA63	Missing/incomplete/invalid principal	CO or PI
	submission/billing error(s) which is needed		diagnosis.	
16	Claim/service lacks information or has	MA64	Our records indicate that we should be the	CO or PI
	submission/billing error(s) which is needed		third payer for this claim. We cannot process	
16	Claim/service lacks information or has	MA65	Missing/incomplete/invalid admitting	CO or PI
	submission/billing error(s) which is needed		diagnosis.	
16	Claim/service lacks information or has	MA66	Missing/incomplete/invalid principal	CO or PI
	submission/billing error(s) which is needed		procedure code.	
16	Claim/service lacks information or has	MA69	Missing/incomplete/invalid remarks.	CO or PI
	submission/billing error(s) which is needed			
16	Claim/service lacks information or has	MA70	Missing/incomplete/invalid provider	CO or PI
	submission/billing error(s) which is needed		representative signature.	
16	Claim/service lacks information or has	MA71	Missing/incomplete/invalid provider	CO or PI
	submission/billing error(s) which is needed		representative signature date.	
16	Claim/service lacks information or has	MA75	Missing/incomplete/invalid patient or	CO or PI
1.6	submission/billing error(s) which is needed	34476	authorized representative signature.	CO DI
16	Claim/service lacks information or has	MA76	Missing/incomplete/invalid provider	CO or PI
	submission/billing error(s) which is needed		identifier for home health agency or hospice	
16	Claim/service lacks information or has	MA81	Missing/incomplete/invalid provider/supplier	CO or PI
1.0	submission/billing error(s) which is needed	3.51.02	signature.	GO PY
16	Claim/service lacks information or has	MA83	Did not indicate whether we are the primary	CO or PI
1.6	submission/billing error(s) which is needed	MAGO	or secondary payer. Missing/incomplete/invalid insured's address	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	MA88	and/or telephone number for the primary	CO or PI
16	Claim/service lacks information or has	MA89	Missing/incomplete/invalid patient's	CO or PI
10	submission/billing error(s) which is needed	IVIAO9	relationship to the insured for the primary	CO of PI
16	Claim/service lacks information or has	MA90	Missing/incomplete/invalid employment	CO or PI
10	submission/billing error(s) which is needed	111170	status code for the primary insured.	20 0111
16	Claim/service lacks information or has	MA92	Missing plan information for other insurance.	CO or PI
10	submission/billing error(s) which is needed	1,11,2	missing plan information for outer missianice.	00 0111
16	Claim/service lacks information or has	MA94	Did not enter the statement "Attending	CO or PI
	submission/billing error(s) which is needed		physician not hospice employee" on the claim	
16	Claim/service lacks information or has	MA96	Claim rejected. Coded as a Medicare	CO or PI
	submission/billing error(s) which is needed	1.1110	Managed Care Demonstration but patient is	20 0111
16	Claim/service lacks information or has	MA97	Missing/incomplete/invalid Medicare	CO or PI
10	submission/billing error(s) which is needed	IVI <i>P</i> 17 /	Managed Care Demonstration contract	CO 01 11
16	Claim/service lacks information or has	MA99	Missing/incomplete/invalid Medigap	CO or PI
10	submission/billing error(s) which is needed	1 V1/1 77	information.	COULT
16	Claim/service lacks information or has	MA100	Missing/incomplete/invalid date of current	CO or PI
	submission/billing error(s) which is needed	1100	illness or symptoms.	20 0111

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

		Table 3		
	Scenario #2: Missing	/Invalid/Incomp	lete Data from Submitted Claim	
Refers to	situations where additional data is needed from the	e billing provide	r for missing or invalid data on the submitted claim	n, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	ASC X12 CAGO
16	Claim/service lacks information or has	MA110	Missing/incomplete/invalid information on	CO or PI
	submission/billing error(s) which is needed		whether the diagnostic test(s) were performed	
	for adjudication. Do not use this code for		by an outside entity or if no purchased tests	
	claims attachment(s)/other documentation. At		are included on the claim.	
16	Claim/service lacks information or has	MA111	Missing/incomplete/invalid purchase price of	CO or PI
	submission/billing error(s) which is needed		the test(s) and/or the performing laboratory's	
16	Claim/service lacks information or has	MA112	Missing/incomplete/invalid group practice	CO or PI
	submission/billing error(s) which is needed		information.	
16	Claim/service lacks information or has	MA113	Incomplete/invalid taxpayer identification	CO or PI
	submission/billing error(s) which is needed		number (TIN) submitted by you per the	
16	Claim/service lacks information or has	MA114	Missing/incomplete/invalid information on	CO or PI
10	submission/billing error(s) which is needed	WATT	where the services were furnished.	COULT
16	Claim/service lacks information or has	MA115	Missing/incomplete/invalid physical location	CO or PI
10	submission/billing error(s) which is needed	MAIL	(name and address, or PIN) where the	COULT
16	Claim/service lacks information or has	MA116	Did not complete the statement 'Homebound'	CO or PI
10	submission/billing error(s) which is needed	14141110	on the claim to validate whether laboratory	CO 01 F1
16	Claim/service lacks information or has	MA120	Missing/incomplete/invalid CLIA	CO or PI
10	submission/billing error(s) which is needed	141/11/20	certification number.	20011
16	Claim/service lacks information or has	MA121	Missing/incomplete/invalid x-ray date.	CO or PI
10	submission/billing error(s) which is needed	WAIZI	wissing/meompiete/mvand x-ray date.	CO 0111
16	Claim/service lacks information or has	MA122	Missing/incomplete/invalid initial treatment	CO or PI
10	submission/billing error(s) which is needed	14171122	date.	CO 0111
16	Claim/service lacks information or has	MA128	Missing/incomplete/invalid FDA approval	CO or PI
	submission/billing error(s) which is needed		number.	00 0111
16	Claim/service lacks information or has	MA130	Your claim contains incomplete and/or	CO or PI
10	submission/billing error(s) which is needed	14111130	invalid information, and no appeal rights are	CO 0111
16	Claim/service lacks information or has	MA134	Missing/incomplete/invalid provider number	CO or PI
10		MA154		COOFFI
	submission/billing error(s) which is needed for adjudication. Do not use this code for		of the facility where the patient resides.	
16	Claim/service lacks information or has	N4	Missing/Incomplete/Invelid major Incomes	CO or PI
10	submission/billing error(s) which is needed	194	Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.	CO or PI
16	Claim/service lacks information or has	N8	Crossover claim denied by previous payer and	CO or PI
16		IN8		CO or PI
16	submission/billing error(s) which is needed Claim/service lacks information or has	N20	complete claim data not forwarded. Resubmit Service not payable with other service	CO or PI
10	submission/billing error(s) which is needed	11/20	rendered on the same date.	COOLL
16	Claim/service lacks information or has	N27	Missing/incomplete/invalid treatment	CO or PI
10	submission/billing error(s) which is needed	114/	number.	COOLFI
16	Claim/service lacks information or has	N31	Missing/incomplete/invalid prescribing	CO or PI
10	submission/billing error(s) which is needed	1131	provider identifier.	20011
16	Claim/service lacks information or has	N32	Claim must be submitted by the provider who	CO or PI
10	submission/billing error(s) which is needed	1132	rendered the service.	20011
16	Claim/service lacks information or has	N34	Incorrect claim form/format for this service.	CO or PI
10	submission/billing error(s) which is needed	1137	and officer chains forms format for this service.	20 0111
16	Claim/service lacks information or has	N37	Missing/incomplete/invalid tooth	CO or PI
1.0	submission/billing error(s) which is needed	1137	number/letter.	200111
16	Claim/service lacks information or has	N39	Procedure code is not compatible with tooth	CO or PI
	submission/billing error(s) which is needed	57	number/letter.	
16	Claim/service lacks information or has	N46	Missing/incomplete/invalid admission hour.	CO or PI
-	submission/billing error(s) which is needed		<i>y</i> 1	
16	Claim/service lacks information or has	N48	Claim information does not agree with	CO or PI
-	submission/billing error(s) which is needed		information received from other insurance	
16	Claim/service lacks information or has	N50	Missing/incomplete/invalid discharge	CO or PI
-	submission/billing error(s) which is needed		information.	
16	Claim/service lacks information or has	N53	Missing/incomplete/invalid point of pick-up	CO or PI
	submission/billing error(s) which is needed		address.	

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

		Table 3		
	Scenario #2: Missing	g/Invalid/Incomp	lete Data from Submitted Claim	
Refers to	situations where additional data is needed from th	e billing provide	r for missing or invalid data on the submitted claim	n, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	ASC X12 CAGC
16	Claim/service lacks information or has	N54	Claim information is inconsistent with pre-	CO or PI
	submission/billing error(s) which is needed		certified/authorized services.	
16	Claim/service lacks information or has	N56	Procedure code billed is not correct/valid for	CO or PI
	submission/billing error(s) which is needed		the services billed or the date of service	
16	Claim/service lacks information or has	N57	Missing/incomplete/invalid prescribing date.	CO or PI
	submission/billing error(s) which is needed			
16	Claim/service lacks information or has	N58	Missing/incomplete/invalid patient liability	CO or PI
	submission/billing error(s) which is needed		amount.	
	for adjudication. Do not use this code for			
16	Claim/service lacks information or has	N62	Dates of service span multiple rate periods.	CO or PI
	submission/billing error(s) which is needed		Resubmit separate claims.	
16	Claim/service lacks information or has	N63	Rebill services on separate claim lines.	CO or PI
	submission/billing error(s) which is needed			
16	Claim/service lacks information or has	N64	The "from" and "to" dates must be different.	CO or PI
	submission/billing error(s) which is needed			
16	Claim/service lacks information or has	N65	Procedure code or procedure rate count	CO or PI
	submission/billing error(s) which is needed		cannot be determined, or was not on file, for	
	for adjudication. Do not use this code for		the date of service/provider.	
16	Claim/service lacks information or has	N75	Missing/incomplete/invalid tooth surface	CO or PI
	submission/billing error(s) which is needed		information.	
16	Claim/service lacks information or has	N76	Missing/incomplete/invalid number of riders.	CO or PI
	submission/billing error(s) which is needed			
16	Claim/service lacks information or has	N77	Missing/incomplete/invalid designated	CO or PI
	submission/billing error(s) which is needed		provider number.	
16	Claim/service lacks information or has	N80	Missing/incomplete/invalid prenatal	CO or PI
	submission/billing error(s) which is needed		screening information.	
16	Claim/service lacks information or has	N147	Long term care case mix or per diem rate	CO or PI
	submission/billing error(s) which is needed		cannot be determined because the patient ID	
16	Claim/service lacks information or has	N148	Missing/incomplete/invalid date of last	CO or PI
	submission/billing error(s) which is needed		menstrual period.	
16	Claim/service lacks information or has	N150	Missing/incomplete/invalid model number.	CO or PI
	submission/billing error(s) which is needed			
16	Claim/service lacks information or has	N152	Missing/incomplete/invalid replacement	CO or PI
	submission/billing error(s) which is needed		claim information.	
16	Claim/service lacks information or has	N153	Missing/incomplete/invalid room and board	CO or PI
	submission/billing error(s) which is needed		rate.	
16	Claim/service lacks information or has	N161	This drug/service/supply is covered only	CO or PI
1.6	submission/billing error(s) which is needed	N1102	when the associated service is covered.	CO PY
16	Claim/service lacks information or has	N182	This claim/service must be billed according to	CO or PI
16	submission/billing error(s) which is needed Claim/service lacks information or has	N188	the schedule for this plan. The approved level of care does not match the	CO or PI
16		N188	* *	CO or PI
1.0	submission/billing error(s) which is needed	N1100	procedure code submitted.	CO DI
16	Claim/service lacks information or has	N190	Missing contract indicator.	CO or PI
1.6	submission/billing error(s) which is needed	Nana	Mining/incomplete/incomidence	CO DI
16	Claim/service lacks information or has	N203	Missing/incomplete/invalid anesthesia	CO or PI
16	submission/billing error(s) which is needed	N207	time/units.	CO on DI
16	Claim/service lacks information or has	N207	Missing/incomplete/invalid weight.	CO or PI
16	submission/billing error(s) which is needed	NOO	Missing/incomplete/invalid DRG code.	CO or PI
10	Claim/service lacks information or has	N208	wissing/incomplete/invalid DKG code.	CO or PI
16	submission/billing error(s) which is needed	NOOO	Missing/incomplete/invalid towards	CO am DI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N209	Missing/incomplete/invalid taxpayer identification number (TIN).	CO or PI
16	Claim/service lacks information or has	N213		CO or PI
10	submission/billing error(s) which is needed	11/213	Missing/incomplete/invalid facility/discrete unit DRG/DRG exempt status information.	COOFFI
16	Claim/service lacks information or has	Noon		CO or PI
16	submission/billing error(s) which is needed	N229	Incomplete/invalid contract indicator.	CO or PI

