| CMS Manual System                | Department of Health &<br>Human Services (DHHS)   |
|----------------------------------|---|
| Pub 100-20 One-Time Notification | Centers for Medicare &<br>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Transmittal 1358, dated March 14, 2014, is being rescinded and replaced by Transmittal 1360, dated March 18, 2014 to include two attachments, both v3.0.3 and v 3.0.4 of the Council for Affordable Quality Health Care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**

Pub. 100-20 Transmittal: 1360 Date: March 18, 2014 Change Request: 8518

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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 <a href="http://www.wpc-edi.com/reference">http://www.wpc-edi.com/reference</a> and for CAQH CORE defined code combination updates go to <a href="http://www.caqh.org/CORECodeCombinations.php">http://www.caqh.org/CORECodeCombinations.php</a> .

**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<br>M<br>E |  |  | M<br>F      | Sha<br>Sys<br>aint<br>M | tem<br>aine<br>V | ers<br>C | Other |
|        |   |                |     | Н | A<br>C      |  |  | I<br>S<br>S | C<br>S                  | M<br>S           | W<br>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<br>MAC     |   |             |             | D<br>M |  |  | Other |
|        |   | A              | В | H<br>H<br>H | E<br>M<br>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<br>MAC     |   |             |             |  |  |  |  | Other |
|        |  | A              | В | H<br>H<br>H | M<br>A<br>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

<sup>&</sup>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<br>Scenarios for the Phase III CORE 360 Uniform Use of Claim<br>Adjustment Reason Codes and Remittance Advice Remark Codes<br>(835) based on published CARC & RARC lists as of June 2011,<br>balloted and approved by CORE members | 06/01/2012                               |
| 3.0.1   | Compliance-based adjustments as part of the CAQH CORE Code<br>Combinations Maintenance Process based on published CARC &<br>RARC lists as of November 2011   | 01/31/2013                               |
| 3.0.2   | Compliance-based adjustments as part of the CAQH CORE Code<br>Combinations Maintenance Process based on published CARC &<br>RARC lists as of March 2013  | 05/24/2013                               |
| 3.0.3   | Compliance-based adjustments as part of the CAQH CORE Code<br>Combinations Maintenance Process based on published CARC &<br>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<br>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. 1 1   |
|   |                                | · 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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#### 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<br>d from the billing provider or an ERA from a prior  | naver.       |
| CARC | CARC Description <sup>2</sup>  | RARC  | RARC Description <sup>3</sup>   | ASC X12 CAGC |
| 112  | Service not furnished directly to the patient  | TEIRC | KAKE 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 2-1 Scenario #1: Additional Information Required – Missing/Invalid/Incomplete Documentation |  |      |  |              |  |  |
|---|--|------|--|--------------|--|--|
|   |  |      |  |              |  |  |
|   | <del></del>  |      | from the billing provider or an ERA from a prior   |              |  |  |
| CARC  | CARC Description <sup>2</sup>  | RARC | RARC Description <sup>3</sup>  | ASC X12 CAGO |  |  |
| 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     |  |  |
| 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     |  |  |

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

|      | Table 2-1  |      |   |              |  |  |  |
|------|--|------|---|--------------|--|--|--|
|      |  |      | - Missing/Invalid/Incomplete Documentation<br>d from the billing provider or an ERA from a prior  | naver        |  |  |  |
| CARC | CARC Description <sup>2</sup>  | RARC | RARC Description <sup>3</sup>   | 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<br>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 Description<sup>2</sup> RARC RARC Description<sup>3</sup> 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 <sup>2</sup>  | RARC              | RARC Description <sup>3</sup>  | ASC X12 CAGO |
| 251  | The attachment/other documentation content received did not contain the content required | N59               | Please refer to your provider manual for additional program and provider information.    | CO or PI     |
|      | to process this claim or service.  |                   |  |              |
| 251  | The attachment/other documentation content received did not contain the content required | N80               | Missing/incomplete/invalid prenatal screening information.                               | CO or PI     |
|      | to process this claim or service.  |                   |  |              |
| 251  | The attachment/other documentation content received did not contain the content required | N102              | This claim has been denied without reviewing the medical record because the requested    | CO or PI     |
|      | to process this claim or service.  |                   | records were not received or were not received timely.                                   |              |
| 251  | The attachment/other documentation content received did not contain the content required | N146              | Missing screening document.  | CO or PI     |
|      | to process this claim or service.  |                   |  |              |
| 251  | The attachment/other documentation content   | N175              | Missing review organization approval.  | CO or PI     |
|      | received did not contain the content required to process this claim or service.          |                   |  |              |
| 251  | The attachment/other documentation content   | N178              | Missing pre-operative photos or visual field   | CO or PI     |
|      | received did not contain the content required to process this claim or service.          |                   | results.   |              |
| 251  | The attachment/other documentation content   | N179              | Additional information has been requested  | CO or PI     |
|      | received did not contain the content required to process this claim or service.          |                   | from the member. The charges will be reconsidered upon receipt of that information.      |              |
| 251  | The attachment/other documentation content   | N186              | Non-Availability Statement (NAS) required for this service. Contact the nearest Military | CO or PI     |
|      | received did not contain the content required to process this claim or service.          |                   | Treatment Facility (MTF) for assistance.   |              |
| 251  | The attachment/other documentation content   | N191              | The provider must update insurance   | CO or PI     |
|      | received did not contain the content required to process this claim or service.          |                   | information directly with payer.   |              |
| 251  | The attachment/other documentation content   | N197              | The subscriber must update insurance   | CO or PI     |
|      | received did not contain the content required to process this claim or service.          |                   | information directly with payer.   |              |
| 251  | The attachment/other documentation content   | N202              | Additional information/explanation will be   | CO or PI     |
|      | received did not contain the content required to process this claim or service.          |                   | sent separately.   |              |
| 251  | The attachment/other documentation content   | N204              | Services under review for possible pre-  | CO or PI     |
|      | received did not contain the content required to process this claim or service.          |                   | existing condition. Send medical records for prior 12 months.                            |              |
| 251  | The attachment/other documentation content   | N205              | Information provided was illegible.  | CO or PI     |
|      | received did not contain the content required to process this claim or service.          |                   |  |              |
| 251  | The attachment/other documentation content   | N206              | The supporting documentation does not  | CO or PI     |
|      | received did not contain the content required to process this claim or service.          |                   | match the claim.   |              |

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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 <sup>2</sup>   | RARC  | RARC Description <sup>3</sup>                      | 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     |
| <i>2.3</i> 1 | 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<br>d from the billing provider or an ERA from a prior                                    | payer.       |
| CARC | CARC Description <sup>2</sup>  | RARC  | RARC Description <sup>3</sup>   | 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 2           |   |              |
|------|--|-------------------|---|--------------|
|      |  |                   | Missing/Invalid/Incomplete Documentation  |              |
|      |  | ntation is needed | l from the billing provider or an ERA from a prior  | payer.       |
| CARC | CARC Description <sup>2</sup>  | RARC              | RARC Description <sup>3</sup>   | 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 <sup>2</sup>                 | RARC              | RARC Description <sup>3</sup>                      | 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 <sup>2</sup>   | RARC    | RARC Description <sup>3</sup>                    | 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 <sup>2</sup>                 | RARC            | RARC Description <sup>3</sup>                     | 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/invalid Bonta 11300is/                  | 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 document   | ntation is needed | from the billing provider or an ERA from a prior  | payer.       |
| CARC | CARC Description <sup>2</sup>  | RARC              | RARC Description <sup>3</sup>   | 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<br>the cause of injuries sustained and medical<br>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 <sup>2</sup>   | RARC              | RARC Description <sup>3</sup>   | 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 |   |      |  |              |  |
|---|---|------|--|--------------|--|
|   |   |      | - Missing/Invalid/Incomplete Documentation<br>d from the billing provider or an ERA from a prior | novon        |  |
| a   |   |      |  |              |  |
| CARC  | CARC Description <sup>2</sup>   | RARC | RARC Description <sup>3</sup>  | 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<br>I from the billing provider or an ERA from a prior  | payer.       |  |  |  |
| CARC | CARC Description <sup>2</sup>   | RARC | RARC Description <sup>3</sup>   | 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<br>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 1 1/4 1 7 7 0   | Table             |   |              |
|------|---|-------------------|---|--------------|
|      |   | •                 | - Missing/Invalid/Incomplete Documentation  |              |
|      |   | ntation is needed | d from the billing provider or an ERA from a prior  | payer.       |
| CARC | CARC Description <sup>2</sup>   | RARC              | RARC Description <sup>3</sup>   | 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 |   |       |   |              |  |
|---|---|-------|---|--------------|--|
|   |   | •     | •   | navan        |  |
| CARC  |   |       | from the billing provider or an ERA from a prior  |              |  |
| CARC  | CARC Description <sup>2</sup>   | RARC  | RARC Description <sup>3</sup>   | 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<br>Refers to situations where additional documentation is needed from the billing provider or an ERA from a prior payer. |   |      |   |              |  |
|  |   |      |   | payer.       |  |
| CARC   | CARC Description <sup>2</sup>   | RARC | RARC Description <sup>3</sup>   | 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 |   |      |  |              |  |
|---|---|------|--|--------------|--|
|   |   | •    | •  |              |  |
| a. 5 a  |   |      | from the billing provider or an ERA from a prior   | -            |  |
| CARC  | CARC Description <sup>2</sup>   | RARC | RARC Description <sup>3</sup>  | 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). | 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<br>for this service. Contact the nearest Military<br>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 |   |      |   |              |  |  |
|   | Refers to situations where additional documentation is needed from the billing provider or an ERA from a prior payer.   |      |   |              |  |  |
| CARC  | CARC Description <sup>2</sup>   | RARC | RARC Description <sup>3</sup>   | 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-<br>existing condition. Send medical records for<br>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<br>I from the billing provider or an ERA from a prior  | payer.       |  |  |  |
| CARC | CARC Description <sup>2</sup>   | RARC | RARC Description <sup>3</sup>   | 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   |   |      |   |              |  |  |
|---|---|------|---|--------------|--|--|
| 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 <sup>2</sup>   | RARC | RARC Description <sup>3</sup>                               | 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

|      | C 1 114   | Table |   |              |
|------|---|-------|---|--------------|
|      |   | •     | - Missing/Invalid/Incomplete Documentation  |              |
|      |   |       | d from the billing provider or an ERA from a prior  |              |
| CARC | CARC Description <sup>2</sup>   | RARC  | RARC Description <sup>3</sup>   | 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

|      | 6 1 14 1 3 3 1 1 2 2  | Table |   |              |
|------|---|-------|---|--------------|
|      |   | •     | Missing/Invalid/Incomplete Documentation  |              |
|      | -   |       | from the billing provider or an ERA from a prior  |              |
| CARC | CARC Description <sup>2</sup>   | RARC  | RARC Description <sup>3</sup>   | 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              |              |
|      | 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 <sup>2</sup>   | RARC              | RARC Description <sup>3</sup>                         | 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). | 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   | Table |  |              |
|------|---|-------|--|--------------|
|      |   | •     | - Missing/Invalid/Incomplete Documentation                       |              |
|      |   |       | d from the billing provider or an ERA from a prior               |              |
| CARC | CARC Description <sup>2</sup>   | RARC  | RARC Description <sup>3</sup>                                    | 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<br>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 <sup>2</sup>   | RARC              | RARC Description <sup>3</sup>                    | 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 <sup>2</sup>   | RARC  | RARC Description <sup>3</sup>                           | 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<br>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   | n novon      |
|      |   |        | from the billing provider or an ERA from a prior   |              |
| CARC | CARC Description <sup>2</sup>   | RARC   | RARC Description <sup>3</sup>  | 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<br>(Coordination of Benefits or Medicare<br>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 <sup>2</sup>   | RARC              | RARC Description <sup>3</sup>                                 | 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<br>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<br>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<br>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<br>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 <sup>2</sup>   | RARC  | RARC Description <sup>3</sup>   | 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

|      | 0 1 114 1 3314 33 5   | 4 D  | Mining Manager 1 1 B  |              |
|------|---|------|---|--------------|
|      |   | •    | Missing/Invalid/Incomplete Documentation  | novon        |
|      | -   |      | from the billing provider or an ERA from a prior  |              |
| CARC | CARC Description <sup>2</sup>   | RARC | RARC Description <sup>3</sup>   | 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 <sup>2</sup>   | RARC    | RARC Description <sup>3</sup>   | 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     |

<sup>&</sup>lt;sup>2</sup>Washington Publishing Company: http://www.wpc-edi.com/reference/

