Guidance on Required Remittance Advice Remark Codes Related to the No Surprises Act

July 17, 2026

Background

On June 4, 2026, the Department of the Treasury, the Department of Labor, and the Department of Health and Human Services (the Departments), along with the Office of Personnel Management (OPM), published the Federal Independent Dispute Resolution Operations final rules to improve the functioning of the Federal Independent Dispute Resolution (IDR) process established under the No Surprises Act.[1]

These final rules, in relevant part, establish new requirements regarding use of claim adjustment reason codes (CARCs) and remittance advice remark codes (RARCs), which are standardized codes that convey information about claims processing. CARCs explain why a claim or service line was paid differently from how it was billed, and RARCs provide additional explanation for the remittance. The final regulations at 26 CFR 54.9816-6A, 29 CFR 2590.716-6A, and 45 CFR 149.100 require group health plans and health insurance issuers offering group or individual health insurance coverage[2] to use CARCs and RARCs, in the manner and timeframe specified in guidance issued by the Departments, when providing any remittance advice (including in paper or electronic form) to an entity (other than a participant, beneficiary, or enrollee) that does not have a contractual relationship, directly or indirectly, with the plan or issuer with respect to the furnishing of an item or service under the plan or coverage, in response to a claim for payment, to communicate whether the item or service is subject to the No Surprises Act's surprise billing and Federal IDR process provisions. These regulations are intended to improve communication between parties by ensuring that remittance advice includes information relevant to adjudication of claims, including information used to determine whether a payment dispute is eligible for the Federal IDR process. These regulations are effective as of August 3, 2026.

This guidance specifies the RARCs to be used for purposes of the final regulations, the circumstances in which each RARC is to be used, and technical instructions to facilitate their use. Use of the specified RARCs in the circumstances detailed in this guidance and any related future guidance will satisfy the requirements related to the use of CARCs and RARCs under the final regulations at 26 CFR 54.9816-6A, 29 CFR 2590.716-6A, and 45 CFR 149.100. Plans and issuers may continue to use the CARC they deem most appropriate for any claim adjustment.[3]

The requirement to provide CARCs and RARCs pursuant to 26 CFR 54.9816-6A, 29 CFR 2590.716-6A, and 45 CFR 149.100, in the manner and timeframe specified in this guidance, applies for items and services furnished on or after January 1, 2027.

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[1] 91 FR 33900 (June 4, 2026).

[2] Under 5 CFR 890.114, Federal Employees Health Benefits Program (FEHB) carriers generally are required to comply with these provisions in the same manner as such provisions apply to a group health plan or health insurance issuer offering group or individual health insurance coverage. For the purposes of this document, the term "plans and issuers" includes FEHB carriers to the extent consistent with 5 CFR 890.114.

[3] The Departments may specify particular CARCs to be used in certain circumstances in future guidance.

Required RARCs Related to the No Surprises Act

When providing any remittance advice (including in paper or electronic form) to an entity (other than a participant, beneficiary, or enrollee) that does not have a contractual relationship, directly or indirectly, with a plan or issuer for the furnishing of an item or service under the plan or coverage, in response to a claim for payment for health care items and services furnished by that entity on or after January 1, 2027, the plan or issuer must use the RARCs specified in this guidance to communicate information related to whether each item or service within the claim is or is not subject to the No Suprises Act's surprise billing and Federal IDR process provisions. The RARCs to be used for this purpose, which are effective as of November 1, 2026, are specified in Table 1 and listed by payment circumstance.

In the column titled "Circumstance," the Departments describe the use case for each RARC. In the column titled "Dispute Eligible for the Federal IDR Process?" the Departments indicate whether a dispute over the out-of-network rate for an item or service in a given circumstance is eligible for the Federal IDR process, if all other conditions for eligibility are met. Plans and issuers are responsible for ensuring that they select the RARC that most accurately applies to each item or service.[4]

Table 1: Required Remittance Advice Remark Codes Related to the No Surprises Act

RARC	RARC Description[5]	Circumstance	Dispute Eligible for the Federal IDR Process?
N871	Alert: This initial payment was calculated based on a specified State law, in accordance with the No Surprises Act. The plan or issuer has determined that any dispute over the payment amount is not eligible for the Federal independent dispute resolution process.	Use when providing an initial payment under the No Surprises Act and the recognized amount[6] (or for air ambulance services, the amount on which cost sharing is based) is the amount determined by a specified State	No.