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

	ituations where additional data is needed from th				
CARC	CARC Description ⁴	RARC	RARC Description ⁵	ASC X12 CAGC	
16	Claim/service lacks information or has	N230	Incomplete/invalid indication of whether the	CO or PI	
	submission/billing error(s) which is needed		patient owns the equipment that requires the		
16	Claim/service lacks information or has	N245	Incomplete/invalid plan information for other	CO or PI	
1.6	submission/billing error(s) which is needed	272.47	insurance.	GO PY	
16	Claim/service lacks information or has	N247	Missing/incomplete/invalid assistant surgeon	CO or PI	
16	submission/billing error(s) which is needed Claim/service lacks information or has	N248	taxonomy. Missing/incomplete/invalid assistant surgeon	CO or PI	
10	submission/billing error(s) which is needed	11240	name.	CO 01 11	
16	Claim/service lacks information or has	N249	Missing/incomplete/invalid assistant surgeon	CO or PI	
	submission/billing error(s) which is needed		primary identifier.		
16	Claim/service lacks information or has	N250	Missing/incomplete/invalid assistant surgeon	CO or PI	
	submission/billing error(s) which is needed		secondary identifier.		
16	Claim/service lacks information or has	N251	Missing/incomplete/invalid attending	CO or PI	
1.6	submission/billing error(s) which is needed	272.52	provider taxonomy.	GO PY	
16	Claim/service lacks information or has submission/billing error(s) which is needed	N252	Missing/incomplete/invalid attending	CO or PI	
16	Claim/service lacks information or has	N253	provider name. Missing/incomplete/invalid attending	CO or PI	
10	submission/billing error(s) which is needed	11233	provider primary identifier.	COOLEI	
16	Claim/service lacks information or has	N254	Missing/incomplete/invalid attending	CO or PI	
	submission/billing error(s) which is needed		provider secondary identifier.		
16	Claim/service lacks information or has	N255	Missing/incomplete/invalid billing provider	CO or PI	
	submission/billing error(s) which is needed		taxonomy.		
16	Claim/service lacks information or has	N256	Missing/incomplete/invalid billing	CO or PI	
	submission/billing error(s) which is needed		provider/supplier name.		
16	Claim/service lacks information or has	N257	Missing/incomplete/invalid billing	CO or PI	
1.6	submission/billing error(s) which is needed	N250	provider/supplier primary identifier.	CO DI	
16	Claim/service lacks information or has submission/billing error(s) which is needed	N258	Missing/incomplete/invalid billing provider/supplier address.	CO or PI	
16	Claim/service lacks information or has	N259	Missing/incomplete/invalid billing	CO or PI	
10	submission/billing error(s) which is needed	11237	provider/supplier secondary identifier.	CO 0111	
16	Claim/service lacks information or has	N260	Missing/incomplete/invalid billing	CO or PI	
	submission/billing error(s) which is needed		provider/supplier contact information.		
16	Claim/service lacks information or has	N261	Missing/incomplete/invalid operating	CO or PI	
	submission/billing error(s) which is needed		provider name.		
16	Claim/service lacks information or has	N262	Missing/incomplete/invalid operating	CO or PI	
1.6	submission/billing error(s) which is needed	112.62	provider primary identifier.	GO PY	
16	Claim/service lacks information or has	N263	Missing/incomplete/invalid operating provider secondary identifier.	CO or PI	
16	submission/billing error(s) which is needed Claim/service lacks information or has	N264	Missing/incomplete/invalid ordering provider	CO or PI	
10	submission/billing error(s) which is needed	11204	name.	CO 01 11	
16	Claim/service lacks information or has	N265	Missing/incomplete/invalid ordering provider	CO or PI	
	submission/billing error(s) which is needed		primary identifier.		
16	Claim/service lacks information or has	N266	Missing/incomplete/invalid ordering provider	CO or PI	
	submission/billing error(s) which is needed		address.		
16	Claim/service lacks information or has	N267	Missing/incomplete/invalid ordering provider	CO or PI	
	submission/billing error(s) which is needed		secondary identifier.		
16	Claim/service lacks information or has	N268	Missing/incomplete/invalid ordering provider	CO or PI	
16	submission/billing error(s) which is needed	NOCO	contact information.	CO DI	
16	Claim/service lacks information or has submission/billing error(s) which is needed	N269	Missing/incomplete/invalid other provider	CO or PI	
16	Claim/service lacks information or has	N270	name. Missing/incomplete/invalid other provider	CO or PI	
10	submission/billing error(s) which is needed	112/0	primary identifier.	COOLEI	
16	Claim/service lacks information or has	N271	Missing/incomplete/invalid other provider	CO or PI	
-	submission/billing error(s) which is needed		secondary identifier.	0.11	
16	Claim/service lacks information or has	N272	Missing/incomplete/invalid other payer	CO or PI	

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

	Scanario #2: Missino	/Invalid/Incom	olete Data from Submitted Claim	
Refers to s			er for missing or invalid data on the submitted clair	n. e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	ASC X12 CAGO
16	Claim/service lacks information or has	N273	Missing/incomplete/invalid other payer	CO or PI
	submission/billing error(s) which is needed		operating provider identifier.	
16	Claim/service lacks information or has	N274	Missing/incomplete/invalid other payer other	CO or PI
	submission/billing error(s) which is needed		provider identifier.	
16	Claim/service lacks information or has	N275	Missing/incomplete/invalid other payer	CO or PI
	submission/billing error(s) which is needed	1775	purchased service provider identifier.	
16	Claim/service lacks information or has	N276	Missing/incomplete/invalid other payer	CO or PI
16	submission/billing error(s) which is needed Claim/service lacks information or has	N277	referring provider identifier. Missing/incomplete/invalid other payer	CO or PI
10	submission/billing error(s) which is needed	N2//	rendering provider identifier.	COOFFI
16	Claim/service lacks information or has	N278	Missing/incomplete/invalid other payer	CO or PI
	submission/billing error(s) which is needed	11270	service facility provider identifier.	00 0.11
16	Claim/service lacks information or has	N279	Missing/incomplete/invalid pay-to provider	CO or PI
	submission/billing error(s) which is needed		name.	
16	Claim/service lacks information or has	N280	Missing/incomplete/invalid pay-to provider	CO or PI
	submission/billing error(s) which is needed		primary identifier.	
16	Claim/service lacks information or has	N281	Missing/incomplete/invalid pay-to provider	CO or PI
	submission/billing error(s) which is needed		address.	
16	Claim/service lacks information or has	N282	Missing/incomplete/invalid pay-to provider	CO or PI
16	submission/billing error(s) which is needed Claim/service lacks information or has	N283	secondary identifier. Missing/incomplete/invalid purchased service	CO or PI
16	submission/billing error(s) which is needed	N283	provider identifier.	CO or PI
16	Claim/service lacks information or has	N284	Missing/incomplete/invalid referring provider	CO or PI
10	submission/billing error(s) which is needed	11204	taxonomy.	COULT
16	Claim/service lacks information or has	N285	Missing/incomplete/invalid referring provider	CO or PI
	submission/billing error(s) which is needed		name.	
16	Claim/service lacks information or has	N286	Missing/incomplete/invalid referring provider	CO or PI
	submission/billing error(s) which is needed		primary identifier.	
16	Claim/service lacks information or has	N287	Missing/incomplete/invalid referring provider	CO or PI
	submission/billing error(s) which is needed		secondary identifier.	
16	Claim/service lacks information or has	N288	Missing/incomplete/invalid rendering	CO or PI
1.6	submission/billing error(s) which is needed	Maga	provider taxonomy.	CO DI
16	Claim/service lacks information or has	N289	Missing/incomplete/invalid rendering	CO or PI
16	submission/billing error(s) which is needed Claim/service lacks information or has	N290	provider name. Missing/incomplete/invalid rendering	CO or PI
10	submission/billing error(s) which is needed	11290	provider primary identifier.	COULT
16	Claim/service lacks information or has	N291	Missing/incomplete/invalid rendering	CO or PI
-	submission/billing error(s) which is needed		provider secondary identifier.	
16	Claim/service lacks information or has	N292	Missing/incomplete/invalid service facility	CO or PI
	submission/billing error(s) which is needed		name.	
16	Claim/service lacks information or has	N293	Missing/incomplete/invalid service facility	CO or PI
	submission/billing error(s) which is needed		primary identifier.	
16	Claim/service lacks information or has	N294	Missing/incomplete/invalid service facility	CO or PI
1.6	submission/billing error(s) which is needed	NOOF	primary address.	CO DI
16	Claim/service lacks information or has	N295	Missing/incomplete/invalid service facility	CO or PI
16	submission/billing error(s) which is needed Claim/service lacks information or has	N296	secondary identifier. Missing/incomplete/invalid supervising	CO or PI
10	submission/billing error(s) which is needed	114270	provider name.	COULL
16	Claim/service lacks information or has	N297	Missing/incomplete/invalid supervising	CO or PI
-	submission/billing error(s) which is needed		provider primary identifier.	
16	Claim/service lacks information or has	N298	Missing/incomplete/invalid supervising	CO or PI
	submission/billing error(s) which is needed		provider secondary identifier.	
16	Claim/service lacks information or has	N299	Missing/incomplete/invalid occurrence	CO or PI
	submission/billing error(s) which is needed		date(s).	
16	Claim/service lacks information or has	N300	Missing/incomplete/invalid occurrence span	CO or PI

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

	Scenario #2: Missing	/Invalid/Incom	plete Data from Submitted Claim	
Refers to	situations where additional data is needed from th	e billing provid	er for missing or invalid data on the submitted claim	n, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	ASC X12 CAGO
16	Claim/service lacks information or has submission/billing error(s) which is needed	N301	Missing/incomplete/invalid procedure date(s).	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N302	Missing/incomplete/invalid other procedure date(s).	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N303	Missing/incomplete/invalid principal procedure date.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N304	Missing/incomplete/invalid dispensed date.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N305	Missing/incomplete/invalid accident date.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N306	Missing/incomplete/invalid acute manifestation date.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N307	Missing/incomplete/invalid adjudication or payment date.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N308	Missing/incomplete/invalid appliance placement date.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N309	Missing/incomplete/invalid assessment date.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N310	Missing/incomplete/invalid assumed or relinquished care date.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N312	Missing/incomplete/invalid begin therapy date.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N313	Missing/incomplete/invalid certification revision date.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N314	Missing/incomplete/invalid diagnosis date.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N317	Missing/incomplete/invalid discharge hour.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N318	Missing/incomplete/invalid discharge or end of care date.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N319	Missing/incomplete/invalid hearing or vision prescription date.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N320	Missing/incomplete/invalid Home Health Certification Period.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N321	Missing/incomplete/invalid last admission period.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N322	Missing/incomplete/invalid last certification date.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N323	Missing/incomplete/invalid last contact date.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N324	Missing/incomplete/invalid last seen/visit date.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N325	Missing/incomplete/invalid last worked date.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N326	Missing/incomplete/invalid last x-ray date.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N327	Missing/incomplete/invalid other insured birth date.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N328	Missing/incomplete/invalid Oxygen Saturation Test date.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N329	Missing/incomplete/invalid patient birth date.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N330	Missing/incomplete/invalid patient death date.	CO or PI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N331	Missing/incomplete/invalid physician order	CO or PI