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<sup>&</sup>lt;sup>3</sup>Washington 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 <sup>4</sup>  | RARC             | RARC Description <sup>5</sup>                        | 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<br>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<br>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  | 11011            | the bilateral procedure rule.                        | 60 0111                 |
|           | missing. Note: Refer to the 835 Healthcare   |                  |  |                         |
|           | Policy Identification Segment (loop 2110   |                  |  |                         |
|           | Service Payment Information REF), if   |                  |  |                         |
| 4         | present.  The procedure code is inconsistent with the                                  | N657             | This should be billed with the appropriate           | CO or PI                |
| 4         | modifier used or a required modifier is  | 11037            | code for these services.                             | COULT                   |
|           | missing. Note: Refer to the 835 Healthcare   |                  |  |                         |
|           | Policy Identification Segment (loop 2110   |                  |  |                         |
|           | Service Payment Information REF), if   |                  |  |                         |
| 9         | present.  The diagnosis is inconsistent with the                                       | NE 17            | Describent a many alaims with the manuscated         | CO on DI                |
| 9         | patient's age. Note: Refer to the 835  | N517             | Resubmit a new claim with the requested information. | CO or PI                |
|           | Healthcare Policy Identification Segment   |                  |  |                         |
|           | (loop 2110 Service Payment Information   |                  |  |                         |
|           | REF), if present.  |                  |  |                         |
| 9         | The diagnosis is inconsistent with the   | N657             | This should be billed with the appropriate           | CO or PI                |
|           | patient's age. Note: Refer to the 835<br>Healthcare Policy Identification Segment      |                  | code for these services.                             |                         |
|           | (loop 2110 Service Payment Information   |                  |  |                         |
|           | REF), if present.  |                  |  |                         |
| 10        | The diagnosis is inconsistent with the   | N517             | Resubmit a new claim with the requested              | CO or PI                |
|           | patient's gender. Note: Refer to the 835   |                  | information.   |                         |
|           | Healthcare Policy Identification Segment<br>(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   |                  |  |                         |
| 11        | REF), if present.  The diagnosis is inconsistent with the                              | N657             | This should be billed with the appropriate           | CO or PI                |
| 11        | procedure. Note: Refer to the 835 Healthcare   | 11037            | code for these services.                             | COULL                   |
|           | 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             | 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 <sup>4</sup>   | RARC              | RARC Description <sup>5</sup>   | 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 <sup>4</sup>   | RARC | RARC Description <sup>5</sup>                        | 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

| <b>D</b> 6 | v.  | •    | elete Data from Submitted Claim                | 92 <b>5</b> D.0                       |
|------------|---|------|--|---------------------------------------|
| CARC       | situations where additional data is needed from the CARC Description <sup>4</sup>   | RARC | RARC Description <sup>5</sup>                  | 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   | e billing provide | r for missing or invalid data on the submitted claim            | m, e.g., an 837 or D.0. |
|------|---|-------------------|---|-------------------------|
| CARC | CARC Description <sup>4</sup>   | RARC              | RARC Description <sup>5</sup>                                   | 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<br>for missing or invalid data on the submitted clai | m, e.g., an 837 or D.0. |
|-----------|---|------|--|-------------------------|
| CARC      | CARC Description <sup>4</sup>   | RARC | RARC Description <sup>5</sup>  | 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.<br>situations where additional data is needed from the  | •    | lete Data from Submitted Claim<br>r for missing or invalid data on the submitted clai | m, e.g., an 837 or D.0. |
|-----------|---|------|---|-------------------------|
| CARC      | CARC Description <sup>4</sup>   | RARC | RARC Description <sup>5</sup>   | 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<br>situations where additional data is needed from the   | •    | lete Data from Submitted Claim<br>r for missing or invalid data on the submitted clai | im, e.g., an 837 or D.0. |
|-----------|---|------|---|--------------------------|
| CARC      | CARC Description <sup>4</sup>   | RARC | RARC Description <sup>5</sup>   | 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

| <b>D</b> 0 | v.  | •    | elete Data from Submitted Claim                     | 02 <b>5</b> D.0 |
|------------|---|------|---|-----------------|
| CARC       | situations where additional data is needed from the  CARC Description <sup>4</sup>  | RARC | RARC Description <sup>5</sup>                       | 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 <sup>4</sup>   | RARC | RARC Description <sup>5</sup>                            | 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

|           | - The state of the | •                         | lete Data from Submitted Claim  |                                       |
|-----------|--|---------------------------|---|---------------------------------------|
| Refers to | situations where additional data is needed from the  | e billing provide<br>RARC | r for missing or invalid data on the submitted clair  RARC Description <sup>5</sup> | 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 <sup>4</sup>   | RARC | RARC Description <sup>5</sup>                      | 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 <sup>4</sup>   | RARC              | RARC Description <sup>5</sup>                                 | 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 <sup>4</sup>   | RARC | RARC Description <sup>5</sup>  | 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/<br>deactivated/withdrawn National Drug Code<br>(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<br>r for missing or invalid data on the submitted clai | im, e.g., an 837 or D.0. |
|-----------|---|------|---|--------------------------|
| CARC      | CARC Description <sup>4</sup>   | RARC | RARC Description <sup>5</sup>   | 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 <sup>4</sup>   | RARC | RARC Description <sup>5</sup>   | 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

|      | situations where additional data is needed from th  | e billing provide | r for missing or invalid data on the submitted clair                   | m, e.g., an 837 or D.0. |
|------|---|-------------------|--|-------------------------|
| CARC | CARC Description <sup>4</sup>   | RARC              | RARC Description <sup>5</sup>  | 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/<br>situations where additional data is needed from the  | •    | lete Data from Submitted Claim  | m. e.g., an 837 or D 0 |
|-----------|---|------|---|------------------------|
| CARC      | CARC Description <sup>4</sup>   | RARC | RARC Description <sup>5</sup>   | 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. |   | •    | olete Data from Submitted Claim   | 925 D.O.     |
|------|---|------|---|--------------|
| CARC | situations where additional data is needed from the  CARC Description <sup>4</sup>  | RARC | RARC Description <sup>5</sup>   | 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 <sup>4</sup> 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 <sup>5</sup> 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 <sup>5</sup>  | 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<br>/Invalid/Incomp | lete Data from Submitted Claim   |              |
|------|---|----------------------------|--|--------------|
|      | situations where additional data is needed from the   |                            |  |              |
| CARC | CARC Description <sup>4</sup>   | RARC                       | RARC Description <sup>5</sup>  | 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<br>r for missing or invalid data on the submitted clai | im, e.g., an 837 or D.0. |
|-----------|---|------|---|--------------------------|
| CARC      | CARC Description <sup>4</sup>   | RARC | RARC Description <sup>5</sup>   | 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<br>r for missing or invalid data on the submitted cla | im, e.g., an 837 or D.0. |
|-----------|---|------|---|--------------------------|
| CARC      | CARC Description <sup>4</sup>   | RARC | RARC Description <sup>5</sup>   | 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<br>r for missing or invalid data on the submitted clai | m, e.g., an 837 or D.0. |
|-----------|---|------|---|-------------------------|
| CARC      | CARC Description <sup>4</sup>   | RARC | RARC Description <sup>5</sup>   | 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  |      |   | m, e.g., an 837 or D.0. |
|------|---|------|---|-------------------------|
| CARC | CARC Description <sup>4</sup>   | RARC | RARC Description <sup>5</sup>   | 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. | 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 th  | •    | lete Data from Submitted Claim<br>r for missing or invalid data on the submitted clain                       | n, e.g., an 837 or D.0. |
|-----------|---|------|--|-------------------------|
| CARC      | CARC Description <sup>4</sup>   | RARC | RARC Description <sup>5</sup>  | 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 <sup>4</sup>   | RARC              | RARC Description <sup>5</sup>                                | 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 <sup>4</sup>   | e billing provide | er for missing or invalid data on the submitted cla<br>RARC Description <sup>5</sup> | 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 <sup>4</sup>   | RARC              | RARC Description <sup>5</sup>   | 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.  | •    | olete Data from Submitted Claim  |   |
|-----------|---|------|--|---|
| Refers to | situations where additional data is needed from the CARC Description <sup>4</sup>   | RARC | er for missing or invalid data on the submitted of RARC Description <sup>5</sup> | 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

| <b>D</b> 6 | v.  | •    | olete Data from Submitted Claim                                    |              |
|------------|---|------|--|--------------|
| CARC       | situations where additional data is needed from the CARC Description <sup>4</sup>   | RARC | RARC Description <sup>5</sup>                                      | 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 <sup>4</sup>   | RARC | RARC Description <sup>5</sup>   | 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.<br>Situations where additional data is needed from the  | •       | lete Data from Submitted Claim                                  | n a g an 827 an D A |
| CARC      | CARC Description <sup>4</sup>   | RARC    | RARC Description <sup>5</sup>                                   | 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

|      | situations where additional data is needed from the   | e billing provide | r for missing or invalid data on the submitted clair  | n, e.g., an 837 or D.0. |
|------|---|-------------------|---|-------------------------|
| CARC | CARC Description <sup>4</sup>   | RARC              | RARC Description <sup>5</sup>   | 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 <sup>4</sup>   | RARC              | RARC Description <sup>5</sup>   | 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/<br>situations where additional data is needed from the  | •    | lete Data from Submitted Claim<br>r for missing or invalid data on the submitted cl                               | aim, e.g., an 837 or D.0. |
|-----------|---|------|---|---------------------------|
| CARC      | CARC Description <sup>4</sup>   | RARC | RARC Description <sup>5</sup>   | 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 <sup>4</sup>   | RARC                | RARC Description <sup>5</sup>  | 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 |   | n, e.g., an 837 or D.0. |
| CARC | CARC Description <sup>4</sup>   | RARC               | RARC Description <sup>5</sup>   | 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/<br>situations where additional data is needed from the  | •     | lete Data from Submitted Claim  | n o g on 837 or D 0 |
|-----------|---|-------|---|---------------------|
| CARC      | CARC Description <sup>4</sup>   | RARC  | RARC Description <sup>5</sup>   | 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

| <b>D</b> 6 | - Carlotte and the Carlotte  | •     | elete Data from Submitted Claim   | 02 <b>5</b> D.0 |
|------------|---|-------|---|-----------------|
| CARC       | situations where additional data is needed from the CARC Description <sup>4</sup>   | RARC  | RARC Description <sup>5</sup>   | 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 <sup>4</sup>   | RARC            | RARC Description <sup>5</sup>                         | 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 <sup>4</sup>   | e billing provider | r for missing or invalid data on the submitted clain  RARC Description <sup>5</sup> | 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<br>r for missing or invalid data on the submitted clain  | m, e.g., an 837 or D.0. |
|-----------|---|-------|---|-------------------------|
| CARC      | CARC Description <sup>4</sup>   | RARC  | RARC Description <sup>5</sup>   | 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 <sup>4</sup>   | RARC | r for missing or invalid data on the submitted claim  RARC Description <sup>5</sup>  | 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<br>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<br>r for missing or invalid data on the submitted c | laim, e.g., an 837 or D.0. |
|-----------|---|------|--|----------------------------|
| CARC      | CARC Description <sup>4</sup>   | RARC | RARC Description <sup>5</sup>  | 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.<br>situations where additional data is needed from the  | •    | lete Data from Submitted Claim<br>r for missing or invalid data on the submitted clai | m, e.g., an 837 or D.0. |
|-----------|---|------|---|-------------------------|
| CARC      | CARC Description <sup>4</sup>   | RARC | RARC Description <sup>5</sup>   | 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

| <b>T</b> | v.  | •    | elete Data from Submitted Claim                 | 02 <b>5</b> D.0 |
|----------|---|------|---|-----------------|
| CARC     | situations where additional data is needed from the CARC Description <sup>4</sup>   | RARC | RARC Description <sup>5</sup>                   | 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

| 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 <sup>4</sup>   | RARC              | RARC Description <sup>5</sup>                              | 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

|           | Scenario #2: Missing/   | /Invalid/Incomp   | lete Data from Submitted Claim   |                                       |
|-----------|---|-------------------|--|---------------------------------------|
| Refers to | situations where additional data is needed from the  CARC Description <sup>4</sup>  | e billing provide | r for missing or invalid data on the submitted cla  RARC Description <sup>5</sup>        | 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

| CARC | situations where additional data is needed from the   | RARC | RARC Description <sup>5</sup>  | 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. | N53  | Missing/incomplete/invalid point of pick-up 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. | 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 <sup>4</sup>   | RARC | er for missing or invalid data on the submitted clair  RARC Description <sup>5</sup>              | 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

|           | - The state of the | •                 | olete Data from Submitted Claim  |                                       |
|-----------|--|-------------------|--|---------------------------------------|
| Refers to | situations where additional data is needed from the  CARC Description <sup>4</sup>   | e billing provide | er for missing or invalid data on the submitted clai                   | 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.  | 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.  | •    | olete Data from Submitted Claim  |                                       |
|-----------|---|------|--|---------------------------------------|
| Refers to | situations where additional data is needed from the CARC Description <sup>4</sup>   | RARC | er for missing or invalid data on the submitted clair  RARC Description <sup>5</sup> | 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/<br>situations where additional data is needed from the  | •    | lete Data from Submitted Claim<br>r for missing or invalid data on the submitted clai                              | m, e.g., an 837 or D.0. |
|-----------|---|------|--|-------------------------|
| CARC      | CARC Description <sup>4</sup>   | RARC | RARC Description <sup>5</sup>  | 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<br>r for missing or invalid data on the submitted clair | n, e.g., an 837 or D.0. |
|-----------|---|------|--|-------------------------|
| CARC      | CARC Description <sup>4</sup>   | RARC | RARC Description <sup>5</sup>  | 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 <sup>4</sup>  | e billing provide | er for missing or invalid data on the submitted clair  RARC Description <sup>5</sup>  | n, e.g., an 837 or D.0.<br>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