[4] The Departments note that certified IDR entities ultimately determine whether a dispute over the out-of-network rate for an item or service is eligible for the Federal IDR process as provided in 26 CFR 54.9816-8(c)(2)(i), 29 CFR 2590.716-8(c)(2)(i), and 45 CFR 149.510(c)(2)(i). Therefore, should a provider, facility, or provider of air ambulance services disagree with a plan's or issuer's use of one or more of the required RARCs, nothing in this guidance precludes the provider, facility, or provider of air ambulance services from initiating the Federal IDR process following the end of the open negotiation period.

[5] CARCs and RARCs are published by X12 and the Washington Publishing Company (WPC). The RARC descriptions in Table 1 of this guidance are effective as of November 1, 2026, and are made available with X12's and WPC's permission for this prescribed purpose. For the complete listing of CARCs and RARCs, as well as for information about use licenses, please visit https://x12.org/codes.

[6] The term "recognized amount" is defined at 29 CFR 2590.716-3 and 45 CFR 149.30. *See also* 26 CFR 54.9816-3T (expired).

RARC	RARC Description[5]	Circumstance	Dispute Eligible for the Federal IDR Process?
		law.[7] Thus, the out-of-network rate will be the amount determined by such specified State law.	
N877	Alert: This initial payment is provided in accordance with the No Surprises Act. The provider or facility may initiate open negotiation if they desire to negotiate a higher out-of-network rate and, if negotiations are unsuccessful, may initiate the Federal independent dispute resolution process to determine the out-of-network rate.	Use when providing an initial payment under the No Surprises Act and the recognized amount (or for air ambulance services, the amount on which cost sharing is based) is the lesser of the qualifying payment amount or the amount billed by the provider or facility. Thus, the out-of-network rate will be either an amount agreed upon by the parties before or during open negotiation or the amount of the determination by a certified IDR entity under the Federal IDR process.	Yes, after completion of the open negotiation period.[8]
N876	Alert: This item or service is covered under the plan or coverage, but no payment is made by the plan or coverage. This is a notice of denial of payment provided in accordance with the No Surprises Act. The provider or facility may initiate open negotiation if they desire to negotiate a higher out-of-network rate than the amount paid by the patient in cost	Use when providing a notice of denial of payment[9] under the No Surprises Act and the recognized amount (or for air ambulance services, the amount on which cost sharing is based) is the lesser of the qualifying payment amount or the amount billed by the provider or facility. Thus, the out-of-network rate will be either an amount agreed upon by the parties before or during	Yes, after completion of the open negotiation period.

[7] The term "specified State law" is defined at 29 CFR 2590.716-3 and 45 CFR 149.30. *See also* 26 CFR 54.9816-3T (expired).

[8] Disputes are ineligible for the Federal IDR process unless the parties satisfy the 30-business-day open negotiation period requirements specified under 26 CFR 54.9816-8(b)(1), 29 CFR 2590.716-8(b)(1), and 45 CFR 149.510(b)(1) and the dispute is initiated generally within 4 business days after the end of the 30-business-day open negotiation period as specified under 26 CFR 54.9816-8(b)(2)(i), 29 CFR 2590.716-8(b)(2)(i), and 45 CFR 149.510(b)(2)(i).

[9] The term "notice of denial of payment" is defined at 29 CFR 2590.716-3 and 45 CFR 149.30. *See also* 26 CFR 54.9816-3T (expired).