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

	Scenario #2: Missing	/Invalid/Incomr	olete Data from Submitted Claim	
Refers to s			er for missing or invalid data on the submitted claim	n, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	ASC X12 CAGC
16	Claim/service lacks information or has	N332	Missing/incomplete/invalid prior hospital	CO or PI
16	submission/billing error(s) which is needed Claim/service lacks information or has	N333	discharge date. Missing/incomplete/invalid prior placement	CO or PI
10	submission/billing error(s) which is needed	14333	date.	CO 01 11
16	Claim/service lacks information or has	N334	Missing/incomplete/invalid re-evaluation	CO or PI
16	submission/billing error(s) which is needed Claim/service lacks information or has	N335	date. Missing/incomplete/invalid referral date.	CO or PI
	submission/billing error(s) which is needed		,	
16	Claim/service lacks information or has submission/billing error(s) which is needed	N336	Missing/incomplete/invalid replacement date.	CO or PI
16	Claim/service lacks information or has	N337	Missing/incomplete/invalid secondary	CO or PI
	submission/billing error(s) which is needed		diagnosis date.	
16	Claim/service lacks information or has submission/billing error(s) which is needed	N338	Missing/incomplete/invalid shipped date.	CO or PI
16	Claim/service lacks information or has	N339	Missing/incomplete/invalid similar illness or	CO or PI
	submission/billing error(s) which is needed		symptom date.	
16	Claim/service lacks information or has submission/billing error(s) which is needed	N340	Missing/incomplete/invalid subscriber birth date.	CO or PI
16	Claim/service lacks information or has	N341	Missing/incomplete/invalid surgery date.	CO or PI
	submission/billing error(s) which is needed			
16	Claim/service lacks information or has	N342	Missing/incomplete/invalid test performed	CO or PI
16	submission/billing error(s) which is needed Claim/service lacks information or has	N343	date. Missing/incomplete/invalid Transcutaneous	CO or PI
10	submission/billing error(s) which is needed	11343	Electrical Nerve Stimulator (TENS) trial start	60 0111
16	Claim/service lacks information or has	N344	Missing/incomplete/invalid Transcutaneous	CO or PI
	submission/billing error(s) which is needed		Electrical Nerve Stimulator (TENS) trial end	
16	Claim/service lacks information or has	N345	Date range not valid with units submitted.	CO or PI
	submission/billing error(s) which is needed	372.11		
16	Claim/service lacks information or has submission/billing error(s) which is needed	N346	Missing/incomplete/invalid oral cavity designation code.	CO or PI
16	Claim/service lacks information or has	N349	The administration method and drug must be	CO or PI
10	submission/billing error(s) which is needed	14347	reported to adjudicate this service.	COULT
16	Claim/service lacks information or has	N350	Missing/incomplete/invalid description of	CO or PI
10	submission/billing error(s) which is needed	1,000	service for a Not Otherwise Classified (NOC)	00 0.11
16	Claim/service lacks information or has	N359	Missing/incomplete/invalid height.	CO or PI
	submission/billing error(s) which is needed			
16	Claim/service lacks information or has	N378	Missing/incomplete/invalid prescription	CO or PI
	submission/billing error(s) which is needed		quantity.	
16	Claim/service lacks information or has	N382	Missing/incomplete/invalid patient identifier.	CO or PI
	submission/billing error(s) which is needed			
16	Claim/service lacks information or has	N388	Missing/incomplete/invalid prescription	CO or PI
16	submission/billing error(s) which is needed Claim/service lacks information or has	N418	number. Misrouted claim. See the payer's claim	CO or PI
10	submission/billing error(s) which is needed	11410	submission instructions.	COOLFI
16	Claim/service lacks information or has	N433	Resubmit this claim using only your National	CO or PI
10	submission/billing error(s) which is needed	11133	Provider Identifier (NPI).	CO 0111
16	Claim/service lacks information or has	N434	Missing/Incomplete/Invalid Present on	CO or PI
	submission/billing error(s) which is needed	-	Admission indicator.	
16	Claim/service lacks information or has	N439	Missing anesthesia physical status	CO or PI
	submission/billing error(s) which is needed		report/indicators.	
16	Claim/service lacks information or has	N440	Incomplete/invalid anesthesia physical status	CO or PI
	submission/billing error(s) which is needed		report/indicators.	
16	Claim/service lacks information or has	N443	Missing/incomplete/invalid total time or	CO or PI
16	submission/billing error(s) which is needed	NI 4771	begin/end time.	CO DI
16	Claim/service lacks information or has submission/billing error(s) which is needed	N471	Missing/incomplete/invalid HIPPS Rate	CO or PI

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

		Table		
			olete Data from Submitted Claim	
		e billing provid	er for missing or invalid data on the submitted clain	n, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	ASC X12 CAGO
16	Claim/service lacks information or has	N479	Missing Explanation of Benefits	CO or PI
16	submission/billing error(s) which is needed Claim/service lacks information or has	N480	(Coordination of Benefits or Medicare Incomplete/invalid Explanation of Benefits	CO or PI
10	submission/billing error(s) which is needed	N480	(Coordination of Benefits or Medicare	CO or PI
	for adjudication. Do not use this code for		Secondary Payer).	
16	Claim/service lacks information or has	N521	Mismatch between the submitted provider	CO or PI
10	submission/billing error(s) which is needed	14321	information and the provider information	CO 01 11
16	Claim/service lacks information or has	N547	A refund request (Frequency Type Code 8)	CO or PI
10	submission/billing error(s) which is needed	14547	was processed previously.	CO 01 11
16	Claim/service lacks information or has	N554	Missing/Incomplete/Invalid Family Planning	CO or PI
	submission/billing error(s) which is needed		Indicator.	
16	Claim/service lacks information or has	N562	The provider number of your incoming claim	CO or PI
	submission/billing error(s) which is needed		does not match the provider number on the	
16	Claim/service lacks information or has	N575	Mismatch between the submitted	CO or PI
	submission/billing error(s) which is needed		ordering/referring provider name and the	
16	Claim/service lacks information or has	N595	Records reflect the injured party did not	CO or PI
	submission/billing error(s) which is needed		complete an Assignment of Benefits for this	
16	Claim/service lacks information or has	N596	Records reflect the injured party did not	CO or PI
	submission/billing error(s) which is needed		complete a Medical Authorization for this	
16	Claim/service lacks information or has	N625	Missing/Incomplete/Invalid Workers'	CO or PI
	submission/billing error(s) which is needed	17150	Compensation Claim Number.	
16	Claim/service lacks information or has	N653	The date of injury does not match the	CO or PI
16	submission/billing error(s) which is needed Claim/service lacks information or has	N657	reported date of loss. This should be billed with the appropriate	CO or PI
10	submission/billing error(s) which is needed	1037	code for these services.	CO or PI
16	Claim/service lacks information or has	N685	Missing/Incomplete/Invalid Prosthesis,	CO or PI
	submission/billing error(s) which is needed	11000	Crown or Inlay Code.	00 0111
18	Exact duplicate claim/service (Use only with	N522	Duplicate of a claim processed, or to be	OA or CO
	Group Code OA except where state workers'		processed, as a crossover claim.	
	compensation regulations requires CO)			
69	Day outlier amount.			CO or PI
0)	Day outher amount.			CO 0111
107	The related or qualifying claim/service was			CO or PI
	not identified on this claim. Note: Refer to			
	the 835 Healthcare Policy Identification			
	Segment (loop 2110 Service Payment			
	Information REF), if present.			
110	Billing date predates service date.	N622	Not covered based on the date of	CO or PI
			injury/accident.	a
129	Prior processing information appears	MA36	Missing/incomplete/invalid patient name.	CO or PI
	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.)			
	ravice Remark Code that is not an ALLIKI.			
129	Prior processing information appears	N48	Claim information does not agree with	CO or PI
	incorrect. At least one Remark Code must be		information received from other insurance	
	provided (may be comprised of either the		carrier.	
	NCPDP Reject Reason Code, or Remittance			
	Advice Remark Code that is not an ALERT.)			
140	Patient/Insured health identification number		+	CO or PI
	and name do not match.			
146	Diagnosis was invalid for the date(s) of	M64	Missing/incomplete/invalid other diagnosis.	CO or PI

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

		Table		
	e de la companya de	•	olete Data from Submitted Claim	
Refers to	situations where additional data is needed from the	e billing provide	er for missing or invalid data on the submitted claim	m, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	ASC X12 CAGO
146	Diagnosis was invalid for the date(s) of service reported.	M76	Missing/incomplete/invalid diagnosis or condition.	CO or PI
146	Diagnosis was invalid for the date(s) of service reported.	MA63	Missing/incomplete/invalid principal diagnosis.	CO or PI
146	Diagnosis was invalid for the date(s) of service reported.	MA65	Missing/incomplete/invalid admitting diagnosis.	CO or PI
146	Diagnosis was invalid for the date(s) of service reported.	N517	Resubmit a new claim with the requested information.	CO or PI
146	Diagnosis was invalid for the date(s) of service reported.	N657	This should be billed with the appropriate code for these services.	CO or PI
175	Prescription is incomplete.	N592	Adjusted because this is not the initial prescription or exceeds the amount allowed for the initial prescription.	CO or PI
175	Prescription is incomplete.	N668	Incomplete/invalid prescription	CO or PI
181	Procedure code was invalid on the date of service.	M20	Missing/incomplete/invalid HCPCS.	CO or PI
181	Procedure code was invalid on the date of service.	N517	Resubmit a new claim with the requested information.	CO or PI
181	Procedure code was invalid on the date of service.	N657	This should be billed with the appropriate code for these services.	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
182	Procedure modifier was invalid on the date of service.	N657	This should be billed with the appropriate code for these services.	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.	N574	Our records indicate the ordering/referring provider is of a type/specialty that cannot order or refer. Please verify that the claim ordering/referring provider information is accurate or contact the ordering/referring provider.	CO or PI
183	The referring provider is not eligible to refer the service billed. Note: Refer to the 835	N630	Referral not authorized by attending physician).	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.	N574	Our records indicate the ordering/referring provider is of a type/specialty that cannot order or refer. Please verify that the claim ordering/referring provider information is accurate or contact the ordering/referring provider.	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.	N684	Payment denied as this is a specialty claim submitted as a general claim.	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
189	'Not otherwise classified' or 'unlisted' procedure code (CPT/HCPCS) was billed	N657	This should be billed with the appropriate code for these services.	CO or PI
199	Revenue code and Procedure code do not match.	N657	This should be billed with the appropriate code for these services.	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

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

		Table	3-1	
	Scenario #2: Missing	/Invalid/Incomp	plete Data from Submitted Claim	
Refers to	situations where additional data is needed from the	e billing provid	er for missing or invalid data on the submitted clair	n, e.g., an 837 or D.0.
CARC	CARC Description ⁴	RARC	RARC Description ⁵	ASC X12 CAGC
207	National Provider identifier - Invalid format.	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 or workers compensation state regulations/ fee schedule requirements.	N644	Reimbursement has been made according to the bilateral procedure rule.	CO or PI
240	The diagnosis is inconsistent with the patient's birth weight. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M76	Missing/incomplete/invalid diagnosis or condition.	CO or PI
240	The diagnosis is inconsistent with the patient's birth weight. Note: Refer to the 835	MA63	Missing/incomplete/invalid principal diagnosis.	CO or PI
240	The diagnosis is inconsistent with the patient's birth weight. Note: Refer to the 835	N207	Missing/incomplete/invalid weight.	CO or PI
240	The diagnosis is inconsistent with the patient's birth weight. Note: Refer to the 835	N657	This should be billed with the appropriate code for these services.	CO or PI
A8	Ungroupable DRG.	N647	Adjusted based on diagnosis-related group (DRG).	CO or PI
A8	Ungroupable DRG.	N657	This should be billed with the appropriate code for these services.	CO or PI
P7	The applicable fee schedule/fee database does not contain the billed code. Please resubmit a bill with the appropriate fee schedule/fee database code(s) that best describe the service(s) provided and supporting documentation if required. To be used for Property and Casualty only.	M51	Missing/incomplete/invalid procedure code(s).	CO or PI
P7	The applicable fee schedule/fee database does not contain the billed code. Please resubmit a bill with the appropriate fee schedule/fee	M119	Missing/incomplete/invalid/ deactivated/withdrawn National Drug Code (NDC).	CO or PI

⁴Washington Publishing Company: http://www.wpc-edi.com/reference/

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⁵Washington Publishing Company: http://www.wpc-edi.com/reference/

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

		Table	4-1	
	Scenario #3: B	illed Service No	ot Covered by Health Plan	
		e the billed serv	vice is not covered by the health plan.	
CARC8	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
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.	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
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.	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
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.	N129	Not eligible due to the patient's age.	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.	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
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.	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

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

		Table	4-1	
	Scenario #3: B	Silled Service No	ot Covered by Health Plan	
	Refers to situations when	e the billed serv	rice is not covered by the health plan.	
CARC8	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGC
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.	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
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.	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.	N684	Payment denied as this is a specialty claim submitted as a general claim.	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
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.	N598	Health care policy coverage is primary.	CO, PI or PR
23	The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)			OA
26	Expenses incurred prior to coverage.	N30	Patient ineligible for this service.	CO, PI or PR
26	Expenses incurred prior to coverage.	N52	Patient not enrolled in the billing provider's managed care plan on the date of service.	CO, PI or PR
26	Expenses incurred prior to coverage.	N128	This amount represents the prior to coverage portion of the allowance.	CO, PI or PR
26	Expenses incurred prior to coverage.	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
26	Expenses incurred prior to coverage.	N622	Not covered based on the date of injury/accident.	CO, PI or PR
26	Expenses incurred prior to coverage.	N650	This policy was not in effect for this date of loss. No coverage is available.	CO, PI or PR
26	Expenses incurred prior to coverage.	N652	The date of service is before the date of loss.	CO, PI or PR