|      | 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 <sup>4</sup>   | RARC              | RARC Description <sup>5</sup>                             | 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<br>or for missing or invalid data on the submitted clai | m, e.g., an 837 or D.0. |
|-----------|---|------|---|-------------------------|
| CARC      | CARC Description <sup>4</sup>   | RARC | RARC Description <sup>5</sup>   | 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 | e de la companya de   | •    | olete Data from Submitted Claim<br>or for missing or invalid data on the submitted clair | n, e.g., an 837 or D.0. |
|-----------|---|------|--|-------------------------|
| CARC      | CARC Description <sup>4</sup>   | RARC | RARC Description <sup>5</sup>  | 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<br>er for missing or invalid data on the submitted clair | n, e.g., an 837 or D.0. |
|-----------|---|------|--|-------------------------|
| CARC      | CARC Description <sup>4</sup>   | RARC | RARC Description <sup>5</sup>  | 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 <sup>4</sup>   | RARC | er for missing or invalid data on the submitted cl  RARC Description <sup>5</sup> | 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   | lete Data from Submitted Claim                                   |                           |
|------|---|-------------------|--|---------------------------|
|      | situations where additional data is needed from the   | e billing provide |  | aim, e.g., an 837 or D.0. |
| CARC | CARC Description <sup>4</sup>   | RARC              | RARC Description <sup>5</sup>                                    | 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 <sup>4</sup>   | RARC | RARC Description <sup>5</sup>  | 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 claim   | n, e.g., an 837 or D.0. |
| CARC | CARC Description <sup>4</sup>   | RARC              | RARC Description <sup>5</sup>   | 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<br>r for missing or invalid data on the submitted clain | n, e.g., an 837 or D.0. |
|-----------|---|------|--|-------------------------|
| CARC      | CARC Description <sup>4</sup>   | RARC | RARC Description <sup>5</sup>  | 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<br>r for missing or invalid data on the submitted clair | n, e.g., an 837 or D.0. |
|-----------|---|------|--|-------------------------|
| CARC      | CARC Description <sup>4</sup>   | RARC | RARC Description <sup>5</sup>  | 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

| <b>D</b> 6 | v.  | •    | olete Data from Submitted Claim                         |              |
|------------|---|------|---|--------------|
| Refers to  | situations where additional data is needed from the CARC Description <sup>4</sup>   | 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 <sup>4</sup>   | RARC              | RARC Description <sup>5</sup>                                       | 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 <sup>4</sup>   | RARC              | RARC Description <sup>5</sup>                              | 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   | 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, e.g., an 837 or D.0. |
| CARC      | CARC Description <sup>4</sup>   | RARC              | RARC Description <sup>5</sup>  | 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 <sup>4</sup>   | RARC | er for missing or invalid data on the submitted c<br>RARC Description <sup>5</sup> | 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<br>r for missing or invalid data on the submitted c | laim, e.g., an 837 or D.0. |
|-----------|---|------|--|----------------------------|
| CARC      | CARC Description <sup>4</sup>   | RARC | RARC Description <sup>5</sup>  | 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

| <b>D</b> 6 | v.  | •    | elete Data from Submitted Claim  | 02 <b>5</b> D.0 |
|------------|---|------|--|-----------------|
| CARC       | situations where additional data is needed from the CARC Description <sup>4</sup>   | RARC | er for missing or invalid data on the submitted clair  RARC Description <sup>5</sup> | 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 <sup>4</sup>   | RARC              | RARC Description <sup>5</sup>                                    | 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

| <b>D</b> 6        | v.  | •    | elete Data from Submitted Claim                                    | 02 <b>5</b> D.0 |
|-------------------|---|------|--|-----------------|
| Refers to<br>CARC | situations where additional data is needed from the CARC Description <sup>4</sup>   | RARC | RARC Description <sup>5</sup>                                      | 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<br>r for missing or invalid data on the submitted cla | im, e.g., an 837 or D.0. |
|-----------|---|------|--|--------------------------|
| CARC      | CARC Description <sup>4</sup>   | RARC | RARC Description <sup>5</sup>  | 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 <sup>4</sup>   | 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

| <b>D</b> 0 | v.  | •    | elete Data from Submitted Claim  | 02 <b>5</b> D.0 |
|------------|---|------|--|-----------------|
| CARC       | situations where additional data is needed from the CARC Description <sup>4</sup>   | RARC | er for missing or invalid data on the submitted clair  RARC Description <sup>5</sup> | 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 <sup>4</sup>   | RARC              | RARC Description <sup>5</sup>   | 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<br>r for missing or invalid data on the submitted cl | aim, e.g., an 837 or D.0. |
|-----------|---|------|---|---------------------------|
| CARC      | CARC Description <sup>4</sup>   | RARC | RARC Description <sup>5</sup>   | 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 <sup>4</sup>   | RARC                   | RARC Description <sup>5</sup>                                  | 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<br>r for missing or invalid data on the submitted clai | im, e.g., an 837 or D.0. |
|-----------|---|------|---|--------------------------|
| CARC      | CARC Description <sup>4</sup>   | RARC | RARC Description <sup>5</sup>   | 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              | n, e.g., an 837 or D.0. |
|-----------|---|--------------------|---|-------------------------|
| CARC      | CARC Description <sup>4</sup>   | RARC               | RARC Description <sup>5</sup>                                     | 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 <sup>4</sup>   | e billing provide | er for missing or invalid data on the submitted claim  RARC Description <sup>5</sup> | 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<br>r for missing or invalid data on the submitted clair | n, e.g., an 837 or D.0. |
|-----------|---|------|--|-------------------------|
| CARC      | CARC Description <sup>4</sup>   | RARC | RARC Description <sup>5</sup>  | 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 <sup>4</sup>   | RARC | RARC Description <sup>5</sup>                                     | 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<br>situations where additional data is needed from t  |      | ete Data from Submitted Claim<br>for missing or invalid data on the submitted cla | im, e.g., an 837 or D.0. |
|-----------|---|------|---|--------------------------|
| CARC      | CARC Description <sup>4</sup>   | RARC | RARC Description <sup>5</sup>   | 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   | 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 clai             | im, e.g., an 837 or D.0. |
| CARC | CARC Description <sup>4</sup>   | RARC              | RARC Description <sup>5</sup>                                   | 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

| <b>D</b> 0 | v.  | •    | elete Data from Submitted Claim                                   |              |
|------------|---|------|---|--------------|
| CARC       | situations where additional data is needed from the CARC Description <sup>4</sup>   | 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

| <b>.</b>  | v.  | •    | olete Data from Submitted Claim  |              |
|-----------|---|------|--|--------------|
| Refers to | situations where additional data is needed from the CARC Description <sup>4</sup>   | RARC | er for missing or invalid data on the submitted cla<br>RARC Description <sup>5</sup> | 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<br>r for missing or invalid data on the submitted clai | im, e.g., an 837 or D.0. |
|-----------|---|------|---|--------------------------|
| CARC      | CARC Description <sup>4</sup>   | RARC | RARC Description <sup>5</sup>   | 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<br>CARC | situations where additional data is needed from the CARC Description <sup>4</sup>   | RARC | r for missing or invalid data on the submitted clain  RARC Description <sup>5</sup> | 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                      |              |
|-----------|---|-----------------|--|--------------|
| Refers to | situations where additional data is needed from the   |                 |  |              |
|           | CARC Description <sup>4</sup>   | RARC            | RARC Description <sup>5</sup>                        | 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<br>situations where additional data is needed from the   | •    | lete Data from Submitted Claim<br>r for missing or invalid data on the submitted cla | nim, e.g., an 837 or D.0. |
|-----------|---|------|--|---------------------------|
| CARC      | CARC Description <sup>4</sup>   | RARC | RARC Description <sup>5</sup>  | 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<br>er for missing or invalid data on the submitted clai | im, e.g., an 837 or D.0. |
|-----------|---|------|---|--------------------------|
| CARC      | CARC Description <sup>4</sup>   | RARC | RARC Description <sup>5</sup>   | 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<br>r for missing or invalid data on the submitted clai | m, e.g., an 837 or D.0. |
|-----------|---|------|--|-------------------------|
| CARC      | CARC Description <sup>4</sup>   | RARC | RARC Description <sup>5</sup>  | 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<br>r for missing or invalid data on the submitted cla | im, e.g., an 837 or D.0. |
|-----------|---|------|--|--------------------------|
| CARC      | CARC Description <sup>4</sup>   | RARC | RARC Description <sup>5</sup>  | 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

|           | - Caracteristic Control of the Caracteristic Control of Caracteristic Caracteristic Control of Caracteristic Caracteri | •    | olete Data from Submitted Claim                      |                                      |
|-----------|--|------|--|--------------------------------------|
| Refers to | situations where additional data is needed from the CARC Description <sup>4</sup>  | 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 <sup>4</sup>   | e billing provide | r for missing or invalid data on the submitted clair  RARC Description <sup>5</sup> | n, e.g., an 837 or D.0.<br>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 <sup>4</sup>   | RARC | RARC Description <sup>5</sup>                                   | 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<br>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 <sup>4</sup>   | RARC | RARC Description <sup>5</sup>                       | 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<br>r for missing or invalid data on the submitted clai | im, e.g., an 837 or D.0. |
|-----------|---|------|---|--------------------------|
| CARC      | CARC Description <sup>4</sup>   | RARC | RARC Description <sup>5</sup>   | 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 <sup>4</sup>   | 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 <sup>4</sup>   | RARC | RARC Description <sup>5</sup>                           | 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 <sup>4</sup>   | RARC | RARC Description <sup>5</sup>                    | 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

| <b>D</b> 0 | v.  | •    | elete Data from Submitted Claim  | 02 <b>5</b> D.0                       |
|------------|---|------|--|---------------------------------------|
| CARC       | situations where additional data is needed from the CARC Description <sup>4</sup>   | RARC | er for missing or invalid data on the submitted clair  RARC Description <sup>5</sup> | 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<br>r for missing or invalid data on the submitted cla | aim, e.g., an 837 or D.0. |
|-----------|---|------|--|---------------------------|
| CARC      | CARC Description <sup>4</sup>   | RARC | RARC Description <sup>5</sup>  | 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<br>r for missing or invalid data on the submitted clair | n, e.g., an 837 or D.0. |
|-----------|---|------|--|-------------------------|
| CARC      | CARC Description <sup>4</sup>   | RARC | RARC Description <sup>5</sup>  | 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                              |                         |
|-----------|---|-------------------|---|-------------------------|
| 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 <sup>4</sup>   | RARC              | RARC Description <sup>5</sup>                               | 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.  | •                 | olete Data from Submitted Claim  |                                       |
|-----------|---|-------------------|--|---------------------------------------|
| Refers to | situations where additional data is needed from the CARC Description <sup>4</sup>   | e billing provide | er for missing or invalid data on the submitted clain  RARC Description <sup>5</sup> | 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

| D.C. | , and the second se  | •    | elete Data from Submitted Claim  | 925 D.A      |
|------|---|------|--|--------------|
| CARC | situations where additional data is needed from the  CARC Description <sup>4</sup>  | RARC | RARC Description <sup>5</sup>  | 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/<br>situations where additional data is needed from the  | •    | lete Data from Submitted Claim<br>r for missing or invalid data on the submitted clair       | m, e.g., an 837 or D.0. |
|-----------|---|------|--|-------------------------|
| CARC      | CARC Description <sup>4</sup>   | RARC | RARC Description <sup>5</sup>  | 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 clain                           | m, e.g., an 837 or D.0. |
|-----------|---|-------------------|---|-------------------------|
| CARC      | CARC Description <sup>4</sup>   | RARC              | RARC Description <sup>5</sup>   | 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<br>er for missing or invalid data on the submitted clain  | n, e.g., an 837 or D.0. |
|-----------|---|------|---|-------------------------|
| CARC      | CARC Description <sup>4</sup>   | RARC | RARC Description <sup>5</sup>   | 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<br>r for missing or invalid data on the submitted clai | im, e.g., an 837 or D.0. |
|-----------|---|------|---|--------------------------|
| CARC      | CARC Description <sup>4</sup>   | RARC | RARC Description <sup>5</sup>   | 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.  | •    | olete Data from Submitted Claim  |              |
|-----------|---|------|--|--------------|
| Refers to | situations where additional data is needed from the CARC Description <sup>4</sup>   | RARC | er for missing or invalid data on the submitted cla<br>RARC Description <sup>5</sup> | 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 <sup>4</sup>   | RARC | RARC Description <sup>5</sup>   | 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<br>situations where additional data is needed from the   | •    | lete Data from Submitted Claim<br>r for missing or invalid data on the submitted clai | im, e.g., an 837 or D.0. |
|-----------|---|------|---|--------------------------|
| CARC      | CARC Description <sup>4</sup>   | RARC | RARC Description <sup>5</sup>   | 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 <sup>4</sup>   | RARC | er for missing or invalid data on the submitted cla<br>RARC Description <sup>5</sup> | 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