RARC	RARC Description[5]	Circumstance	Dispute Eligible for the Federal IDR Process?
	sharing and, if negotiations are unsuccessful, may initiate the Federal independent dispute resolution process.	open negotiation or the amount of the determination by a certified IDR entity under the Federal IDR process. A notice of denial of payment is not considered a notice of benefit denial due to an adverse benefit determination.[10]	
N944	Alert: This item or service is covered under the plan or coverage, but no payment is made by the plan or coverage. This is a notice of denial of payment provided in accordance with the No Surprises Act. The amount paid by the patient in cost sharing was calculated based on a specified State law or All-Payer Model Agreement. The plan or issuer has determined that any dispute over the payment amount is not eligible for the Federal independent dispute resolution process.	Use when providing a notice of denial of payment under the No Surprises Act and the recognized amount (or for air ambulance services, the amount on which cost sharing is based) is the amount determined in accordance with a specified State law or an All-Payer Model Agreement under section 1115A of the Social Security Act. Thus, the out-of-network rate will be determined in accordance with such specified State law or All-Payer Model Agreement. A notice of denial of payment is not considered a notice of benefit denial due to an adverse benefit determination.	No.

[10] The term "adverse benefit determination" is defined at 26 CFR 54.9815-2719, 29 CFR 2560.503-1(m)(4) and 2590.715-2719, and 45 CFR 147.136. Adverse benefit determinations are subject to the claims and appeals procedures described therein.

RARC	RARC Description[5]	Circumstance	Dispute Eligible for the Federal IDR Process?
N872	Alert: This final payment was calculated based on a specified State law, in accordance with the No Surprises Act. The plan or issuer has determined that any dispute over the payment amount is not eligible for the Federal independent dispute resolution process.	Use when providing a total plan or coverage payment[11] (i.e., final payment) under the No Surprises Act and the out-of-network rate for the item or service is the amount determined in accordance with a specified State law.	No.
N873	Alert: This final payment was calculated based on an All-Payer Model Agreement, in accordance with the No Surprises Act. The plan or issuer has determined that any dispute over the payment amount is not eligible for the Federal independent dispute resolution process.	Use when providing a total plan or coverage payment (i.e., final payment) under the No Surprises Act and the out-of-network rate for the item or service is the amount approved by a State under an All-Payer Model Agreement under section 1115A of the Social Security Act.	No.
N874	Alert: This final payment was determined through open negotiation, in accordance with the No Surprises Act. The plan or issuer has determined that any dispute over the payment amount is not eligible for the Federal independent dispute resolution process.	Use when providing a total plan or coverage payment (i.e., final payment) under the No Suprises Act and the out-of-network rate for the item or service is the amount agreed on through open negotiation for the item or service.	No.
N875	Alert: This final payment equals the amount selected as the out-of-network rate for an item or service under the Federal independent dispute resolution process, in	Use when providing a total plan or coverage payment (i.e., final payment) under the No Surprises Act and the out-of-network rate for the item or service is the amount of the	No.

[11] The term "total plan or coverage payment" refers to the out-of-network rate (as defined in 29 CFR 2590.716-3 and 45 CFR 149.30) for an item or service, less the sum of any initial payment and any cost sharing paid or owed for the item or service. *See* 29 CFR 2590.716-4(b)(3)(iv)(B), 2590.716-5(c)(4), and 2590.717-1(b)(4)(ii); and 45 CFR 149.110(b)(3)(iv)(B), 149.120(c)(4), and 149.130(b)(4)(ii). *See also* 26 CFR 54.9816-4T(b)(3)(iv)(B), 54.9816-5T(c)(4), and 54.9817-1T(b)(4)(ii) (expired).

RARC	RARC Description[5]	Circumstance	Dispute Eligible for the Federal IDR Process?
	accordance with the No Surprises Act, less the sum of the initial payment and any cost sharing paid or owed for the item or service. The payment determination generally is binding upon all parties involved.	determination by a certified IDR entity under the Federal IDR process.[12]	
N943	Alert: Under the circumstances furnished, this item or service is not subject to the surprise billing provisions of the No Surprises Act. The plan or issuer has determined that any dispute over the payment amount is not eligible for the Federal independent dispute resolution process.	Use when the item or service is not subject to the surprise billing provisions of the No Surprises Act, including because the notice and consent criteria of 45 CFR 149.410(b) through (e) or 45 CFR 149.420(c) through (i), as applicable, have been satisfied.	No.