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

		Table		
			t Covered by Health Plan	
		re the billed serv	ice is not covered by the health plan.	
CARC8	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGC
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
27	Expenses incurred after coverage terminated.	N30	Patient ineligible for this service.	CO, PI or PR
27	Expenses incurred after coverage terminated.	N45	Payment based on authorized amount.	CO, PI or PR
27	Expenses incurred after coverage terminated.	N52	Patient not enrolled in the billing provider's managed care plan on the date of service.	CO, PI or PR
27	Expenses incurred after coverage terminated.	N381	Consult our contractual agreement for restrictions/billing/payment information related to these charges.	CO, PI or PR
27	Expenses incurred after coverage terminated.	N418	Misrouted claim. See the payer's claim submission instructions.	CO, PI or PR
27	Expenses incurred after coverage terminated.	N619	Coverage terminated for non-payment of premium.	CO, PI or PR
27	Expenses incurred after coverage terminated.	N622	Not covered based on the date of injury/accident.	CO, PI or PR
27	Expenses incurred after coverage terminated.	N650	This policy was not in effect for this date of loss. No coverage is available.	CO, PI or PR
29	The time limit for filing has expired.	N30	Patient ineligible for this service.	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
32	Our records indicate that this dependent is not an eligible dependent as defined.	N52	Patient not enrolled in the billing provider's managed care plan on the date of service.	CO, PI or PR
32	Our records indicate that this dependent is not an eligible dependent as defined.	N129	Not eligible due to the patient's age.	CO, PI or PR
33	Insured has no dependent coverage.	N578	Coverages do not apply to this loss.	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
35	Lifetime benefit maximum has been reached.	N587	Policy benefits have been exhausted.	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

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

	Scenario #3: I	Billed Service No	t Covered by Health Plan	
	Refers to situations when	e the billed serv	ice is not covered by the health plan.	
CARC8	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGC
49	This is a non-covered service because it is a routine/preventive exam or a diagnostic/screening procedure done in conjunction with a routine/preventive exam. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO or PR
49	This is a non-covered service because it is a routine/preventive exam or a diagnostic/screening procedure done in	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	CO or PR
49	This is a non-covered service because it is a routine/preventive exam or a	N390	This service/report cannot be billed separately.	CO or PR
49	This is a non-covered service because it is a routine/preventive exam or a	N427	Payment for eyeglasses or contact lenses can be made only after cataract surgery.	CO or PR
49	This is a non-covered service because it is a routine/preventive exam or a	N429	Not covered when considered routine.	CO or PR
49	This is a non-covered service because it is a routine/preventive exam or a	N567	Not covered when considered preventative.	CO, PI 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
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.	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
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.	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
50	These are non-covered services because this is not deemed a 'medical necessity' by the	M64	Missing/incomplete/invalid other diagnosis.	CO, PI or PR
50	These are non-covered services because this is not deemed a 'medical necessity' by the	M76	Missing/incomplete/invalid diagnosis or condition.	CO, PI or PR
50	These are non-covered services because this is not deemed a 'medical necessity' by the	M85	Subjected to review of physician evaluation and management services.	CO, PI or PR
50	These are non-covered services because this is not deemed a 'medical necessity' by the	MA46	The new information was considered but additional payment will not be issued.	CO, PI or PR

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

		Table 4		
	Scenario #3:	Billed Service No	t Covered by Health Plan	
	Refers to situations who	ere the billed servi	ice is not covered by the health plan.	
CARC8	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGO
50	These are non-covered services because this is not deemed a 'medical necessity' by the	MA91	This determination is the result of the appeal you filed.	CO, PI or PR
50	These are non-covered services because this is not deemed a 'medical necessity' by the	MA126	Pancreas transplant not covered unless kidney transplant performed.	CO, PI 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	N10	Payment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	CO, PI or PR
50	These are non-covered services because this is not deemed a 'medical necessity' by the	N45	Payment based on authorized amount.	CO, PI 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.	N102	This claim has been denied without reviewing the medical/dental record because the requested records were not received or were not received timely.	CO, PI 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	N109	This claim/service was chosen for complex review and was denied after reviewing the medical records.	CO, PI 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.	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
50	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Note: Refer to the 835 Healthcare	N129	Not eligible due to the patient's age.	CO, PI 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	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	CO, PI 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	N161	This drug/service/supply is covered only when the associated service is covered.	CO, PI 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	N163	Medical record does not support code billed per the code definition.	CO, PI 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	N180	This item or service does not meet the criteria for the category under which it was billed.	CO, PI 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	N206	The supporting documentation does not match the information sent on the claim.	CO, PI 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	N225	Incomplete/invalid documentation/orders/notes/summary/report/c hart.	CO, PI 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	N229	Incomplete/invalid contract indicator.	CO, PI 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	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO, PI or PR

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

	Scenario #3: B	Table	ot Covered by Health Plan	
			vice is not covered by the health plan.	
CARC8	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGC
50	These are non-covered services because this is not deemed a 'medical necessity' by the payer. Note: Refer to the 835 Healthcare	N372	Only reasonable and necessary maintenance/service charges are covered.	CO, PI 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	N383	Not covered when deemed cosmetic.	CO, PI 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.	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
50	These are non-covered services because this is not deemed a 'medical necessity' by the	N607	Service provided for non-compensable condition(s).	CO, PI or PR
50	These are non-covered services because this is not deemed a 'medical necessity' by the	N658	Services by an unlicensed provider are not reimbursable.	CO, PI 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	N661	Documentation does not support that the services rendered were medically necessary.	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 advisor/dental advisor/peer review.	CO or PR
51	These are non-covered services because this is a pre-existing condition. Note: Refer to the 835 Healthcare Policy Identification Segment	N29	Missing documentation/orders/notes/summary/report/c hart.	CO or PR
51	These are non-covered services because this is a pre-existing condition. Note: Refer to the 835 Healthcare Policy Identification Segment	N45	Payment based on authorized amount.	CO or PR
51	These are non-covered services because this is a pre-existing condition. Note: Refer to the 835 Healthcare Policy Identification Segment	N174	This is not a covered service/procedure/ equipment/bed, however patient liability is limited to amounts shown in the adjustments	CO or PR
51	These are non-covered services because this is a pre-existing condition. Note: Refer to the 835 Healthcare Policy Identification Segment	N204	Services under review for possible pre- existing condition. Send medical records for prior 12 months.	CO or PR
51	These are non-covered services because this is a pre-existing condition. Note: Refer to the 835 Healthcare Policy Identification Segment	N607	Service provided for non-compensable condition(s).	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.	N646	Reimbursement has been adjusted based on the guidelines for an assistant.	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 present.	M49	Missing/incomplete/invalid value code(s) or amount(s).	CO, PI, or PR

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

	Scenario #3: B	Table 4	t Covered by Health Plan	
			ice is not covered by the health plan.	
CARC8	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGC
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 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
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 present.	N563	Missing required provider/supplier issuance of advance patient notice of non-coverage. The patient is not liable for payment for this service.	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 present.	N623	Not covered when deemed unscientific/unproven/outmoded/experimenta l/excessive/inappropriate.	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.	N563	Missing required provider/supplier issuance of advance patient notice of non-coverage. The patient is not liable for payment for this service.	CO or PI
56	Procedure/treatment has not been deemed 'proven to be effective' by the payer. Note: Refer to the 835 Healthcare Policy	N623	Not covered when deemed unscientific/unproven/outmoded/experimenta l/excessive/inappropriate.	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.	N563	Missing required provider/supplier issuance of advance patient notice of non-coverage. The patient is not liable for payment for this service.	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.	N633	Additional anesthesia time units are not allowed.	CO or PI
59	Processed based on multiple or concurrent procedure rules. (For example multiple	N644	Reimbursement has been made according to the bilateral procedure rule.	CO or PI
59	Processed based on multiple or concurrent procedure rules. (For example multiple	N670	This service code has been identified as the primary procedure code subject to the	CO or PI
60	Charges for outpatient services are not covered when performed within a period of time prior to or after inpatient services.	N676	Service does not qualify for payment under the Outpatient Facility Fee Schedule.	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.	N584	Not covered based on the insured's noncompliance with policy or statutory conditions.	CO, PI or PR

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

Table 4-1						
			ot Covered by Health Plan			
G + D G0			rice is not covered by the health plan.			
CARC8	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGC		
95	Plan procedures not followed.	N593	Not covered based on failure to attend a scheduled Independent Medical Exam (IME).	CO, PI or PR		
95	Plan procedures not followed.	N594	Records reflect the injured party did not complete an Application for Benefits for this loss.	CO, PI or PR		
95	Plan procedures not followed.	N595	Records reflect the injured party did not complete an Assignment of Benefits for this loss.	CO, PI or PR		
95	Plan procedures not followed.	N596	Records reflect the injured party did not complete a Medical Authorization for this loss.	CO, PI or PR		
95	Plan procedures not followed.	N630	Referral not authorized by attending physician).	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 ALERT.) 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		
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	M2	Not paid separately when the patient is an inpatient.	CO, PI or PR		
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	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		
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	M13	Only one initial visit is covered per specialty per medical group.	CO, PI or PR		
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	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	CO, PI or PR		
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	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		

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Tab 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					
G 1 TO GG		re the billed serv	rice is not covered by the health plan.		
CARC8	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGO	
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	M28	This does not qualify for payment under Part B when Part A coverage is exhausted or not otherwise available.	CO, PI or PR	
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	M37	Not covered when the patient is under age 35.	CO, PI or PR	
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	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	CO, PI or PR	
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	M41	We do not pay for this as the patient has no legal obligation to pay for this.	CO, PI or PR	
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	M49	Missing/incomplete/invalid value code(s) or amount(s).	CO, PI or PR	
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	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	
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	M61	We cannot pay for this as the approval period for the FDA clinical trial has expired.	CO, PI or PR	
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO, PI or PR	
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	M82	Service is not covered when patient is under age 50.	CO, PI or PR	
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	M83	Service is not covered unless the patient is classified as at high risk.	CO, PI or PR	
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO, PI or PR	
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	M87	Claim/service(s) subjected to CFO-CAP prepayment review.	CO, PI or PR	
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	M89	Not covered more than once under age 40.	CO, PI or PR	
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	M90	Not covered more than once in a 12 month period.	CO, PI or PR	
96	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	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	
96	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 ALERT.) Note: Refer to the 835	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	

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

		Table 4		
	Scenario #3:	Billed Service Not	Covered by Health Plan	
	Refers to situations wh	ere the billed servi	ce is not covered by the health plan.	
CARC8	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGC
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	M111	We do not pay for chiropractic manipulative treatment when the patient refuses to have an x-ray taken.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information	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
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	M117	Not covered unless submitted via electronic claim.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	M121	We pay for this service only when performed with a covered cryosurgical ablation.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	M134	Performed by a facility/supplier in which the provider has a financial interest.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment	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
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	M139	Denied services exceed the coverage limit for the demonstration.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835	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
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	MA24	Christian Science Sanitarium/ Skilled Nursing Facility (SNF) bill in the same benefit period.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	MA25	A patient may not elect to change a hospice provider more than once in a benefit period.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information	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
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	MA54	Physician certification or election consent for hospice care not received timely.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835	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

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

	Compuis #2. D	Table		
			ot Covered by Health Plan rice is not covered by the health plan.	
CARC8	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGO
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	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
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	MA57	Patient submitted written request to revoke his/her election for religious non-medical health care services.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	MA67	Correction to a prior claim.	CO, PI or PR
96	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	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
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	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
96	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	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
96	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	MA123	Your center was not selected to participate in this study, therefore, we cannot pay for these services.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of	MA126	Pancreas transplant not covered unless kidney transplant performed.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Uselbage Reliev Identification Segment	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
96	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 ALERT.) Note: Refer to the 835	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
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N7	Processing of this claim/service has included consideration under Major Medical provisions.	CO, PI or PR
96	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	N10	Payment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	CO, PI or PR