| <b>.</b>  | , and the second se  | •    | olete Data from Submitted Claim  |  |
|-----------|---|------|--|--|
| Refers to | situations where additional data is needed from the  CARC Description <sup>4</sup>  | 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/<br>situations where additional data is needed from the  | •    | lete Data from Submitted Claim<br>r for missing or invalid data on the submitted cla                   | im, e.g., an 837 or D.0. |
|-----------|---|------|--|--------------------------|
| CARC      | CARC Description <sup>4</sup>   | RARC | RARC Description <sup>5</sup>  | 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 <sup>4</sup>   | RARC | RARC Description <sup>5</sup>  | 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 <sup>4</sup>  | RARC | er for missing or invalid data on the submitted clair  RARC Description <sup>5</sup>  | 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 <sup>4</sup>   | RARC | er for missing or invalid data on the submitted cla  RARC Description <sup>5</sup>        | 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

|           | Campuia #2. Missing   | Table 3 | lete Data from Submitted Claim  |                         |
|-----------|---|---------|---|-------------------------|
| Refere to | Scenario #2: Missing<br>situations where additional data is needed from the   |         |   | uim e.g. an 837 ar D.O. |
| CARC      | CARC Description <sup>4</sup>   | RARC    | RARC Description <sup>5</sup>   | 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<br>Group Code OA except where state workers'<br>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.   |         | 1   | 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 <sup>4</sup>                               | RARC             | RARC Description <sup>5</sup>                                       | 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                |
| 146       | service reported.  Diagnosis was invalid for the date(s) of | N517             | diagnosis.  Resubmit a new claim with the requested                 | CO or PI                |
| 140       | service reported.   | N317             | information.  | COOFFI                  |
| 146       | Diagnosis was invalid for the date(s) of                    | N657             | This should be billed with the appropriate                          | CO or PI                |
| 140       | service reported.   | 11057            | code for these services.  | COULT                   |
| 175       | Prescription is incomplete.                                 | N592             | Adjusted because this is not the initial                            | CO or PI                |
|           |   |                  | prescription or exceeds the amount allowed                          |                         |
|           |   |                  | 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                |
|           | service.  |                  |   |                         |
| 181       | Procedure code was invalid on the date of                   | N517             | Resubmit a new claim with the requested                             | CO or PI                |
| 101       | service.  | NICET            | information.  | CO - DI                 |
| 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               | N517             | Resubmit a new claim with the requested                             | CO or PI                |
| 104       | service.  | 11011            | information.  | COULL                   |
| 182       | Procedure modifier was invalid on the date of               | N657             | This should be billed with the appropriate                          | CO or PI                |
|           | service.  |                  | code for these services.  |                         |
| 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                  |                  |   |                         |
|           | 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 : |  |              |
|------|--|---------|--|--------------|
|      |  |         | olete Data from Submitted Claim  |              |
|      |  |         | er for missing or invalid data on the submitted claim  |              |
| CARC | CARC Description <sup>4</sup>  | RARC    | RARC Description <sup>5</sup>  | 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 <sup>4</sup>  | RARC  | RARC Description <sup>5</sup>                                       | 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     |  |  |  |

<sup>&</sup>lt;sup>4</sup>Washington Publishing Company: http://www.wpc-edi.com/reference/

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<sup>&</sup>lt;sup>5</sup>Washington 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 <sup>6</sup>  | RARC              | RARC Description <sup>7</sup>  | 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.E.C |  |       | rice is not covered by the health plan.   |              |
| CARC   | CARC Description <sup>6</sup>  | RARC  | RARC Description <sup>7</sup>   | 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-<br>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 <sup>6</sup>   | RARC              | RARC Description <sup>7</sup>   | 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-<br>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 <sup>6</sup>  | RARC                 | RARC Description <sup>7</sup>  | 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 <sup>6</sup>  | RARC                 | RARC Description <sup>7</sup>   | 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 <sup>6</sup>  | RARC              | RARC Description <sup>7</sup>  | 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 <sup>6</sup>  | RARC              | RARC Description <sup>7</sup>  | 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 <sup>6</sup>  | RARC                   | RARC Description <sup>7</sup>  | 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<br>documentation/orders/notes/summary/report/c<br>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             |   |              |
|------|--|-------------------|---|--------------|
|      | 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 <sup>6</sup>  | RARC              | RARC Description <sup>7</sup>   | ASC X12 CAG  |
| 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 <sup>6</sup>   | RARC                   | RARC Description <sup>7</sup>   | 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/<br>equipment/bed, however patient liability is<br>limited to amounts shown in the adjustments<br>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-<br>existing condition. Send medical records for<br>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<br>experimental/investigational by the payer.<br>Note: Refer to the 835 Healthcare Policy<br>Identification Segment (loop 2110 Service<br>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 <sup>6</sup>  | RARC                 | RARC Description <sup>7</sup>   | 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<br>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 <sup>6</sup>  | RARC  | RARC Description <sup>7</sup>   | 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 <sup>8</sup> | Non-covered charge(s). At least one Remark<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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<br>the test was conducted by a medical supplier<br>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: F  | 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 <sup>6</sup>   | RARC              | RARC Description <sup>7</sup>   | 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 <sup>6</sup>  | RARC              | RARC Description <sup>7</sup>   | 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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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-<br>emetic drugs that are not administered with a<br>covered oral anti-cancer drug.  | CO, PI or PR |
| 96   | Non-covered charge(s). At least one Remark<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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 <sup>6</sup>  | RARC              | RARC Description <sup>7</sup>   | 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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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 <sup>6</sup>  | RARC              | RARC Description <sup>7</sup>   | 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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>REF), if present. | M117              | Not covered unless submitted via electronic claim.  | CO, PI or PR |
| 96   | Non-covered charge(s). At least one Remark<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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 <sup>6</sup>  | RARC              | RARC Description <sup>7</sup>  | 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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>REF), if present. | MA24              | Christian Science Sanitarium/ Skilled<br>Nursing Facility (SNF) bill in the same<br>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 <sup>6</sup>  | RARC              | RARC Description <sup>7</sup>  | 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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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 <sup>6</sup>  | RARC              | RARC Description <sup>7</sup>   | ASC X12 CAGC |
| 96   | Non-covered charge(s). At least one Remark<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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 <sup>6</sup>  | RARC              | RARC Description <sup>7</sup>  | 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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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 <sup>6</sup>  | RARC              | RARC Description <sup>7</sup>  | 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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>REF), if present. | N35               | Program integrity/utilization review decision.   | CO, PI or PR |
| 96   | Non-covered charge(s). At least one Remark<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>REF), if present. | N43               | Bed hold or leave days exceeded.   | CO, PI or PR |
| 96   | Non-covered charge(s). At least one Remark<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>REF), if present. | N45               | Payment based on authorized amount.  | CO, PI or PR |
| 96   | Non-covered charge(s). At least one Remark<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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 <sup>6</sup>  | RARC              | RARC Description <sup>7</sup>   | 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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>REF), if present. | N56               | Procedure code billed is not correct/valid for<br>the services billed or the date of service<br>billed. | CO, PI or PR |
| 96   | Non-covered charge(s). At least one Remark<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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 <sup>6</sup>  | RARC              | RARC Description <sup>7</sup>  | 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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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 <sup>6</sup> 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<br>N95 | RARC Description <sup>7</sup> 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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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 <sup>6</sup>  | RARC              | RARC Description <sup>7</sup>  | 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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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 <sup>6</sup>   | RARC                    | RARC Description <sup>7</sup>   | 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 <sup>6</sup>  | RARC              | RARC Description <sup>7</sup>   | 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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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   | Silled 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 <sup>6</sup>  | RARC              | RARC Description <sup>7</sup>   | 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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>REF), if present. | N174              | This is not a covered service/procedure/<br>equipment/bed, however patient liability is<br>limited to amounts shown in the adjustments<br>under group 'PR'.   | CO, PI or PR |
| 96   | Non-covered charge(s). At least one Remark<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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 <sup>6</sup>  | RARC              | RARC Description <sup>7</sup>  | 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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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 <sup>6</sup>  | RARC              | RARC Description <sup>7</sup>   | 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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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 <sup>6</sup>   | RARC      | RARC Description <sup>7</sup>   | 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 <sup>6</sup>  | RARC              | RARC Description <sup>7</sup>  | 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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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 <sup>6</sup>  | RARC              | RARC Description <sup>7</sup>  | 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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>REF), if present. | N426              | No coverage when self-administered.  | CO, PI or PR |
| 96   | Non-covered charge(s). At least one Remark<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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 <sup>6</sup>  | RARC              | RARC Description <sup>7</sup>  | 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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>REF), if present. | N442              | Payment based on an alternate fee schedule.  | CO, PI or PR |
| 96   | Non-covered charge(s). At least one Remark<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>REF), if present. | N507              | Plan distance requirements have not been met.  | CO, PI or PR |
| 96   | Non-covered charge(s). At least one Remark<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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 <sup>6</sup>  | RARC              | RARC Description <sup>7</sup>   | 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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>REF), if present. | N567              | Not covered when considered preventative.   | CO, PI or PR |
| 96   | Non-covered charge(s). At least one Remark<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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 <sup>6</sup>  | RARC              | RARC Description <sup>7</sup>  | 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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>REF), if present. | N578              | Coverages do not apply to this loss.   | CO, PI or PR |
| 96   | Non-covered charge(s). At least one Remark<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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 <sup>6</sup>  | RARC              | RARC Description <sup>7</sup>   | 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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>REF), if present. | N607              | Service provided for non-compensable condition(s).  | CO, PI or PR |
| 96   | Non-covered charge(s). At least one Remark<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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 <sup>6</sup>  | RARC              | RARC Description <sup>7</sup>  | 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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>REF), if present. | N630              | Referral not authorized by attending physician   | CO, PI or PR |
| 96   | Non-covered charge(s). At least one Remark<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>REF), if present. | N633              | Additional anesthesia time units are not allowed.  | CO, PI or PR |
| 96   | Non-covered charge(s). At least one Remark<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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 <sup>6</sup>  | RARC              | RARC Description <sup>7</sup>  | 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<br>Covered or Non-Covered (NC) in the<br>applicable state fee schedule. | CO, PI or PR |
| 96   | Non-covered charge(s). At least one Remark<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>REF), if present. | N647              | Adjusted based on diagnosis-related group (DRG).   | CO, PI or PR |
| 96   | Non-covered charge(s). At least one Remark<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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 <sup>6</sup>  | RARC                   | RARC Description <sup>7</sup>  | ASC X12 CAGC |
| 96   | Non-covered charge(s). At least one Remark<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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<br>the Outpatient Facility Fee Schedule.                                      | CO, PI or PR |
| 108  | Rent/purchase guidelines were not met. Note:<br>Refer to the 835 Healthcare Policy<br>Identification Segment (loop 2110 Service<br>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:<br>Refer to the 835 Healthcare Policy<br>Identification Segment (loop 2110 Service<br>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            | <del>l</del> -1   |              |
|------|--|--------------------|---|--------------|
|      | Scenario #3: E                                 | 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 <sup>6</sup>                  | RARC               | RARC Description <sup>7</sup>   | 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.  |                    |   | 22,11111     |
|      |  |                    |   |              |
| 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 |
| 110  | occurrence has been reached.                   | 1400               | service.  | CO DI DD     |
| 119  | Benefit maximum for this time period or        | M80                | Not covered when performed during the same session/date as a previously processed service | CO, PI or PR |
|      | occurrence has been reached.                   |                    | for the patient.  |              |
| 119  | Benefit maximum for this time period or        | M83                | Service is not covered unless the patient is  | CO, PI or PR |
| 117  | occurrence has been reached.                   | 11103              | classified as at high risk.   | 55,110/1K    |
| 119  | Benefit maximum for this time period or        | M86                | Service denied because payment already  | CO, PI or PR |
|      | occurrence has been reached.                   | 2.100              | made for same/similar procedure within set  | ,            |
|      |  |                    | time frame.   |              |
| 119  | Benefit maximum for this time period or        | M89                | Not covered more than once under age 40.  | CO, PI or PR |
|      | occurrence has been reached.                   |                    |   | ,            |
| 119  | Benefit maximum for this time period or        | M90                | Not covered more than once in a 12 month  | CO, PI or PR |
|      | occurrence has been reached.                   |                    | period.   |              |
| 119  | Benefit maximum for this time period or        | M139               | Denied services exceed the coverage limit for   | CO, PI or PR |
|      | occurrence has been reached.                   |                    | the demonstration.  |              |
| 119  | Benefit maximum for this time period or        | MA115              | Missing/incomplete/invalid physical location  | CO, PI or PR |
|      | occurrence has been reached.                   |                    | (name and address, or PIN) where the  |              |
|      |  |                    | service(s) were rendered in a Health  |              |
|      |  |                    | Professional Shortage Area (HPSA).  |              |