To facilitate determining whether the Federal IDR process, a specified State law, or an All-Payer Model Agreement applies to the item or service, please see the CMS guidance titled "Chart for Determining the Applicability for the Federal Independent Dispute Resolution (IDR) Process."[13]

The Departments will continue to assess existing RARCs related to the No Surprises Act and make recommendations to the RARC Committee to remove existing RARCs or approve new RARCs should the Departments determine that doing so will improve communications related to the No Surprises Act between plans or issuers and providers, facilities, or providers of air ambulance services. The Departments will communicate any changes in required use of CARCs or RARCs related to the No Surprises Act and the applicability date for those changes in future guidance.

[12] *See* 26 CFR 54.9816-8(c)(5)(ix), 29 CFR 2590.716-8(c)(5)(ix), and 45 CFR 149.510(c)(5)(ix) (providing that if applicable, the amount of the offer selected by the certified IDR entity (less the sum of the initial payment and any cost sharing paid or owed by the participant or beneficiary) must be paid directly to the provider, facility, or provider of air ambulance services not later than 30 calendar days after the determination by the certified IDR entity).
[13] *See* "Chart for Determining the Applicability for the Federal Independent Dispute Resolution (IDR) Process" (updated Jan. 13, 2023), available at https://www.cms.gov/files/document/caa-federal-idr-applicability-chart.pdf.

Technical Instructions

- **Electronic Remittance Advice - ASC X12 835:**[14] For all applicable items or services, plans and issuers must include one of the required RARCs listed in Table 1 of this guidance in the LQ Segment (Health Care Remark Codes) in Loop 2110 (Service Payment Information) for each line item in the transaction. Nothing in this guidance precludes plans or issuers from repeating the LQ segment to include additional RARCs that may be required by State or Federal laws or as deemed necessary by plans, issuers, and the entities with which they conduct electronic transactions.
- **Paper Remittance Advice:** For all applicable items or services, plans and issuers must include one of the required RARCs listed in Table 1 of this guidance for each line item identified in the remittance advice in such a way that allows entities receiving the remittance advice to reasonably identify which RARC applies to each line item. The RARCs must be included within the remittance advice and cannot be sent in a separate document or under separate cover.

Enforcement

For concerns about a group health plan's or health insurance issuer's compliance with the requirements related to the use of CARCs and RARCs under the final regulations at 26 CFR 54.9816-6A, 29 CFR 2590.716-6A, and 45 CFR 149.100, contact the No Surprises Help Desk at 1-800-985-3059 or submit a complaint at https://www.cms.gov/nosurprises/policies-and-resources/providers-submit-a-billing-complaint.

If a plan or issuer fails to comply with the requirements regarding the use of CARCs and RARCs, providers, facilities, or providers of air ambulance services retain the right to initiate the open negotiation period within 30 days of receiving the initial payment or notice of denial of payment for otherwise qualified IDR items and services. Alternatively, if a plan or issuer fails to comply with the requirements, and that failure results in a provider, facility, or provider of air ambulance services lacking the information necessary to initiate the 30-business-day open negotiation period (when applicable) by the deadline to initiate the Federal IDR process, the provider, facility, or provider of air ambulance services may request an extension to initiate the Federal IDR process by emailing a request for extension due to extenuating circumstances to *FederalIDRQuestions@cms.hhs.gov*.

[14] The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated the adoption of electronic standards for certain health care transactions, including health care payment and remittance advice. All electronic remittance advice transactions must comply with the Accredited Standards Committee (ASC) X12 835 transaction standard adopted by HHS under 45 CFR 162.1602.