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

		Table 4-		
	Scenario #3: I	Billed Service Not	Covered by Health Plan	
	Refers to situations when	re the billed servi	e is not covered by the health plan.	
CARC8	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGO
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment	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
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of	N15	Services for a newborn must be billed separately.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N16	Family/member Out-of-Pocket maximum has been met. Payment based on a higher percentage.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of	N20	Service not payable with other service rendered on the same date.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N30	Patient ineligible for this service.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code	N32	Claim must be submitted by the provider who rendered the service.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of	N35	Program integrity/utilization review decision.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of	N43	Bed hold or leave days exceeded.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of	N45	Payment based on authorized amount.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N52	Patient not enrolled in the billing provider's managed care plan on the date of service.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N54	Claim information is inconsistent with pre- certified/authorized services.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N55	Procedures for billing with group/referring/performing providers were not followed.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	CO, PI or PR
96	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	N59	Please refer to your provider manual for additional program and provider information.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N61	Rebill services on separate claims.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N70	Consolidated billing and payment applies.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N81	Procedure billed is not compatible with tooth surface code.	CO, PI or PR

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

		Table 4-		
	Scenario #3: 1	Billed Service Not	Covered by Health Plan	
	Refers to situations whe	re the billed servic	e is not covered by the health plan.	
CARC8	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGC
96	Non-covered charge(s). At least one Remark	N83	No appeal rights. Adjudicative decision based	CO, PI or PR
	Code must be provided (may be comprised of		on the provisions of a demonstration project.	
	either the NCPDP Reject Reason [sic] Code,			
96	Non-covered charge(s). At least one Remark	N86	A failed trial of pelvic muscle exercise	CO, PI or PR
	Code must be provided (may be comprised of		training is required in order for biofeedback	
	either the NCPDP Reject Reason [sic] Code,		training for the treatment of urinary	
	or Remittance Advice Remark Code that is		incontinence to be covered.	
96	Non-covered charge(s). At least one Remark	N87	Home use of biofeedback therapy is not	CO, PI or PR
	Code must be provided (may be comprised of		covered.	,
	either the NCPDP Reject Reason [sic] Code,			
96	Non-covered charge(s). At least one Remark	N90	Covered only when performed by the	CO, PI or PR
	Code must be provided (may be comprised of		attending physician.	
	either the NCPDP Reject Reason [sic] Code,			
96	Non-covered charge(s). At least one Remark	N92	This facility is not certified for digital	CO, PI or PR
	Code must be provided (may be comprised of		mammography.	
0.1	either the NCPDP Reject Reason [sic] Code,			
96	Non-covered charge(s). At least one Remark	N95	This provider type/provider specialty may not bill this service.	CO, PI or PR
	Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,		bili this service.	
96	Non-covered charge(s). At least one Remark	N96	Patient must be refractory to conventional	CO, PI or PR
	Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,		therapy (documented behavioral, pharmacologic and/or surgical corrective	
	or Remittance Advice Remark Code that is		therapy) and be an appropriate surgical	
	not an ALERT.) Note: Refer to the 835		candidate such that implantation with	
	Healthcare Policy Identification Segment		anesthesia can occur.	
96	Non-covered charge(s). At least one Remark	N102	This claim has been denied without reviewing	CO, PI or PR
	Code must be provided (may be comprised of		the medical/dental record because the	,
	either the NCPDP Reject Reason [sic] Code,		requested records were not received or were	
	or Remittance Advice Remark Code that is		not received timely.	
	not an ALERT.) Note: Refer to the 835			
96	Non-covered charge(s). At least one Remark	N103	Records indicate this patient was a prisoner	CO, PI or PR
	Code must be provided (may be comprised of		or in custody of a Federal, State, or local	
	either the NCPDP Reject Reason [sic] Code,		authority when the service was rendered. This	
	or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835		payer does not cover items and services furnished to an individual while he or she is	
	Healthcare Policy Identification Segment		in custody under a penal statute or rule,	
	(loop 2110 Service Payment Information		unless under State or local law, the individual	
	REF), if present.		is personally liable for the cost of his or her	
			health care while in custody and the State or	
			local government pursues the collection of	
			such debt in the same way and with the same	
			vigor as the collection of its other debts. The	
			provider can collect from the Federal/State/	
			Local Authority as appropriate.	
96	Non-covered charge(s). At least one Remark	N104	This claim/service is not payable under our	CO, PI or PR
	Code must be provided (may be comprised of		claims jurisdiction area. You can identify the	,
	either the NCPDP Reject Reason [sic] Code,		correct Medicare contractor to process this	
	or Remittance Advice Remark Code that is		claim/service through the CMS website at	
	not an ALERT.) Note: Refer to the 835		www.cms.gov.	
96	Non-covered charge(s). At least one Remark	N109	This claim/service was chosen for complex	CO, PI or PR
	Code must be provided (may be comprised of		review and was denied after reviewing the	
	either the NCPDP Reject Reason [sic] Code,		medical records.	

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

		Table		
	Scenario #3: I	Billed Service No	ot Covered by Health Plan	
	Refers to situations when	e the billed serv	ice is not covered by the health plan.	
CARC8	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGO
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N110	This facility is not certified for film mammography.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N113	Only one initial visit is covered per physician, group practice or provider.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	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
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N117	This service is paid only once in a patient's lifetime.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N118	This service is not paid if billed more than once every 28 days.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	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
96	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 ALERT.) Note: Refer to the 835	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
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	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
96	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 ALERT.) Note: Refer to the 835	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
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N129	Not eligible due to the patient's age.	CO, PI or PR

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

		Table 4	4-1	
	Scenario #3: B	illed Service No	t Covered by Health Plan	
	Refers to situations wher	e the billed serv	ice is not covered by the health plan.	
CARC8	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGC
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	CO, PI or PR
96	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	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
96	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	N143	The patient was not in a hospice program during all or part of the service dates billed.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N157	Transportation to/from this destination is not covered.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N158	Transportation in a vehicle other than an ambulance is not covered.	CO, PI or PR
96	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	N159	Payment denied/reduced because mileage is not covered when the patient is not in the ambulance.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N161	This drug/service/supply is covered only when the associated service is covered.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code.	N163	Medical record does not support code billed per the code definition.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of	N167	Charges exceed the post-transplant coverage limit.	CO, PI or PR
96	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	N171	Payment for repair or replacement is not covered or has exceeded the purchase price.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittan Advice Remark Code that is	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
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment	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
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N180	This item or service does not meet the criteria for the category under which it was billed.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of	N188	The approved level of care does not match the procedure code submitted.	CO, PI or PR

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

		Table		
			ot Covered by Health Plan	
G L D CC			rice is not covered by the health plan.	
CARC8	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGC
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N193	Specific Federal/state/local program may cover this service through another payer.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N194	Technical component not paid if provider does not own the equipment used.	CO, PI or PR
96	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	N198	Rendering provider must be affiliated with the pay-to provider.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N202	Additional information/explanation will be sent separately.	CO, PI or PR
96	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	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
96	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	N348	You chose that this service/supply/drug would be rendered/supplied and billed by a different practitioner/supplier.	CO, PI or PR
96	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	N351	Service date outside of the approved treatment plan service dates.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N356	Not covered when performed with, or subsequent to, a non-covered service.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of	N383	Not covered when deemed cosmetic.	CO, PI or PR
96	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 ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	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
96	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	N405	This service is only covered when the donor's insurer(s) do not provide coverage for the service.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N406	This service is only covered when the recipient's insurer(s) do not provide coverage for the service.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N408	This payer does not cover deductibles assessed by a previous payer.	CO, PI or PR

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

		Table		
			ot Covered by Health Plan	
CARC8			rice is not covered by the health plan.	
	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGO
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code, or Remittan Advice Remark Code that is	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
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N410	Not covered unless the prescription changes.	CO, PI or PR
96	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	N418	Misrouted claim. See the payer's claim submission instructions.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N424	Patient does not reside in the geographic area required for this type of payment.	CO, PI or PR
96	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	N425	Statutorily excluded service(s).	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N426	No coverage when self-administered.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N428	Not covered when performed in this place of service.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N429	Not covered when considered routine.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N431	Not covered with this procedure.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N435	Exceeds number/frequency approved /allowed within time period without support documentation.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N441	This missed/cancelled appointment is not covered.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N442	Payment based on an alternate fee schedule.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N448	This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N450	Covered only when performed by the primary treating physician or the designee.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N507	Plan distance requirements have not been met.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N525	These services are not covered when performed within the global period of another service.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N528	Patient is entitled to benefits for Institutional Services only.	CO, PI or PR

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

		Table		
	Scenario #3: 1	Billed Service No	ot Covered by Health Plan	
	Refers to situations when	re the billed serv	rice is not covered by the health plan.	
CARC8	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGC
96	Non-covered charge(s). At least one Remark	N529	Patient is entitled to benefits for Professional	CO, PI or PR
	Code must be provided (may be comprised of		Services only.	
	either the NCPDP Reject Reason [sic] Code,			
96	Non-covered charge(s). At least one Remark	N563	Missing required provider/supplier issuance	CO, PI or PR
	Code must be provided (may be comprised of		of advance patient notice of non-coverage.	
	either the NCPDP Reject Reason [sic] Code,		The patient is not liable for payment for this	
96	Non-covered charge(s). At least one Remark	N564	Patient did not meet the inclusion criteria for	CO, PI or PR
	Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,		the demonstration project or pilot program.	
96	Non-covered charge(s). At least one Remark	N567	Not covered when considered preventative	CO, PI or PR
90	Code must be provided (may be comprised of	N307	Not covered when considered preventative.	CO, PI of PR
	either the NCPDP Reject Reason [sic] Code,			
96	Non-covered charge(s). At least one Remark	N569	Not covered when performed for the reported	CO, PI or PR
, ,	Code must be provided (may be comprised of	1.005	diagnosis.	00,110111
	either the NCPDP Reject Reason [sic] Code,			
96	Non-covered charge(s). At least one Remark	N576	Services not related to the specific	CO, PI or PR
	Code must be provided (may be comprised of		incident/claim/accident/loss being reported.	,
	either the NCPDP Reject Reason [sic] Code,			
96	Non-covered charge(s). At least one Remark	N578	Coverages do not apply to this loss.	CO, PI or PR
	Code must be provided (may be comprised of			
	either the NCPDP Reject Reason [sic] Code,			
96	Non-covered charge(s). At least one Remark	N584	Not covered based on the insured's	CO, PI or PR
	Code must be provided (may be comprised of		noncompliance with policy or statutory	
	either the NCPDP Reject Reason [sic] Code,		conditions.	
96	Non-covered charge(s). At least one Remark	N588	The patient has instructed that medical	CO, PI or PR
	Code must be provided (may be comprised of		claims/bills are not to be paid.	
	either the NCPDP Reject Reason [sic] Code,			
96	Non-covered charge(s). At least one Remark	N589	Coverage is excluded to any person injured as	CO, PI or PR
	Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,		a result of operating a motor vehicle while in an intoxicated condition or while the ability	
	or Remittance Advice Remark Code that is		to operate such a vehicle is impaired by the	
	not an ALERT.) Note: Refer to the 835		use of a drug.	
96	Non-covered charge(s). At least one Remark	N590	Missing independent medical exam detailing	CO, PI or PR
	Code must be provided (may be comprised of		the cause of injuries sustained and medical	
	either the NCPDP Reject Reason [sic] Code,		necessity of services rendered.	
96	Non-covered charge(s). At least one Remark	N592	Adjusted because this is not the initial	CO, PI or PR
	Code must be provided (may be comprised of		prescription or exceeds the amount allowed	
	either the NCPDP Reject Reason [sic] Code,		for the initial prescription.	
96	or Remittance Advice Remark Code that is Non-covered charge(s). At least one Remark	N593	Not covered based on failure to attend a	CO, PI or PR
70	Code must be provided (may be comprised of	11373	scheduled Independent Medical Exam (IME).	CO, 11011K
	either the NCPDP Reject Reason [sic] Code,		(
96	Non-covered charge(s). At least one Remark	N607	Service provided for non-compensable	CO, PI or PR
70	Code must be provided (may be comprised of	1100/	condition(s).	CO, 1101 FK
	either the NCPDP Reject Reason [sic] Code,			
96	Non-covered charge(s). At least one Remark	N621	Charges for Jurisdiction required forms,	CO, PI or PR
	Code must be provided (may be comprised of		reports, or chart notes are not payable.	
	either the NCPDP Reject Reason [sic] Code,			
96	Non-covered charge(s). At least one Remark	N622	Not covered based on the date of	CO, PI or PR
	Code must be provided (may be comprised of		injury/accident.	
	either the NCPDP Reject Reason [sic] Code,			
96	Non-covered charge(s). At least one Remark	N624	The associated Workers' Compensation claim	CO, PI or PR
	Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,		has been withdrawn.	