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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 <sup>6</sup>   | RARC              | RARC Description <sup>7</sup>   | 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<br>/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: 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 <sup>6</sup>   | RARC               | RARC Description <sup>7</sup>   | ASC X12 CAGO |
| 152  | Payer deems the information submitted does<br>not support this length of service. Note: Refer<br>to the 835 Healthcare Policy Identification<br>Segment (loop 2110 Service Payment<br>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 <sup>6</sup>   | RARC                   | RARC Description <sup>7</sup>  | ASC X12 CAGC |
| 170  | Payment is denied when performed/billed by<br>this type of provider. Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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<br>this type of provider. Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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<br>this type of provider. Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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 <sup>6</sup>   | RARC                   | RARC Description <sup>7</sup>   | 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-<br>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 <sup>6</sup>  | RARC                  | RARC Description <sup>7</sup>  | 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 <sup>6</sup>   | RARC              | RARC Description <sup>7</sup>  | 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<br>care providers. Notes: This code replaces<br>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<br>care providers. Notes: This code replaces<br>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<br>care providers. Notes: This code replaces<br>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<br>care providers. Notes: This code replaces<br>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<br>care providers. Notes: This code replaces<br>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-<br>payable reporting codes and appropriate<br>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<br>benefits not available under this plan. Submit<br>these services to the patient's medical plan for<br>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            | <del>1</del> -1                                 |              |
|------|--|------------------|---|--------------|
|      | Scenario #3: B                                   | illed Service No | ot Covered by Health Plan                       |              |
|      |  |                  | ice is not covered by the health plan.          |              |
| CARC | CARC Description <sup>6</sup>                    | RARC             | RARC Description <sup>7</sup>                   | ASC X12 CAGC |
| 254  | Claim received by the dental plan, but           | N202             | Additional information/explanation will be      | CO, PI or PR |
|      | benefits not available under this plan. Submit   |                  | sent separately                                 |              |
|      | these services to the patient's medical plan for |                  |   |              |
|      | further consideration.                           |                  |   |              |
| 256  | Service not payable per managed care             | M14              | No separate payment for an injection            | CO, PI or PR |
| 200  | contract.  |                  | administered during an office visit, and no     | 00,110111    |
|      | contract.  |                  | payment for a full office visit if the patient  |              |
|      |  |                  | only received an injection.                     |              |
| 256  | Service not payable per managed care             | M37              | Not covered when the patient is under age 35.   | CO, PI or PR |
| 230  | contract.  | W137             | ivot covered when the patient is under age 33.  | CO, FIGURE   |
| 256  | Service not payable per managed care             | M38              | The patient is liable for the charges for this  | CO, PI or PR |
| 230  | contract.  | 14130            | service as you informed the patient in writing  | CO, 11011K   |
|      | contract.  |                  | before the service was furnished that we        |              |
|      |  |                  |   |              |
|      |  |                  | would not pay for it, and the patient agreed to |              |
| 256  | Service not payable per managed care             | M20              | pay.  | CO, PI or PR |
| 256  | 1 1 0  | M39              | The patient is not liable for payment for this  | CO, PI of PR |
|      | contract.  |                  | service as the advance notice of non-coverage   |              |
|      |  |                  | you provided the patient did not comply with    |              |
|      |  |                  | program requirements.                           |              |
| 256  | Service not payable per managed care             | M61              | We cannot pay for this as the approval period   | CO, PI or PR |
|      | contract.  |                  | for the FDA clinical trial has expired.         |              |
| 256  |  | 3.501            | Y   | GO DI DD     |
| 256  | Service not payable per managed care             | M81              | You are required to code to the highest level   | CO, PI or PR |
| 256  | contract.  | 1.502            | of specificity.                                 | GO DI DD     |
| 256  | Service not payable per managed care             | M82              | Service is not covered when patient is under    | CO, PI or PR |
|      | contract.  |                  | age 50.   |              |
| 256  | Service not payable per managed care             | M89              | Not covered more than once under age 40.        | CO, PI or PR |
| 256  | contract.  | 1400             | Not assessed assess the assessing 12 months     | CO DI DD     |
| 256  | Service not payable per managed care             | M90              | Not covered more than once in a 12 month        | CO, PI or PR |
|      | contract.  | 3.50.5           | period.   | 20 PV PP     |
| 256  | Service not payable per managed care             | M96              | The technical component of a service            | CO, PI or PR |
|      | contract.  |                  | 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.   |              |
| 256  | Service not payable per managed care             | M97              | Not paid to practitioner when provided to       | CO, PI or PR |
|      | contract.  |                  | patient in this place of service. Payment       |              |
|      |  |                  | included in the reimbursement issued the        |              |
|      |  |                  | facility.                                       |              |
| 256  | Service not payable per managed care             | M139             | Denied services exceed the coverage limit for   | CO, PI or PR |
|      | contract.  |                  | the demonstration.                              |              |
| 256  | Service not payable per managed care             | MA16             | The patient is covered by the Black Lung        | CO, PI or PR |
|      | contract.  |                  | Program. Send this claim to the Department      |              |
|      |  |                  | of Labor, Federal Black Lung Program, P.O.      |              |
|      |  |                  | Box 828, Lanham-Seabrook MD 20703.              |              |
|      |  |                  |   |              |
| 256  | Service not payable per managed care             | N52              | Patient not enrolled in the billing provider's  | CO, PI or PR |
|      | contract.  |                  | managed care plan on the date of service.       |              |
|      |  |                  |   |              |
| 256  | Service not payable per managed care             | N95              | This provider type/provider specialty may not   | CO, PI or PR |
|      | contract.  |                  | bill this service.                              |              |

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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 <sup>6</sup>   | RARC  | RARC Description <sup>7</sup>   | 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 <sup>6</sup>  | RARC              | RARC Description <sup>7</sup>  | 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 <sup>6</sup>   | RARC               | RARC Description <sup>7</sup>  | 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<br>Clinical Laboratory Improvement<br>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 |

<sup>&</sup>lt;sup>6</sup>Washington Publishing Company: http://www.wpc-edi.com/reference/

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<sup>&</sup>lt;sup>7</sup>Washington 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 <sup>6</sup>  | RARC | RARC Description <sup>7</sup> | ASC X12 CAGC |  |

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

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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 service or benefit is not separately payable by the health plan. |                    |  |              |  |  |  |
| CARC | CARC Description <sup>9</sup>  | RARC               | RARC Description <sup>10</sup>   | 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<br>(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  | WIIS               | bundled as they are considered components of   | CO, 11011K   |  |  |  |
|      | 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                | Coming deviat become account during  | CO, PI or PR |  |  |  |
| 91   | payment/allowance for another  | IVI80              | Service denied because payment already<br>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  |                    | time nume.   |              |  |  |  |
|      | 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 |  |  |  |
| 71   | payment/allowance for another  | 171144             | in the allowance for the surgery/procedure.  | CO, F101 FK  |  |  |  |
|      | service/procedure that has already been  |                    | and anowanes for the surgery/procedure.  |              |  |  |  |
|      | 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  | 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<br>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 |

<sup>&</sup>lt;sup>9</sup>Washington Publishing Company: http://www.wpc-edi.com/reference/

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<sup>&</sup>lt;sup>10</sup>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 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   | ing/Invalid/Incomplet      | e Data from Submitted Claim                                       |                         |  |  |  |
| Refers | to situations where additional data is needed from   | n the billing provider for | 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 <sup>11</sup>   | RARC                       | RARC Description <sup>12</sup>                                    | ASC X12 CAGC            |  |  |  |
| 16     | Claim/service lacks information which is<br>needed for adjudication. At least one Remark<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason Code [sic],<br>or Remittance Advice Remark Code that is<br>not an ALERT). | Not Applicable             | For retail pharmacy the NCPDP External Code List must be used. 13 | CO or PI                |  |  |  |

<sup>&</sup>lt;sup>11</sup>Washington Publishing Company: http://www.wpc-edi.com/reference/

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<sup>&</sup>lt;sup>12</sup>Washington Publishing Company: http://www.wpc-edi.com/reference/

<sup>&</sup>lt;sup>13</sup>http://www.ncpdp.org/members/members\_download.aspx. NCPDP Reject Codes are in Appendix A

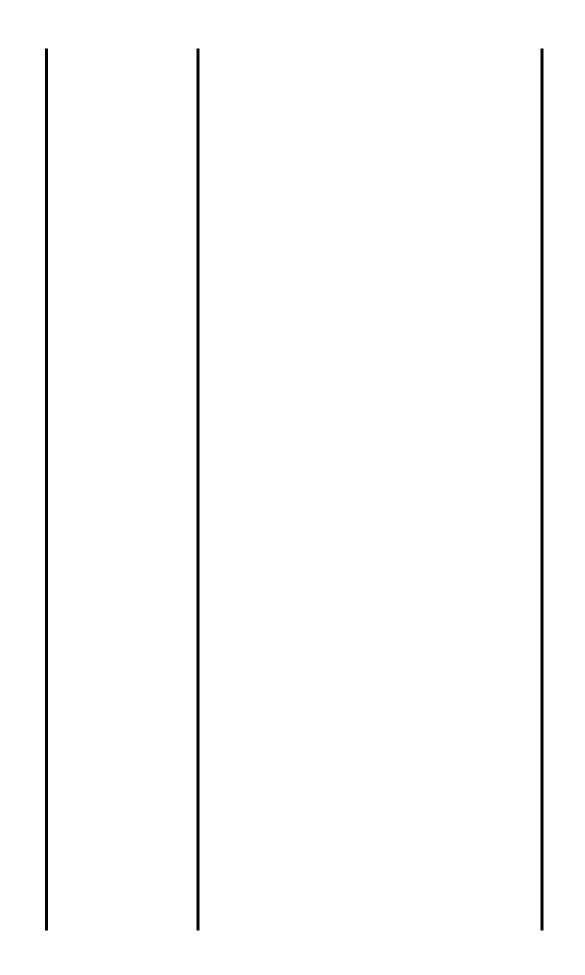
#### Change Log for CORE-required Code Combinations for CORE-defined B

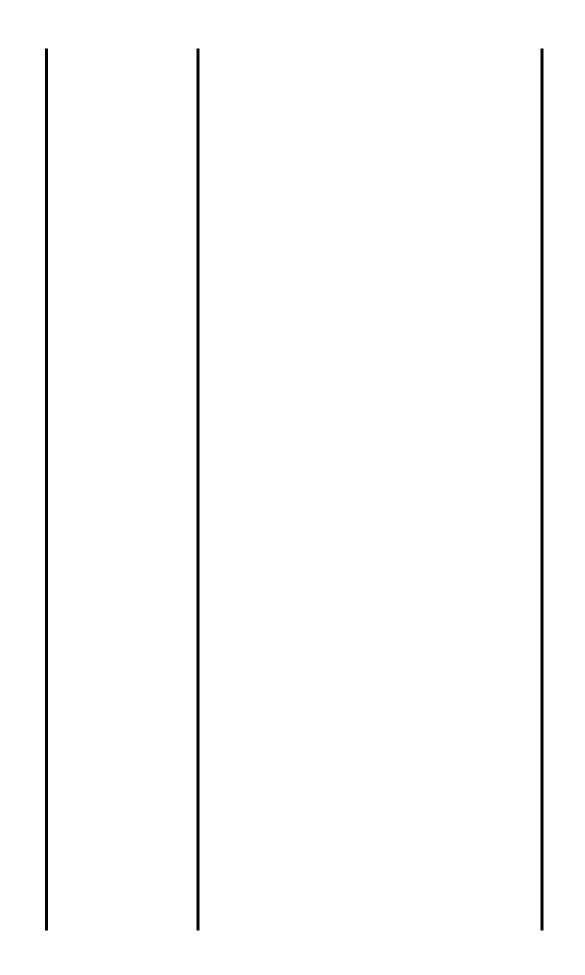
| Version | Description  |
|---------|--|
| 3.0.0   | CORE-required Code Combinations for CORE-defined Business<br>Scenarios for the Phase III CORE 360 Uniform Use of Claim<br>Adjustment Reason Codes and Remittance Advice Remark Codes<br>(835) based on published CARC & RARC lists as of June 2011,<br>balloted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

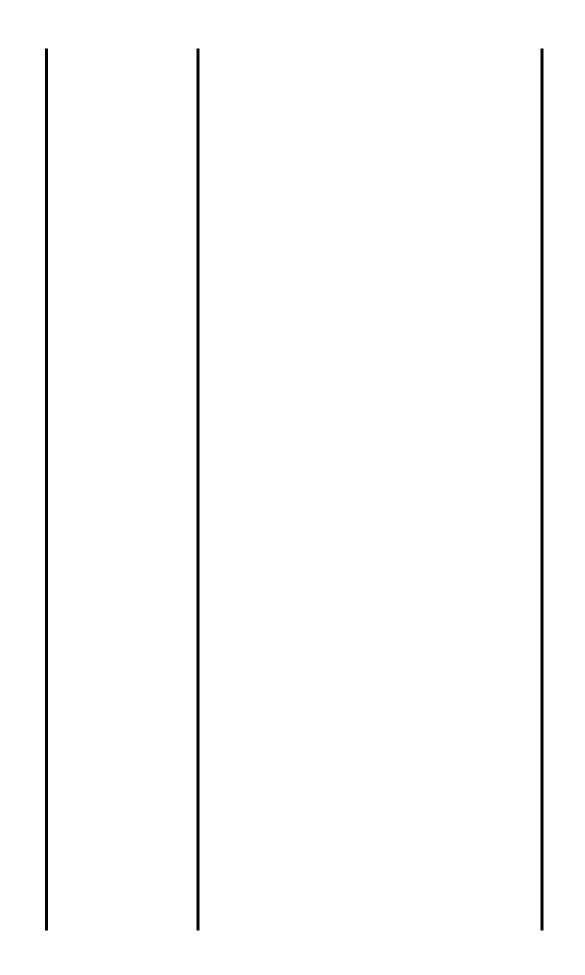
| Detailed Description of Updates for the October 2013 v3.0.3 CORE Code Con                         |  |  |  |  |
|---|--|--|--|--|
| Scenario  | Adjustment                                       |  |  |  |
| Business Scenario #1 – Additional Information Required – Missing/Invalid/Incomplete Documentation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

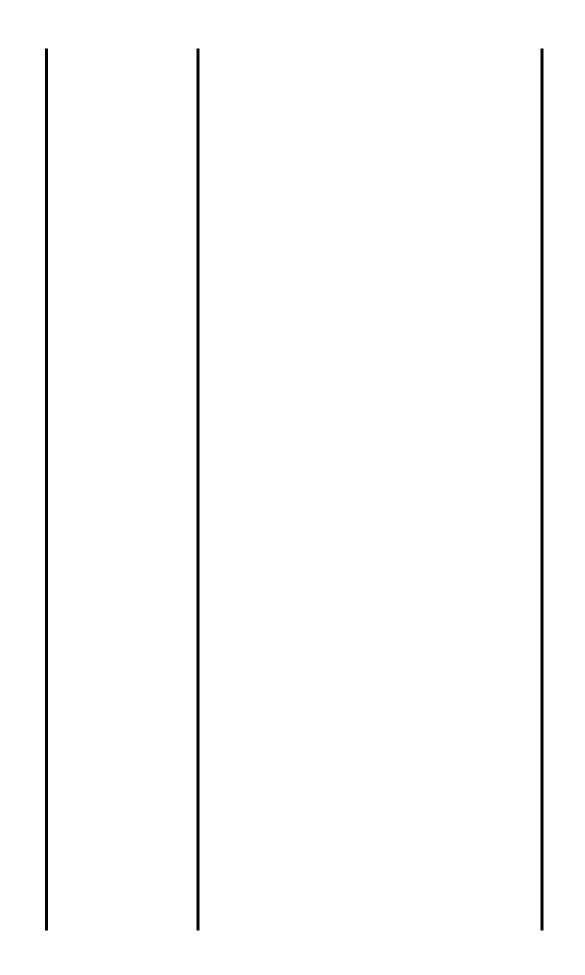
| Business Scenario #2 –                   | · 3 CARC descriptions modified |
|--|--------------------------------|
| Additional Information                   |                                |
| Required –<br>Missing/Invalid/Incomplete |                                |
| Data from Submitted Claim                |                                |
|  | · 29 RARCs added               |
|  |                                |
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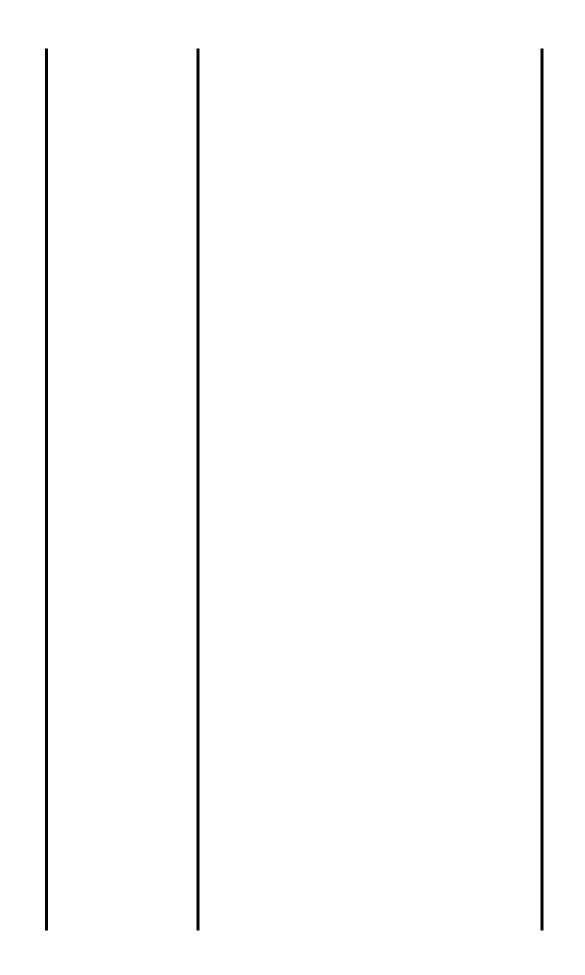
| Rusiness Scenario #3 – Billed         | · 1 code combination removed   |
|---------------------------------------|--------------------------------|
| Service Not Covered by<br>Health Plan | r code comonidaton removed     |
|                                       | · 2 RARC descriptions modified |
|                                       | · 4 CARC descriptions modified |
|                                       |                                |
|                                       | · 5 CARCs added                |
|                                       |                                |
|                                       | · 134 RARCs added              |
|                                       |                                |
|                                       |                                |
|                                       |                                |
|                                       |                                |
|                                       |                                |
| I                                     |                                |

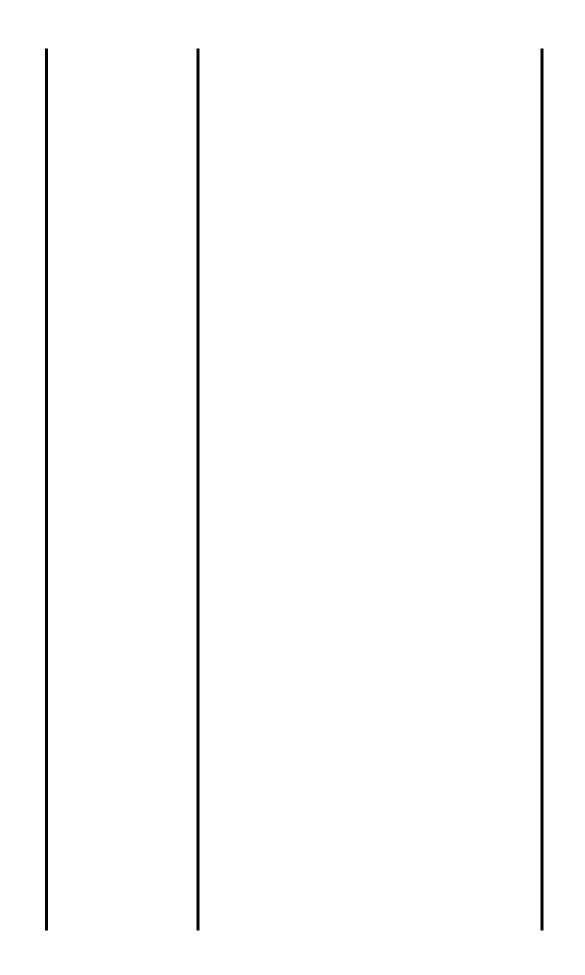












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| Business Scenario #4 –         | · 1 CARC added  |   |
| Benefit for Billed Service Not | · 8 RARCs added |   |
| Separately Payable             | o RARCS auutu   |   |
|                                |                 |   |
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#### 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<br>was modified     Description of CARC 164<br>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<br>Adjustment   |
| Business Scenario #1 – Additional<br>Information Required –<br>Missing/Invalid/Incomplete<br>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   |
|  |                               | <ul> <li>RARC N681 was associated with CARC 164</li> <li>RARC N682 was associated with CARC 164</li> <li>RARC N683 was associated</li> </ul>                    |
|  |                               | 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                                     |
|  |                                | <ul> <li>RARC N682 was associated<br/>with CARC 250</li> </ul> |
|  |                                | with CARC 250  |
|  |                                | · RARC N681 was associated                                     |
|  |                                | with CARC 250  |
|  |                                | · RARC N680 was associated                                     |
|  |                                | <ul> <li>RARC N679 was associated<br/>with CARC 250</li> </ul> |
|  |                                | 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<br>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   |
|                  | <ul> <li>RARC N627 was removed<br/>from association with CARC</li> </ul>   |
|                  | 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                | <ul> <li>RARC M80 was associated</li> </ul>  |
|                  | · 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  |
| <ul> <li>RARC N653 was associated<br/>with CARC P21</li> </ul> |
| · 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<br>Billed Service Not Separately<br>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 M19 was associated with CARC P14 RARC N19 was associated with CARC P14 RARC N20 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 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<br>Scenarios for the Phase III CORE 360 Uniform Use of Claim<br>Adjustment Reason Codes and Remittance Advice Remark Codes<br>(835) based on published CARC & RARC lists as of June 2011,<br>balloted and approved by CORE members | 06/01/2012       |
| 3.0.1   | Compliance-based adjustments as part of the CAQH CORE Code<br>Combinations Maintenance Process based on published CARC &<br>RARC lists as of November 2011   | 01/31/2013       |
| 3.0.2   | Compliance-based adjustments as part of the CAQH CORE Code<br>Combinations Maintenance Process based on published CARC &<br>RARC lists as of March 2013  | 05/24/2013       |
| 3.0.3   | Compliance-based adjustments as part of the CAQH CORE Code<br>Combinations Maintenance Process based on published CARC &<br>RARC lists as of July 2013   | 10/01/2013       |
| 3.0.4   | Compliance-based adjustments as part of the CAQH CORE Code<br>Combinations Maintenance Process based on published CARC &<br>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                      |  |
|   |   | <ul> <li>CARC W6 with RARC N130 was removed due to<br/>deactivation of CARC</li> </ul> |
|   |   | · 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 P21  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<br>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  |
|   | · 13 RARCs added              | • RARC M2 was associated with CARC P14  |
|   |                               | TO THE WAS ASSOCIATED WITH CARC I 17  |
|   | 13 To Inces added             | · RARC M15 was associated with CARC P14   |

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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/CAGC<sup>1</sup> 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

|      |  | Table |   |              |
|------|--|-------|---|--------------|
|      |  |       | - Missing/Invalid/Incomplete Documentation  |              |
|      |  |       | d from the billing provider or an ERA from a prior  |              |
| CARC | CARC Description <sup>2</sup>  | RARC  | RARC Description <sup>3</sup>   | 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,<br>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,<br>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 <sup>2</sup>  | RARC             | RARC Description <sup>3</sup>   | 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,<br>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 <sup>2</sup>  | RARC              | RARC Description <sup>3</sup>  | 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  | navon        |
| a    |  |       | from the billing provider or an ERA from a prior  |              |
| CARC | CARC Description <sup>2</sup>  | RARC  | RARC Description <sup>3</sup>   | 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<br>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 <sup>2</sup>  | RARC              | RARC Description <sup>3</sup>   | 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<br>the test(s) and/or the performing laboratory's<br>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<br>documentation/orders/notes/summary/report/c<br>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<br>d from the billing provider or an ERA from a prior  | paver.       |
| CARC | CARC Description <sup>2</sup>  | RARC  | RARC Description <sup>3</sup>   | ASC X12 CAGC |
| 251  | The attachment/other documentation content received did not contain the content required to process this claim or service. | N42   | No record of mental health assessment.  | CO or PI     |
| 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<br>for this service. Contact the nearest Military<br>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-<br>existing condition. Send medical records for<br>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 <sup>2</sup>  | RARC  | RARC Description <sup>3</sup>   | 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<br>d from the billing provider or an ERA from a prior                                    | naver        |
| CARC | CARC Description <sup>2</sup>  | RARC          | RARC Description <sup>3</sup>   | 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 <sup>2</sup>  | RARC              | RARC Description <sup>3</sup>   | 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 <sup>2</sup>  | RARC              | RARC Description <sup>3</sup>                                    | 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 <sup>2</sup> 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 <sup>3</sup> 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 <sup>2</sup> 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<br>N461<br>N462 | RARC Description <sup>3</sup> 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<br>N461<br>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<br>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   | 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<br>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 <sup>2</sup> The attachment/other documentation content   | N478  | RARC Description <sup>3</sup> 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<br>(Coordination of Benefits or Medicare<br>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<br>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<br>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<br>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<br>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 <sup>2</sup>  | RARC | RARC Description <sup>3</sup>   | 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<br>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 <sup>2</sup>  | RARC | RARC Description <sup>3</sup>   | 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,<br>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 <sup>2</sup> An attachment/other documentation is                      | RARC<br>M1 | RARC Description <sup>3</sup> 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<br>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      | inisonig rudiology reporti   | 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<br>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 <sup>2</sup>   | RARC              | RARC Description <sup>3</sup>   | 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<br>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 <sup>2</sup>   | RARC  | RARC Description <sup>3</sup>   | 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). | 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 <sup>2</sup>   | RARC               | RARC Description <sup>3</sup>   | 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 <sup>2</sup>   | RARC  | RARC Description <sup>3</sup>   | 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). | 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   | N204  | Services under review for possible pre-<br>existing condition. Send medical records for<br>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<br>documentation/orders/notes/summary/report/c<br>hart.  | CO or PI     |