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

		Table	4-1	
	Scenario #3: B	Billed Service No	ot Covered by Health Plan	
		e the billed serv	rice is not covered by the health plan.	
CARC8	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGC
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N628	Out-patient follow up visits on the same date of service as a scheduled test or treatment is disallowed.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N630	Referral not authorized by attending physician	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N633	Additional anesthesia time units are not allowed.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N636	Adjusted because this is reimbursable only once per injury.	CO, PI or PR
96	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	N637	Consultations are not allowed once treatment has been rendered by the same provider.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N640	Exceeds number/frequency approved/allowed within time period.	CO, PI or PR
96	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	N643	The services billed are considered Not Covered or Non-Covered (NC) in the applicable state fee schedule.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N647	Adjusted based on diagnosis-related group (DRG).	CO, PI or PR
96	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	N651	No Personal Injury Protection/Medical Payments Coverage on the policy at the time of the loss.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N653	The date of injury does not match the reported date of loss.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N658	The billed service(s) are not considered medical expenses.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N665	Services by an unlicensed provider are not reimbursable.	CO, PI or PR
96	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	N666	Only one evaluation and management code at this service level is covered during the course of care.	CO, PI or PR
96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason [sic] Code,	N676	Service does not qualify for payment under the Outpatient Facility Fee Schedule.	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

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

	Scenario #3· R	Table	ot Covered by Health Plan	
			rice is not covered by the health plan.	
CARC8	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGC
108	Rent/purchase guidelines were not met. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	CO, PI or PR
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	N36	Claim must meet primary payer's processing requirements before we can consider payment.	CO, PI or PR
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	CO, PI or PR
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	N193	Specific Federal/state/local program may cover this service through another payer.	CO, PI or PR
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	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
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	N381	Consult our contractual agreement for restrictions/billing/payment information related to these charges.	CO, PI or PR
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	N418	Misrouted claim. See the payer's claim submission instructions.	CO, PI or PR
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	N448	This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement.	CO, PI or PR
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	N557	This claim/service is not payable under our service area. The claim must be filed to the Payer/Plan in whose service area the specimen was collected.	CO, PI or PR
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	N558	This claim/service is not payable under our service area. The claim must be filed to the Payer/Plan in whose service area the equipment was received.	CO, PI or PR
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	N559	This claim/service is not payable under our service area. The claim must be filed to the Payer/Plan in whose service area the Ordering Physician is located.	CO, PI or PR
109	Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor.	N576	Services not related to the specific incident/claim/accident/loss being reported.	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.	N623	Not covered when deemed unscientific/unproven/outmoded/experimenta l/excessive/inappropriate.	CO, PI or PR
115	Procedure postponed, canceled, or delayed.		i i	CO, PI or PR

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

	Scenario #3	Table 4	t Covered by Health Plan	
			ice is not covered by the health plan.	
CARC8	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGO
117	Transportation is only covered to the closest	-		CO, PI or PR
	facility that can provide the necessary care.			00,110,111
119	Benefit maximum for this time period or occurrence has been reached.	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
119	Benefit maximum for this time period or occurrence has been reached.	M53	Missing/incomplete/invalid days or units of service.	CO, PI or PR
119	Benefit maximum for this time period or occurrence has been reached.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO, PI or PR
119	Benefit maximum for this time period or occurrence has been reached.	M83	Service is not covered unless the patient is classified as at high risk.	CO, PI or PR
119	Benefit maximum for this time period or occurrence has been reached.	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO, PI or PR
119	Benefit maximum for this time period or occurrence has been reached.	M89	Not covered more than once under age 40.	CO, PI or PR
119	Benefit maximum for this time period or occurrence has been reached.	M90	Not covered more than once in a 12 month period.	CO, PI or PR
119	Benefit maximum for this time period or occurrence has been reached.	M139	Denied services exceed the coverage limit for the demonstration.	CO, PI or PR
119	Benefit maximum for this time period or occurrence has been reached.	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
119	Benefit maximum for this time period or occurrence has been reached.	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
119	Benefit maximum for this time period or occurrence has been reached.	N45	Payment based on authorized amount.	CO, PI or PR
119	Benefit maximum for this time period or occurrence has been reached.	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
119	Benefit maximum for this time period or occurrence has been reached.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	CO, PI or PR
119	Benefit maximum for this time period or occurrence has been reached.	N357	Time frame requirements between this service/procedure/supply and a related service/procedure/supply have not been met.	CO, PI or PR
119	Benefit maximum for this time period or occurrence has been reached.	N362	The number of Days or Units of Service exceeds our acceptable maximum.	CO, PI or PR
119	Benefit maximum for this time period or occurrence has been reached.	N381	Consult our contractual agreement for restrictions/billing/payment information related to these charges.	CO, PI or PR

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

	Scenario #3: B	Table	ot Covered by Health Plan	
			rice is not covered by the health plan.	
CARC8	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGC
119	Benefit maximum for this time period or occurrence has been reached.	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
119	Benefit maximum for this time period or occurrence has been reached.	N418	Misrouted claim. See the payer's claim submission instructions.	CO, PI or PR
119	Benefit maximum for this time period or occurrence has been reached.	N435	Exceeds number/frequency approved /allowed within time period without support documentation.	CO, PI or PR
119	Benefit maximum for this time period or occurrence has been reached.	N587	Policy benefits have been exhausted.	CO, PI or PR
119	Benefit maximum for this time period or occurrence has been reached.	N636	Adjusted because this is reimbursable only once per injury.	CO, PI or PR
119	Benefit maximum for this time period or occurrence has been reached.	N640	Exceeds number/frequency approved/allowed within time period.	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.	N584	Not covered based on the insured's noncompliance with policy or statutory conditions.	CO, PI or PR
149	Lifetime benefit maximum has been reached for this service/benefit category.	N587	Policy benefits have been exhausted.	CO, PI or PR
150	Payer deems the information submitted does not support this level of service.	N640	Exceeds number/frequency approved/allowed within time period.	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.	N640	Exceeds number/frequency approved/allowed within time period.	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
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
160	Injury/illness was the result of an activity that is a benefit exclusion.	N167	Charges exceed the post-transplant coverage limit.	CO, PI or PR

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

		Table	4-1	
	Scenario #3: I	Billed Service No	ot Covered by Health Plan	
	Refers to situations when	re the billed serv	ice is not covered by the health plan.	
CARC8	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGO
160	Injury/illness was the result of an activity that is a benefit exclusion.	N356	Not covered when performed with, or subsequent to, a non-covered service.	CO, PI or PR
160	Injury/illness was the result of an activity that is a benefit exclusion.	N607	Service provided for non-compensable condition(s).	CO, PI or PR
160	Injury/illness was the result of an activity that is a benefit exclusion.	N622	Not covered based on the date of injury/accident.	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
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.	N607	Service provided for non-compensable condition(s).	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.	N647	Adjusted based on diagnosis-related group (DRG).	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
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.	N90	Covered only when performed by the attending physician.	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.	N95	This provider type/provider specialty may not bill 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.	N348	You chose that this service/supply/drug would be rendered/supplied and billed by a different practitioner/supplier.	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.	N665	Services by an unlicensed provider are not reimbursable.	CO, PI or PR

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

		Table		
			ot Covered by Health Plan	
CAD CO			rice is not covered by the health plan.	
CARC8	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGC
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
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.	N92	This facility is not certified for digital mammography.	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.	N110	This facility is not certified for film mammography.	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.	N428	Not covered when performed in this place of service.	CO, PI or PR
173	Service/equipment was not prescribed by a physician.	N667	Missing prescription	CO, PI or PR
173	Service/equipment was not prescribed by a physician.	N668	Incomplete/invalid prescription	CO, PI or PR
174	Service was not prescribed prior to delivery.	N667	Missing prescription	CO, PI or PR
174	Service was not prescribed prior to delivery.	N668	Incomplete/invalid prescription	CO, PI or PR
176	Prescription is not current.	N592	Adjusted because this is not the initial prescription or exceeds the amount allowed for the initial prescription.	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
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

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

		Table 4	4-1	
	Scenario #3: I	Billed Service No	t Covered by Health Plan	
	Refers to situations when	re the billed serv	ice is not covered by the health plan.	
CARC8	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGC
198	Precertification/authorization exceeded.	M62	Missing/incomplete/invalid treatment authorization code.	CO, PI or PR
198	Precertification/authorization exceeded.	N54	Claim information is inconsistent with pre- certified/authorized services.	CO, PI or PR
198	Precertification/authorization exceeded.	N351	Service date outside of the approved treatment plan service dates.	CO, PI or PR
200	Expenses incurred during lapse in coverage.	N619	Coverage terminated for non-payment of premium.	CO, PI or PR
200	Expenses incurred during lapse in coverage.	N650	This policy was not in effect for this date of loss. No coverage is available.	CO, PI or PR
202	Non-covered personal comfort or convenience services.	N658	The billed service(s) are not considered medical expenses.	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
204	This service/equipment/drug is not covered under the patient's current benefit plan.	N448	This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement.	CO, PI or PR
204	This service/equipment/drug is not covered under the patient's current benefit plan.	N567	Not covered when considered preventative.	CO, PI or PR
204	This service/equipment/drug is not covered under the patient's current benefit plan.	N569	Not covered when performed for the reported diagnosis.	CO, PI or PR
204	This service/equipment/drug is not covered under the patient's current benefit plan.	N651	No Personal Injury Protection/Medical Payments Coverage on the policy at the time of the loss.	CO, PI or PR
204	This service/equipment/drug is not covered under the patient's current benefit plan.	N658	The billed service(s) are not considered medical expenses.	CO, PI or PR
204	This service/equipment/drug is not covered under the patient's current benefit plan.	N666	Only one evaluation and management code at this service level is covered during the course of care.	CO, PI or PR
212	Administrative surcharges are not covered.	N658	The billed service(s) are not considered medical expenses.	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.	N587	Policy benefits have been exhausted.	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.	N633	Additional anesthesia time units are not allowed.	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.	N640	Exceeds number/frequency approved/allowed within time period.	CO, PI or PR

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

	Scenario #3 · R	Table	ot Covered by Health Plan	
			vice is not covered by the health plan.	
CARC8	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGO
228	Denied for failure of this provider, another provider or the subscriber to supply requested information to a previous payer for their adjudication.	N555	Missing medication list.	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.	N556	Incomplete/invalid medication list.	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.	N628	Out-patient follow up visits on the same date of service as a scheduled test or treatment is disallowed.	CO, PI or PR
233	Services/charges related to the treatment of a hospital-acquired condition or preventable medical error.			CO, PI or PR
238	Claim spans eligible and ineligible periods of coverage, this is the reduction for the ineligible period. (Use only with Group Code PR)			PR
239	Claim spans eligible and ineligible periods of coverage. Rebill separate claims.			CO, PI or PR
242	Services not provided by network/primary care providers. Notes: This code replaces deactivated code 38	M115	This item is denied when provided to this patient by a non-contract or non-demonstration supplier.	CO, PI or PR
242	Services not provided by network/primary care providers. Notes: This code replaces deactivated code 38	N95	This provider type/provider specialty may not bill this service.	CO, PI or PR
242	Services not provided by network/primary care providers. Notes: This code replaces deactivated code 38	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	CO, PI or PR
242	Services not provided by network/primary care providers. Notes: This code replaces deactivated code 38	N202	Additional information/explanation will be sent separately.	CO, PI or PR
242	Services not provided by network/primary care providers. Notes: This code replaces deactivated code 38	N450	Covered only when performed by the primary treating physician or the designee.	CO, PI or PR
243	Services not authorized by network/primary care providers. Notes: This code replaces deactivated code 38	M115	This item is denied when provided to this patient by a non-contract or non-demonstration supplier.	CO, PI or PR
243	Services not authorized by network/primary care providers. Notes: This code replaces deactivated code 38	N95	This provider type/provider specialty may not bill this service.	CO, PI or PR
243	Services not authorized by network/primary care providers. Notes: This code replaces deactivated code 38	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	CO, PI or PR
243	Services not authorized by network/primary care providers. Notes: This code replaces deactivated code 38	N202	Additional information/explanation will be sent separately.	CO, PI or PR
243	Services not authorized by network/primary care providers. Notes: This code replaces deactivated code 38	N450	Covered only when performed by the primary treating physician or the designee.	CO, PI or PR
243	Services not authorized by network/primary care providers. Notes: This code replaces deactivated code 38	N630	Referral not authorized by attending physician).	CO, PI or PR