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

|      | Coonario #1. Additional Informa-  | Table | - Missing/Invalid/Incomplete Documentation  |              |
|------|---|-------|---|--------------|
|      |   | •     | Missing/invalid/incomplete Documentation<br>I from the billing provider or an ERA from a prior  | naver        |
| CARC | CARC Description <sup>2</sup>   | RARC  | RARC Description <sup>3</sup>   | 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 <sup>2</sup>   | RARC  | RARC Description <sup>3</sup>   | 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 <sup>2</sup>   | RARC    | RARC Description <sup>3</sup>                                    | 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<br>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 <sup>2</sup>   | RARC              | RARC Description <sup>3</sup>                        | 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<br>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

|      | Sagnario #1. Additional Inform  | Table | Missing/Invalid/Incomplete Documentation   |              |
|------|---|-------|--|--------------|
|      |   |       | Missing/Invalid/Incomplete Documentation<br>I from the billing provider or an ERA from a prio      | r naver      |
|      |   |       |  |              |
| CARC | CARC Description <sup>2</sup>   | RARC  | RARC Description <sup>3</sup>  | 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<br>(Coordination of Benefits or Medicare<br>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<br>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! d 1 T. C   | Table |   |              |
|--------|---|-------|---|--------------|
|        |   |       | - Missing/Invalid/Incomplete Documentation<br>d from the billing provider or an ERA from a prio | r novor      |
| G. D.G |   |       |   |              |
| CARC   | CARC Description <sup>2</sup>   | RARC  | RARC Description <sup>3</sup>   | 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<br>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<br>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<br>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<br>required to adjudicate this claim/service. At<br>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 <sup>2</sup>   | RARC    | RARC Description <sup>3</sup>   | 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<br>the cause of injuries sustained and medical<br>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<br>I from the billing provider or an ERA from a prio | or payer.    |
| CARC | CARC Description <sup>2</sup>   | RARC    | RARC Description <sup>3</sup>   | 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     |

<sup>&</sup>lt;sup>2</sup>Washington Publishing Company: http://www.wpc-edi.com/reference/

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<sup>&</sup>lt;sup>3</sup>Washington 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 | 3-1<br>olete Data from Submitted Claim   |                     |
|-----------|---|-------|--|---------------------|
| Refere to | o de la companya de   | •     | otete Data from Submitted Claim<br>er for missing or invalid data on the submitted clair                         | m a g an 837 or D 0 |
| CARC      | CARC Description <sup>4</sup>   | RARC  | RARC Description <sup>5</sup>  | 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-<br>payable reporting codes and appropriate<br>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                          | n on 927 D O |
| CARC     |   | RARC    | er for missing or invalid data on the submitted claim    | ASC X12 CAG  |
|          | CARC Description <sup>4</sup>   |         | RARC Description <sup>5</sup>                            |              |
| 16       | Claim/service lacks information or has<br>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    | Missing Community Com 111 11 11 11 11 11 11              | CO DY        |
| 16       | Claim/service lacks information or has  | M56     | Missing/incomplete/invalid payer identifier.             | CO or PI     |
| 16       | submission/billing error(s) which is needed   | Mag     | Missing/incomplete/inv-1: 4 #4-# 4-4-(-X-C               | 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       | claim/service lacks information or has submission/billing error(s) which is needed    | MOO     | Missing Certificate of Medical Necessity.                | CO or PI     |
| 16       | Claim/service lacks information or has  | M62     | Missing/incomplete/invalid treatment                     | CO or PI     |
| 10       | submission/billing error(s) which is needed   | 1010∠   | authorization code.                                      | CO or PI     |
| 16       | Claim/service lacks information or has  | M64     | Missing/incomplete/invalid other diagnosis.              | CO or PI     |
| 10       |   | 1/104   | ivitssing/incomplete/invalid other diagnosis.            | CO or PI     |
| 16       | submission/billing error(s) which is needed Claim/service lacks information or has    | M67     | Missing/incomplete/invalid other procedure               | CO or PI     |
| 16       |   | 1/10/   |  | CO or PI     |
| 16       | submission/billing error(s) which is needed Claim/service lacks information or has    | M76     | code(s).  Missing/incomplete/invalid diagnosis or        | CO or PI     |
| 10       | submission/billing error(s) which is needed   | IVI / O |  | CO or PI     |
| 16       |   | M77     | condition.  Missing/incomplete/invalid place of service. | CO or PI     |
| 10       | Claim/service lacks information or has<br>submission/billing error(s) which is needed | M77     | ivitssing/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

|           |  | 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 <sup>4</sup>  | RARC              | RARC Description <sup>5</sup>  | 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<br>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<br>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<br>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  | /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 <sup>4</sup>   | RARC            | RARC Description <sup>5</sup>  | ASC X12 CAGO            |
| 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   | 3.5.1.50        | 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<br>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   | 141/401         | 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                |
| 1.6         | submission/billing error(s) which is needed   | 34477           | representative signature date.   | CO DI                   |
| 16          | Claim/service lacks information or has  | MA75            | Missing/incomplete/invalid patient or  | CO or PI                |
| 16          | submission/billing error(s) which is needed Claim/service lacks information or has    | MA76            | authorized representative signature.  Missing/incomplete/invalid provider            | CO or PI                |
| 10          | submission/billing error(s) which is needed   | WA/0            | identifier for home health agency or hospice   | COOLL                   |
| 1.5         |   | 3.64.01         |  | GO PY                   |
| 16          | Claim/service lacks information or has submission/billing error(s) which is needed    | MA81            | Missing/incomplete/invalid provider/supplier   | CO or PI                |
| 16          | Claim/service lacks information or has  | MA83            | signature.  Did not indicate whether we are the primary                              | CO or PI                |
| 10          | submission/billing error(s) which is needed   | WIA65           | or secondary payer.  | CO or PI                |
| 16          | Claim/service lacks information or has  | MA88            | Missing/incomplete/invalid insured's address   | CO or PI                |
| 10          | submission/billing error(s) which is needed   | 1417400         | and/or telephone number for the primary  | 20 0111                 |
| 16          | Claim/service lacks information or has  | MA89            | Missing/incomplete/invalid patient's   | CO or PI                |
| 10          | submission/billing error(s) which is needed   | 1111107         | relationship to the insured for the primary  | 20 0111                 |
| 16          | Claim/service lacks information or has  | MA90            | Missing/incomplete/invalid employment  | CO or PI                |
| -           | submission/billing error(s) which is needed   |                 | status code for the primary insured.   |                         |
| 16          | Claim/service lacks information or has  | MA92            | Missing plan information for other insurance.  | CO or PI                |
|             | submission/billing error(s) which is needed   |                 |  |                         |
| 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   |                 | Managed Care Demonstration but patient is  |                         |
| 16          | Claim/service lacks information or has  | MA97            | Missing/incomplete/invalid Medicare  | CO or PI                |
|             | submission/billing error(s) which is needed   |                 | Managed Care Demonstration contract  |                         |
| 16          | Claim/service lacks information or has  | MA99            | Missing/incomplete/invalid Medigap   | CO or PI                |
|             | submission/billing error(s) which is needed   |                 | information.   |                         |
| 16          | Claim/service lacks information or has  | MA100           | Missing/incomplete/invalid date of current   | CO or PI                |
|             | submission/billing error(s) which is needed   |                 | illness or symptoms.   |                         |

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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 <sup>4</sup>  | RARC              | RARC Description <sup>5</sup>  | 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        |  | WA154             |  | 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 <sup>4</sup>   | RARC              | RARC Description <sup>5</sup>  | 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<br>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<br>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   | 11/2/13           | 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 <sup>4</sup>  | RARC   | RARC Description <sup>5</sup>                                       | 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<br>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 |   |                | er for missing or invalid data on the submitted clair                  | n. e.g., an 837 or D.0. |
| CARC      | CARC Description <sup>4</sup>   | RARC           | RARC Description <sup>5</sup>  | ASC X12 CAGC            |
| 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   | 3745           | 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.   | CO or PI                |
| 16        | Claim/service lacks information or has  | N278           | Missing/incomplete/invalid other payer                                 | CO or PI                |
| 10        | submission/billing error(s) which is needed   | 1,2,0          | service facility provider identifier.                                  | 00 0111                 |
| 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   | 17404          | 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                |
| 10        | submission/billing error(s) which is needed   | N283           | provider identifier.   | COOFFI                  |
| 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                |
| 16        | submission/billing error(s) which is needed   | NOO            | provider taxonomy.   | CO DI                   |
| 16        | Claim/service lacks information or has<br>submission/billing error(s) which is needed | N289           | Missing/incomplete/invalid rendering provider name.                    | CO or PI                |
| 16        | Claim/service lacks information or has  | N290           | Missing/incomplete/invalid rendering                                   | CO or PI                |
| 10        | submission/billing error(s) which is needed   | 11250          | 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.  | a                       |
| 16        | Claim/service lacks information or has  | N294           | Missing/incomplete/invalid service facility                            | CO or PI                |
| 16        | submission/billing error(s) which is needed Claim/service lacks information or has    | N295           | primary address.  Missing/incomplete/invalid service facility          | CO or PI                |
| 10        |   | N293           |  | COOFFI                  |
| 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   | 11270          | provider name.   | CO 01 11                |
| 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 <sup>4</sup>   | RARC             | RARC Description <sup>5</sup>                                   | 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<br>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 <sup>4</sup>  | RARC            | RARC Description <sup>5</sup>                               | 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            |  |                         |
|------|---|------------------|--|-------------------------|
|      |   |                  | plete Data from Submitted Claim  |                         |
|      |   | e billing provid | er for missing or invalid data on the submitted clair                            | n, e.g., an 837 or D.0. |
| CARC | CARC Description <sup>4</sup>   | RARC             | RARC Description <sup>5</sup>  | 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   | 11037            | code for these services.   | COOLL                   |
| 16   | Claim/service lacks information or has  | N685             | Missing/Incomplete/Invalid Prosthesis,   | CO or PI                |
|      | submission/billing error(s) which is needed   |                  | Crown or Inlay Code.   |                         |
| 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,   | Duy Guinor amounts  |                  |  | 00 0.11                 |
| 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                |
| 100  | D: : : : : :  | 34.00            | injury/accident.   |                         |
| 129  | Prior processing information appears incorrect. At least one Remark Code must be    | MA36             | Missing/incomplete/invalid patient name.   | CO or PI                |
|      | provided (may be comprised of either the  |                  |  |                         |
|      | NCPDP Reject Reason Code, or Remittance   |                  |  |                         |
|      | Advice Remark Code that is not an ALERT.)   |                  |  |                         |
|      | The vice remains code that is not an right thin                                     |                  |  |                         |
| 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 <sup>4</sup>  | RARC              | RARC Description <sup>5</sup>  | 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<br>the service billed. Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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'<br>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 <sup>4</sup>  | RARC             | RARC Description <sup>5</sup>   | 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                |

<sup>&</sup>lt;sup>4</sup>Washington Publishing Company: http://www.wpc-edi.com/reference/