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

	9 . "2	Table 4		
			t Covered by Health Plan	
G + Th G0			ice is not covered by the health plan.	
CARC8	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGO
246	This non-payable code is for required reporting only.	N572	This procedure is not payable unless non- payable reporting codes and appropriate modifiers are submitted.	CO, PI or PR
249	This claim has been identified as a readmission. (Use only with Group Code CO)			СО
254	Claim received by the dental plan, but benefits not available under this plan. Submit these services to the patient's medical plan for further consideration.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	CO, PI or PR
254	Claim received by the dental plan, but benefits not available under this plan. Submit these services to the patient's medical plan for further consideration.	N202	Additional information/explanation will be sent separately	CO, PI or PR
256	Service not payable per managed care contract.	M14	No separate payment for an injection administered during an office visit, and no payment for a full office visit if the patient only received an injection.	CO, PI or PR
256	Service not payable per managed care contract.	M37	Not covered when the patient is under age 35.	CO, PI or PR
256	Service not payable per managed care contract.	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
256	Service not payable per managed care contract.	M39	The patient is not liable for payment for this service as the advance notice of non-coverage you provided the patient did not comply with program requirements.	CO, PI or PR
256	Service not payable per managed care contract.	M61	We cannot pay for this as the approval period for the FDA clinical trial has expired.	CO, PI or PR
256	Service not payable per managed care contract.	M81	You are required to code to the highest level of specificity.	CO, PI or PR
256	Service not payable per managed care contract.	M82	Service is not covered when patient is under age 50.	CO, PI or PR
256	Service not payable per managed care contract.	M89	Not covered more than once under age 40.	CO, PI or PR
256	Service not payable per managed care contract.	M90	Not covered more than once in a 12 month period.	CO, PI or PR
256	Service not payable per managed care contract.	M96	The technical component of a service furnished to an inpatient may only be billed by that inpatient facility. You must contact the inpatient facility for technical component reimbursement. If not already billed, you should bill us for the professional component only.	CO, PI or PR
256	Service not payable per managed care contract.	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
256	Service not payable per managed care contract.	M139	Denied services exceed the coverage limit for the demonstration.	CO, PI or PR

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

		Table		
			ot Covered by Health Plan	
CARCO			ice is not covered by the health plan.	
CARC8	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGC
256	Service not payable per managed care contract.	MA16	The patient is covered by the Black Lung Program. Send this claim to the Department of Labor, Federal Black Lung Program, P.O. Box 828, Lanham-Seabrook MD 20703.	CO, PI or PR
256	Service not payable per managed care contract.	N52	Patient not enrolled in the billing provider's managed care plan on the date of service.	CO, PI or PR
256	Service not payable per managed care contract.	N95	This provider type/provider specialty may not bill this service.	CO, PI or PR
256	Service not payable per managed care contract.	N103	Records indicate this patient was a prisoner or in custody of a Federal, State, or local authority when the service was rendered. This payer does not cover items and services furnished to an individual while he or she is in custody under a penal statute or rule, unless under State or local law, the individual is personally liable for the cost of his or her health care while in custody and the State or local government pursues the collection of such debt in the same way and with the same vigor as the collection of its other debts. The provider can collect from the Federal/State/Local Authority as appropriate.	CO, PI or PR
256	Service not payable per managed care contract.	N117		CO, PI or PR
256	Service not payable per managed care contract.	N118	This service is not paid if billed more than once every 28 days.	CO, PI or PR
256	Service not payable per managed care contract.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	CO, PI or PR
256	Service not payable per managed care contract.	N202	Additional information/explanation will be sent separately	CO, PI or PR
256	Service not payable per managed care contract.	N246	State regulated patient payment limitations apply to this service.	CO, PI or PR
256	Service not payable per managed care contract.	N428	Not covered when performed in this place of service.	CO, PI or PR
256	Service not payable per managed care contract.	N448	This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement	CO, PI or PR
256	Service not payable per managed care contract.	N623	Not covered when deemed unscientific/unproven/outmoded/experimenta l/excessive/inappropriate.	CO, PI or PR
258	Claim/service not covered when patient is in custody/incarcerated. Applicable federal, state or local authority may cover the claim/service.	N30	Patient ineligible for this service.	CO, PI or PR

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

	Scenario #3. R	Table of the control	ot Covered by Health Plan	
			rice is not covered by the health plan.	
CARC8	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGO
258	Claim/service not covered when patient is in custody/incarcerated. Applicable federal, state or local authority may cover the claim/service.	N103	Records indicate this patient was a prisoner or in custody of a Federal, State, or local authority when the service was rendered. This payer does not cover items and services furnished to an individual while he or she is in custody under a penal statute or rule, unless under State or local law, the individual is personally liable for the cost of his or her health care while in custody and the State or local government pursues the collection of such debt in the same way and with the same vigor as the collection of its other debts. The provider can collect from the Federal/State/Local Authority as appropriate.	CO, PI or PR
258	Claim/service not covered when patient is in custody/incarcerated. Applicable federal, state or local authority may cover the claim/service.	N193	Specific federal/state/local program may cover this service through another payer.	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
B1	Non-covered visits.	N628	Out-patient follow up visits on the same date of service as a scheduled test or treatment is disallowed.	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
B11	The claim/service has been transferred to the proper payer/processor for processing. Claim/service not covered by this payer/processor.	N381	Consult our contractual agreement for restrictions/billing/payment information related to these charges.	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.	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
B14	Only one visit or consultation per physician per day is covered.	N2	This allowance has been made in accordance with the most appropriate course of treatment provision of the plan.	CO, PI or PR
B14	Only one visit or consultation per physician per day is covered.	N628	Out-patient follow up visits on the same date of service as a scheduled test or treatment is disallowed.	CO, PI or PR
B14	Only one visit or consultation per physician per day is covered.	N637	Consultations are not allowed once treatment has been rendered by the same provider.	CO, PI or PR

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

		Table		
			t Covered by Health Plan	
		e the billed serv	ice is not covered by the health plan.	
CARC8	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGO
B14	Only one visit or consultation per physician per day is covered.	N666	Only one evaluation and management code at this service level is covered during the course of care.	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
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.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	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.	N20	Service not payable with other service rendered on the same date.	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.	N674	Not covered unless a pre-requisite procedure/service has been provided.	CO, PI or PR
B16	'New Patient' qualifications were not met.		1	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
В5	Coverage/program guidelines were not met or were exceeded.	N584	Not covered based on the insured's noncompliance with policy or statutory conditions.	CO, PI or PR
В5	Coverage/program guidelines were not met or were exceeded.	N593	Not covered based on failure to attend a scheduled Independent Medical Exam (IME).	CO, PI or PR
B5	Coverage/program guidelines were not met or were exceeded.	N630	Referral not authorized by attending physician	CO, PI or PR
B5	Coverage/program guidelines were not met or were exceeded.	N640	Exceeds number/frequency approved/allowed within time period.	CO, PI or PR

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Tab 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 wh	ere the billed service	is not covered by the health plan.	
CARC8	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGC
В7	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.	N570	Missing/incomplete/invalid credentialing data	CO, PI or PR
В7	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.	N612	Medical provider not authorized/certified to provide treatment to injured workers in this jurisdiction.	CO, PI or PR
В7	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.	N665	Services by an unlicensed provider are not reimbursable.	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
В9	Patient is enrolled in a Hospice.			CO, PI or PR
P16	Medical provider not authorized/certified to provide treatment to injured workers in this jurisdiction. To be used for Workers' Compensation only. (Use with Group Code CO or OA)			CO or OA
P17	Referral not authorized by attending physician per regulatory requirement. To be used for Property and Casualty only.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	CO, PI or PR
P2	Not a work related injury/illness and thus not the liability of the workers' compensation carrier Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only.			CO, PI or PR
P20	Service not paid under jurisdiction allowed outpatient facility fee schedule. To be used for Property and Casualty only.	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
P20	Service not paid under jurisdiction allowed outpatient facility fee schedule. To be used for Property and Casualty only.	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	CO, PI or PR

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

	Scangwig #2. B	Table	ot Covered by Health Plan	
			vice is not covered by the health plan.	
CARC8	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGO
P21	Payment denied based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional regulations or payment policies, use only if no other code is applicable. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier IG') if the jurisdictional regulation applies. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF) if the regulations apply. To be used for Property and Casualty Auto only.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO, PI or PR
P21	Payment denied based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional regulations or payment policies, use only if no other code is applicable. Note: If	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, PI or PR
P21	Payment is at the Claim Level the payer Payment denied based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional regulations or payment policies, use only if	N10	Payment based on the findings of a review organization/professional consult/manual adjudication/medical advisor/dental advisor/peer review.	CO, PI or PR
P21	Payment denied based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional regulations or payment policies, use only if	N36	Claim must meet primary payer's processing requirements before we can consider payment.	CO, PI or PR
P21	Payment denied based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional	N95	This provider type/provider specialty may not bill this service.	CO, PI or PR
P21	Payment denied based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional regulations or payment policies, use only if	N158	Transportation in a vehicle other than an ambulance is not covered.	CO, PI or PR
P21	Payment denied based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional regulations or payment policies, use only if no other code is applicable. Note: If	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
P21	Payment denied based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional	N479	Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).	CO, PI or PR
P21	Payment denied based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional	N576	Services not related to the specific incident/claim/accident/loss being reported.	CO, PI or PR
P21	Payment denied based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional	N577	Personal Injury Protection (PIP) Coverage.	CO, PI or PR
P21	Payment denied based on Medical Payments Coverage (MPC) or Personal Injury Protection (PIP) Benefits jurisdictional	N578	Coverages do not apply to this loss.	CO, PI or PR

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

		Table	4-1	
	Scenario #3: F	Billed Service No	ot Covered by Health Plan	
	Refers to situations when	e the billed serv	rice is not covered by the health plan.	
CARC8	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGC
P21	Payment denied based on Medical Payments	N579	Medical Payments Coverage (MPC).	CO, PI or PR
	Coverage (MPC) or Personal Injury			
	Protection (PIP) Benefits jurisdictional			
P21	Payment denied based on Medical Payments	N580	Determination based on the provisions of the	CO, PI or PR
	Coverage (MPC) or Personal Injury		insurance policy.	
	Protection (PIP) Benefits jurisdictional			
P21	Payment denied based on Medical Payments	N582	Benefits suspended pending the patient's	CO, PI or PR
	Coverage (MPC) or Personal Injury		cooperation.	
	Protection (PIP) Benefits jurisdictional			
P21	Payment denied based on Medical Payments	N583	Patient was not an occupant of our insured	CO, PI or PR
	Coverage (MPC) or Personal Injury		vehicle and therefore, is not an eligible	
	Protection (PIP) Benefits jurisdictional		injured person.	
	regulations or payment policies, use only if		· ·	
P21	Payment denied based on Medical Payments	N584	Not covered based on the insured's	CO, PI or PR
	Coverage (MPC) or Personal Injury		noncompliance with policy or statutory	
	Protection (PIP) Benefits jurisdictional		conditions.	
P21	Payment denied based on Medical Payments	N585	Benefits are no longer available based on a	CO, PI or PR
	Coverage (MPC) or Personal Injury		final injury settlement.	
P21	Protection (PIP) Repetits jurisdictional Payment denied based on Medical Payments	N586	The injured ments does not excite for	CO, PI or PR
P21	Coverage (MPC) or Personal Injury	N380	The injured party does not qualify for benefits.	CO, PI of PR
	* ' '			
P21	Payment denied based on Medical Payments	N587	Policy benefits have been exhausted.	CO, PI or PR
201	Coverage (MPC) or Personal Injury	*****		
P21	Payment denied based on Medical Payments	N588	The patient has instructed that medical	CO, PI or PR
	Coverage (MPC) or Personal Injury		claims/bills are not to be paid.	
P21	Payment denied based on Medical Payments	N589	Coverage is excluded to any person injured as	CO, PI or PR
	Coverage (MPC) or Personal Injury		a result of operating a motor vehicle while in	
	Protection (PIP) Benefits jurisdictional		an intoxicated condition or while the ability	
	regulations or payment policies, use only if		to operate such a vehicle is impaired by the	
	no other code is applicable. Note: If		use of a drug.	
201	adjustment is at the Claim Level, the paver	*****		
P21	Payment denied based on Medical Payments	N590	Missing independent medical exam detailing	CO, PI or PR
	Coverage (MPC) or Personal Injury		the cause of injuries sustained and medical	
	Protection (PIP) Benefits jurisdictional		necessity of services rendered.	
P21	Payment denied based on Medical Payments	N593	Not covered based on failure to attend a	CO, PI or PR
	Coverage (MPC) or Personal Injury		scheduled Independent Medical Exam (IME).	
	Protection (PIP) Benefits jurisdictional			
D21	Payment denied based on Medical Payments	N504	Decords reflect the injured ments did not	CO DI am DD
P21	Payment denied based on Medical Payments Coverage (MPC) or Personal Injury	N594	Records reflect the injured party did not complete an Application for Benefits for this	CO, PI or PR
	Protection (PIP) Benefits jurisdictional			
	regulations or payment policies, use only if		loss.	
P21	Payment denied based on Medical Payments	N595	Records reflect the injured party did not	CO, PI or PR
	Coverage (MPC) or Personal Injury		complete an Assignment of Benefits for this	
	Protection (PIP) Benefits jurisdictional		loss.	
P21	Payment denied based on Medical Payments	N596	Records reflect the injured party did not	CO, PI or PR
	Coverage (MPC) or Personal Injury		complete a Medical Authorization for this	,
	Protection (PIP) Benefits jurisdictional		loss.	
	regulations or payment policies, use only if			
P21	Payment denied based on Medical Payments	N598	Health care policy coverage is primary.	CO, PI or PR
	Coverage (MPC) or Personal Injury			
P21	Payment denied based on Medical Payments	N607	Service provided for non-compensable	CO, PI or PR
	Coverage (MPC) or Personal Injury		condition(s).	

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

		Table	4-1	
	Scenario #3: B	illed Service No	ot Covered by Health Plan	
	Refers to situations wher	e the billed serv	vice is not covered by the health plan.	
CARC8	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGC
P21	Payment denied based on Medical Payments	N611	Claim in litigation. Contact insurer for more	CO, PI or PR
	Coverage (MPC) or Personal Injury		information.	
	Protection (PIP) Renefits jurisdictional			
P21	Payment denied based on Medical Payments	N621	Charges for Jurisdiction required forms,	CO, PI or PR
	Coverage (MPC) or Personal Injury		reports, or chart notes are not payable.	
Dat	Protection (PIP) Benefits jurisdictional	37.522	N	CO DI DD
P21	Payment denied based on Medical Payments	N622	Not covered based on the date of	CO, PI or PR
	Coverage (MPC) or Personal Injury		injury/accident.	
P21	Payment denied based on Medical Payments	N650	This policy was not in effect for this date of	CO, PI or PR
	Coverage (MPC) or Personal Injury		loss. No coverage is available.	
	Protection (PIP) Benefits jurisdictional			
P21	Payment denied based on Medical Payments	N651	No Personal Injury Protection/Medical	CO, PI or PR
	Coverage (MPC) or Personal Injury		Payments Coverage on the policy at the time	
	Protection (PIP) Benefits jurisdictional		of the loss.	
P21	Payment denied based on Medical Payments	N652	The date of service is before the date of loss.	CO, PI or PR
121	Coverage (MPC) or Personal Injury	11032	The date of service is before the date of loss.	CO, 11011K
	Protection (PIP) Benefits jurisdictional			
P21	Payment denied based on Medical Payments	N653	The date of injury does not match the	CO, PI or PR
1 21	Coverage (MPC) or Personal Injury	14033	reported date of loss.	CO, 11011K
	Protection (PIP) Benefits jurisdictional		reported date of loss.	
P21	Payment denied based on Medical Payments	N657	This should be billed with the appropriate	CO, PI or PR
	Coverage (MPC) or Personal Injury		code for these services.	,
	Protection (PIP) Benefits jurisdictional			
P21	Payment denied based on Medical Payments	N658	The billed service(s) are not considered	CO, PI or PR
	Coverage (MPC) or Personal Injury		medical expenses.	,
	Protection (PIP) Benefits jurisdictional		·	
P21	Payment denied based on Medical Payments	N661	Documentation does not support that the	CO, PI or PR
	Coverage (MPC) or Personal Injury		services rendered were medically necessary.	
	Protection (PIP) Benefits jurisdictional			
	regulations or payment policies, use only if			
P21	Payment denied based on Medical Payments	N665	Services by an unlicensed provider are not	CO, PI or PR
	Coverage (MPC) or Personal Injury		reimbursable.	,
	Protection (PIP) Benefits jurisdictional			
P21	Payment denied based on Medical Payments	N666	Only one evaluation and management code at	CO, PI or PR
	Coverage (MPC) or Personal Injury	11000	this service level is covered during the course	00,110111
	Protection (PIP) Benefits jurisdictional		of care.	
P21	Payment denied based on Medical Payments	N667	Missing prescription	CO, PI or PR
1 21	Coverage (MPC) or Personal Injury	14007	ivissing prescription	CO, 11011K
P21	Payment denied based on Medical Payments	N668	Incomplete/invalid prescription	CO, PI or PR
	Coverage (MPC) or Personal Injury		F	,
Р3	Workers' Compensation case settled. Patient			PR
	is responsible for amount of this claim/service		1	
	through WC 'Medicare set aside arrangement'		1	
	or other agreement. To be used for Workers'		1	
	Compensation only. (Use only with Group		1	
	Code PR)			

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Tab 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.						
CARC8	CARC Description ⁶	RARC	RARC Description ⁷	ASC X12 CAGC			
P4	Workers' Compensation claim adjudicated as non-compensable. This Payer not liable for claim or service/treatment. Note: If adjustment is at the Claim Level, the payer must send and the provider should refer to the 835 Insurance Policy Number Segment (Loop 2100 Other Claim Related Information REF qualifier 'IG') for the jurisdictional regulation. If adjustment is at the Line Level, the payer must send and the provider should refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment information REF). To be used for Workers' Compensation only	N612	Medical provider not authorized/certified to provide treatment to injured workers in this jurisdiction.	CO, PI or PR			

⁶Washington Publishing Company: http://www.wpc-edi.com/reference/

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⁷Washington Publishing Company: http://www.wpc-edi.com/reference/

⁸CARC 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

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 RARC RARC RARC RARC RARC RARC RAR					
CARC	CARC Description ⁹	RARC	RARC Description ¹⁰		
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	
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	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	
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	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO, PI or PR	
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been	M86	Service denied because payment already made for same/similar procedure within set time frame.	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	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	
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.	M144	Pre-/post-operative care payment is included in the allowance for the surgery/procedure.	CO, PI or PR	
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been	N19	Procedure code incidental to primary procedure.	CO, PI or PR	
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been	N20	Service not payable with other service rendered on the same date.	CO, PI or PR	
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been	N22	This procedure code was added/changed because it more accurately describes the services rendered.	CO, PI or PR	
97	The benefit for this service is included in the	N45	Payment based on authorized amount.	CO, PI or PR	
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been	N56	Procedure code billed is not correct/valid for the services billed or the date of service billed.	CO, PI or PR	
97	The benefit for this service is included in the payment/allowance for another	N63	Rebill services on separate claim lines.	CO, PI or PR	
97	The benefit for this service is included in the payment/allowance for another	N70	Consolidated billing and payment applies.	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	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	

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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	l service or ben	efit is not separately payable by the health plan.		
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.	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	
97	The benefit for this service is included in the payment/allowance for another	N122	Add-on code cannot be billed by itself.	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 \$35.	N123	This is a split service and represents a portion of the units from the originally submitted service.	CO, PI or PR	
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been	N130	Consult plan benefit documents/guidelines for information about restrictions for this service.	CO, PI or PR	
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been	N202	Additional information/explanation will be sent separately.	CO, PI or PR	
97	The benefit for this service is included in the payment/allowance for another	N370	Billing exceeds the rental months covered/approved by the payer.	CO, PI or PR	
97	The benefit for this service is included in the payment/allowance for another	N390	This service/report cannot be billed separately.	CO, PI or PR	
97	The benefit for this service is included in the payment/allowance for another	N432	Adjustment based on a Recovery Audit.	CO, PI or PR	
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been	N525	These services are not covered when performed within the global period of another service.	CO, PI or PR	
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been	N626	New or established patient E/M codes are not payable with chiropractic care codes.	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: Pafer to the \$35	N628	Out-patient follow up visits on the same date of service as a scheduled test or treatment is disallowed.	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	N637	Consultations are not allowed once treatment has been rendered by the same provider.	CO, PI or PR	
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been	N646	Reimbursement has been adjusted based on the guidelines for an assistant.	CO, PI or PR	
97	The benefit for this service is included in the payment/allowance for another service/procedure that has already been	N666	Only one evaluation and management code at this service level is covered during the course of care.	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	

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

		Table	5-1	
			ervice Not Separately Payable	
			efit is not separately payable by the health plan.	
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.)	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	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.)	N626	New or established patient E/M codes are not payable with chiropractic care codes.	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.)	N628	Out-patient follow up visits on the same date of service as a scheduled test or treatment is disallowed.	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.)	N676	Service does not qualify for payment under the Outpatient Facility Fee Schedule.	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
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.	M144	Pre-/post-operative care payment is included in the allowance for the surgery/procedure.	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.	N22	This procedure code was added/changed because it more accurately describes the services rendered.	CO, PI or PR
P14	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. To be used for Property and Casualty only.	M2	Not paid separately when the patient is an inpatient.	CO, PI or PR
P14	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day. Note: Refer to the 835	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

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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 bille	d service or bene	fit is not separately payable by the health plan.	
P14	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. To be used for Property and Casualty only.	M75	Multiple automated multichannel tests performed on the same day combined for payment.	CO, PI or PR
P14	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. To be used for Property and Casualty only.	M80	Not covered when performed during the same session/date as a previously processed service for the patient.	CO, PI or PR
P14	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day. Note: Pefer to the \$35	M86	Service denied because payment already made for same/similar procedure within set time frame.	CO, PI or PR
P14	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day. Note: Refer to the 835 Healthcare Policy Identification Segment	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
P14	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day. Note: Refer to the 835	M144	Pre-/post-operative care payment is included in the allowance for the surgery/procedure.	CO, PI or PR
P14	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on	N19	Procedure code incidental to primary procedure.	CO, PI or PR
P14	The Benefit for this Service is included in the payment/allowance for another	N20	Service not payable with other service rendered on the same date.	CO, PI or PR
P14	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. To be used for Property and Casualty only.	N67	Professional provider services not paid separately. Included in facility payment under a demonstration project. Apply to that facility for payment, or resubmit your claim if: the facility notifies you the patient was excluded from this demonstration; or if you furnished these services in another location on the date of the patient's admission or discharge from a demonstration hospital. If services were furnished in a facility not involved in the demonstration on the same date the patient was discharged from or admitted to a demonstration facility, you must report the provider ID number for the non-demonstration facility on the new claim.	CO, PI or PR
P14	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day. Note: Refer to the 835	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

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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.					
P14	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. To be used for Property and Casualty only.	N390	This service/report cannot be billed separately.	CO, PI or PR		
P14	The Benefit for this Service is included in the payment/allowance for another service/procedure that has been performed on the same day. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. To be used for Property and Casualty only.	N525	These services are not covered when performed within the global period of another service.	CO, PI or PR		
P19	Procedure has a relative value of zero in the jurisdiction fee schedule, therefore no payment is due. To be used for Property and Casualty only.			CO, PI or PR		

⁹Washington Publishing Company: http://www.wpc-edi.com/reference/

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 $^{^{10}} Washington\ Publishing\ Company:\ http://www.wpc-edi.com/reference/$

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 Inform	nation Required – M	issing/Invalid/Incomplete Documentation	
	Refers to situations where additional docu	mentation is needed fr	rom the billing provider or an ERA from a prior	payer.
	Scenario #2: Missi	ng/Invalid/Incomplet	e Data from Submitted Claim	
Refer	s to situations where additional data is needed from	the billing provider fo	or missing or invalid data on the submitted clain	n, e.g., an 837 or D.0.
	Scenario #3	: Billed Service Not C	Covered by Health Plan	
	Refers to situations w	here 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 or has	Not Applicable	For retail pharmacy the NCPDP External	CO or PI
	submission/billing error(s) which is needed		Code List must be used. 13	
	for adjudication. Do not use this code for			
	claims attachment(s)/other documentation. At			
	least one Remark Code must be provided			
	(may be comprised of either the NCPDP			
	Reject Reason Code, or Remittance Advice			
	Remark Code that is not an ALERT.) Note:			
	Refer to the 835 Healthcare Policy			
	Identification Segment (loop 2110 Service			
	Payment Information REF), if present.			

¹¹Washington Publishing Company: http://www.wpc-edi.com/reference/

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¹²Washington Publishing Company: http://www.wpc-edi.com/reference/

¹³http://www.ncpdp.org/members/members_download.aspx. NCPDP Reject Codes are in Appendix A