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<sup>&</sup>lt;sup>5</sup>Washington 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 <sup>6</sup>  | RARC              | RARC Description <sup>7</sup>  | 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 <sup>6</sup>  | RARC              | RARC Description <sup>7</sup>  | 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-<br>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 <sup>6</sup>   | RARC               | RARC Description <sup>7</sup>   | 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-<br>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 <sup>6</sup>   | RARC              | RARC Description <sup>7</sup>  | 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 <sup>6</sup>  | RARC                 | RARC Description <sup>7</sup>  | 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 <sup>6</sup>  | RARC  | RARC Description <sup>7</sup>   | 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/<br>equipment/bed, however patient liability is<br>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-<br>existing condition. Send medical records for<br>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 <sup>6</sup>  | RARC    | RARC Description <sup>7</sup>   | ASC X12 CAGC |
| 55    | Procedure/treatment is deemed<br>experimental/investigational by the payer.<br>Note: Refer to the 835 Healthcare Policy<br>Identification Segment (loop 2110 Service<br>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<br>experimental/investigational by the payer.<br>Note: Refer to the 835 Healthcare Policy<br>Identification Segment (loop 2110 Service<br>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<br>experimental/investigational by the payer.<br>Note: Refer to the 835 Healthcare Policy<br>Identification Segment (loop 2110 Service<br>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<br>unscientific/unproven/outmoded/experimenta<br>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<br>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   |              |  |  |
|                 |   | e the billed serv | vice is not covered by the health plan.   |              |  |  |
| CARC8           | CARC Description <sup>6</sup>   | RARC              | RARC Description <sup>7</sup>   | 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 <sup>8</sup> | 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<br>Code must be provided (may be comprised of<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,  | M8                | We do not accept blood gas tests results when<br>the test was conducted by a medical supplier<br>or taken while the patient is on oxygen.   | CO, PI or PR |  |  |
| 96              | Non-covered charge(s). At least one Remark<br>Code must be provided (may be comprised of<br>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<br>Code must be provided (may be comprised of<br>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 |   |                    |  |              |  |
|-----------|---|--------------------|--|--------------|--|
|           |   |                    | ot Covered by Health Plan  |              |  |
|           |   | re the billed serv | rice is not covered by the health plan.  |              |  |
| CARC8     | CARC Description <sup>6</sup>   | RARC               | RARC Description <sup>7</sup>  | ASC X12 CAGC |  |
| 96        | Non-covered charge(s). At least one Remark<br>Code must be provided (may be comprised of<br>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<br>Code must be provided (may be comprised of<br>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<br>Code must be provided (may be comprised of<br>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<br>Code must be provided (may be comprised of<br>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<br>Code must be provided (may be comprised of<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,  | M55                | We do not pay for self-administered anti-<br>emetic drugs that are not administered with a<br>covered oral anti-cancer drug.   | CO, PI or PR |  |
| 96        | Non-covered charge(s). At least one Remark<br>Code must be provided (may be comprised of<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,  | M80                | Not covered when performed during the same<br>session/date as a previously processed service<br>for the patient.   | CO, PI or PR |  |
| 96        | Non-covered charge(s). At least one Remark<br>Code must be provided (may be comprised of<br>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<br>Code must be provided (may be comprised of<br>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<br>Code must be provided (may be comprised of<br>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<br>Code must be provided (may be comprised of<br>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<br>Code must be provided (may be comprised of<br>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<br>Code must be provided (may be comprised of<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835 | M100               | We do not pay for an oral anti-emetic drug<br>that is not administered for use immediately<br>before, at, or within 48 hours of<br>administration of a covered chemotherapy<br>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 <sup>6</sup>   | RARC                 | RARC Description <sup>7</sup>   | ASC X12 CAGC |
| 96    | Non-covered charge(s). At least one Remark<br>Code must be provided (may be comprised of<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(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<br>Code must be provided (may be comprised of<br>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<br>Code must be provided (may be comprised of<br>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<br>Code must be provided (may be comprised of<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>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<br>Code must be provided (may be comprised of<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>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<br>Nursing Facility (SNF) bill in the same<br>benefit period.   | CO, PI or PR |
| 96    | Non-covered charge(s). At least one Remark<br>Code must be provided (may be comprised of<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(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<br>Code must be provided (may be comprised of<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>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

|       | G 1 #2 P  | Table |  |                              |
|-------|---|-------|--|------------------------------|
|       |   |       | ot Covered by Health Plan  |                              |
| CARC8 |   |       | ice is not covered by the health plan.   | ASC V12 CACC                 |
| 96    | CARC Description <sup>6</sup> 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  | RARC Description <sup>7</sup> 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. | ASC X12 CAGO<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>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 Uselbages 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<br>Code must be provided (may be comprised of<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>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: 1  | Billed Service Not   | Covered by Health Plan   |              |
|       | Refers to situations when   | re the billed servic | e is not covered by the health plan.   |              |
| CARC8 | CARC Description <sup>6</sup>   | RARC                 | RARC Description <sup>7</sup>  | ASC X12 CAGO |
| 96    | Non-covered charge(s). At least one Remark<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835<br>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<br>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<br>Code must be provided (may be comprised of<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,  | N54                  | Claim information is inconsistent with pre-<br>certified/authorized services.  | CO, PI or PR |
| 96    | Non-covered charge(s). At least one Remark<br>Code must be provided (may be comprised of<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,  | N56                  | Procedure code billed is not correct/valid for<br>the services billed or the date of service<br>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<br>Code must be provided (may be comprised of<br>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<br>Code must be provided (may be comprised of<br>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<br>Code must be provided (may be comprised of<br>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:  | 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 <sup>6</sup>   | RARC                 | RARC Description <sup>7</sup>  | 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.:   | either the NCPDP Reject Reason [sic] Code,  |                      |  | a            |
| 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,<br>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<br>not an ALERT.) Note: Refer to the 835     |                      | payer does not cover items and services<br>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/   |              |
|       | 1   |                      | 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 <sup>6</sup>   | RARC              | RARC Description <sup>7</sup>   | ASC X12 CAGO |
| 96    | Non-covered charge(s). At least one Remark<br>Code must be provided (may be comprised of<br>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<br>Code must be provided (may be comprised of<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>not an ALERT.) Note: Refer to the 835   | N121              | Medicare Part B does not pay for items or<br>services provided by this type of practitioner<br>for beneficiaries in a Medicare Part A covered<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is<br>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<br>Code must be provided (may be comprised of<br>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 <sup>6</sup>   | RARC              | RARC Description <sup>7</sup>   | 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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>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<br>Code must be provided (may be comprised of<br>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<br>Code must be provided (may be comprised of<br>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<br>Code must be provided (may be comprised of<br>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/<br>equipment/bed, however patient liability is<br>limited to amounts shown in the adjustments<br>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<br>Code must be provided (may be comprised of<br>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<br>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 <sup>6</sup>   | RARC  | RARC Description <sup>7</sup>   | ASC X12 CAGC |
| 96       | Non-covered charge(s). At least one Remark<br>Code must be provided (may be comprised of<br>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<br>Code must be provided (may be comprised of<br>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<br>Code must be provided (may be comprised of<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>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<br>Code must be provided (may be comprised of<br>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<br>Code must be provided (may be comprised of<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>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<br>Code must be provided (may be comprised of<br>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<br>Code must be provided (may be comprised of<br>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 <sup>6</sup>  | RARC  | RARC Description <sup>7</sup>  | ASC X12 CAGO |
| 96    | Non-covered charge(s). At least one Remark<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>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<br>Code must be provided (may be comprised of<br>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<br>Code must be provided (may be comprised of<br>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<br>Code must be provided (may be comprised of<br>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<br>Code must be provided (may be comprised of<br>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<br>Code must be provided (may be comprised of<br>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<br>Code must be provided (may be comprised of<br>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<br>Code must be provided (may be comprised of<br>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<br>Code must be provided (may be comprised of<br>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<br>Code must be provided (may be comprised of<br>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<br>Code must be provided (may be comprised of<br>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<br>Code must be provided (may be comprised of<br>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<br>Code must be provided (may be comprised of<br>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 <sup>6</sup>  | RARC               | RARC Description <sup>7</sup>   | ASC X12 CAGO |
| 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   | 1907               | 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<br>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<br>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   | TNUU/              | 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 <sup>6</sup>  | RARC              | RARC Description <sup>7</sup>   | ASC X12 CAGC |
| 96    | Non-covered charge(s). At least one Remark<br>Code must be provided (may be comprised of<br>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<br>Code must be provided (may be comprised of<br>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<br>Code must be provided (may be comprised of<br>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<br>Code must be provided (may be comprised of<br>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<br>Code must be provided (may be comprised of<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>or Remittance Advice Remark Code that is | N643              | The services billed are considered Not<br>Covered or Non-Covered (NC) in the<br>applicable state fee schedule.          | CO, PI or PR |
| 96    | Non-covered charge(s). At least one Remark<br>Code must be provided (may be comprised of<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>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<br>Code must be provided (may be comprised of<br>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<br>Code must be provided (may be comprised of<br>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<br>Code must be provided (may be comprised of<br>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<br>Code must be provided (may be comprised of<br>either the NCPDP Reject Reason [sic] Code,<br>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:<br>Refer to the 835 Healthcare Policy<br>Identification Segment (loop 2110 Service<br>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 <sup>6</sup>  | RARC  | RARC Description <sup>7</sup>  | ASC X12 CAGC |
| 108   | Rent/purchase guidelines were not met. Note:<br>Refer to the 835 Healthcare Policy<br>Identification Segment (loop 2110 Service<br>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<br>unscientific/unproven/outmoded/experimenta<br>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 <sup>6</sup>  | RARC    | RARC Description <sup>7</sup>   | 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<br>session/date as a previously processed service<br>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<br>(name and address, or PIN) where the<br>service(s) were rendered in a Health<br>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 <sup>6</sup>   | RARC  | RARC Description <sup>7</sup>   | 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<br>not support this length of service. Note: Refer<br>to the 835 Healthcare Policy Identification<br>Segment (loop 2110 Service Payment<br>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 <sup>6</sup>  | RARC               | RARC Description <sup>7</sup>   | 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<br>this type of provider. Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>REF), if present. | N90                | Covered only when performed by the attending physician.   | CO, PI or PR |
| 170   | Payment is denied when performed/billed by<br>this type of provider. Note: Refer to the 835<br>Healthcare Policy Identification Segment<br>(loop 2110 Service Payment Information<br>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 <sup>6</sup>  | RARC  | RARC Description <sup>7</sup>  | 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 <sup>6</sup>  | RARC               | RARC Description <sup>7</sup>  | 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-<br>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<br>the fee schedule or contracted/legislated fee<br>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<br>Payments Coverage on the policy at the time<br>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 <sup>6</sup>  | RARC  | RARC Description <sup>7</sup>  | 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<br>hospital-acquired condition or preventable<br>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<br>care providers. Notes: This code replaces<br>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<br>care providers. Notes: This code replaces<br>deactivated code 38   | N202  | Additional information/explanation will be sent separately.  | CO, PI or PR |
| 242   | Services not provided by network/primary<br>care providers. Notes: This code replaces<br>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<br>care providers. Notes: This code replaces<br>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<br>care providers. Notes: This code replaces<br>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<br>care providers. Notes: This code replaces<br>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 <sup>6</sup>  | RARC    | RARC Description <sup>7</sup>   | ASC X12 CAGO |
| 246       | This non-payable code is for required reporting only.  | N572    | This procedure is not payable unless non-<br>payable reporting codes and appropriate<br>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<br>benefits not available under this plan. Submit<br>these services to the patient's medical plan for<br>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<br>benefits not available under this plan. Submit<br>these services to the patient's medical plan for<br>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 <sup>6</sup>  | RARC  | RARC Description <sup>7</sup>   | ASC X12 CAGC |
| 256   | Service not payable per managed care contract.   | MA16  | The patient is covered by the Black Lung<br>Program. Send this claim to the Department<br>of Labor, Federal Black Lung Program, P.O.<br>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<br>the fee schedule or contracted/legislated fee<br>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: B   | Table 4 | t Covered by Health Plan  |              |
|-------|--|---------|---|--------------|
|       | Refers to situations wher  |         | ice is not covered by the health plan.  |              |
| CARC8 | CARC Description <sup>6</sup>  | RARC    | RARC Description <sup>7</sup>   | 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 <sup>6</sup>   | RARC              | RARC Description <sup>7</sup>  | 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 <sup>6</sup>   | RARC                   | RARC Description <sup>7</sup>  | 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<br>outpatient facility fee schedule. To be used<br>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 <sup>6</sup>   | RARC  | RARC Description <sup>7</sup>   | 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<br>Coverage (MPC) or Personal Injury<br>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<br>Coverage (MPC) or Personal Injury   | 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 <sup>6</sup>  | RARC              | RARC Description <sup>7</sup>   | 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<br>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<br>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 <sup>6</sup>                   | RARC              | RARC Description <sup>7</sup>                   | 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             | wissing 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 <sup>6</sup>  | RARC | RARC Description <sup>7</sup>   | 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 |  |  |  |

<sup>&</sup>lt;sup>6</sup>Washington Publishing Company: http://www.wpc-edi.com/reference/

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<sup>&</sup>lt;sup>7</sup>Washington Publishing Company: http://www.wpc-edi.com/reference/

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

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

| Table 5-1  |   |      |  |              |  |
|--|---|------|--|--------------|--|
| Scenario #4: Benefit for Billed Service Not Separately Payable   |   |      |  |              |  |
| Refers to situations where the billed service or benefit is not separately payable by the health plan. |   |      |  |              |  |
| CARC   | CARC Description <sup>9</sup>   | RARC | RARC Description <sup>10</sup>   | ASC X12 CAGO |  |
| 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<br>the services billed or the date of service<br>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<br>Refers to situations where the billed service or benefit is not separately payable by the health plan. |  |      |  |              |  |
|  |  |      |  |              |  |
| 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  |              |  |
|--|--|-------|--|--------------|--|
| Scenario #4: Benefit for Billed Service 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<br>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: Befor 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 |  |  |  |

<sup>&</sup>lt;sup>9</sup>Washington Publishing Company: http://www.wpc-edi.com/reference/

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

#### 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                       |                         |
| Refers | 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 <sup>11</sup>  | RARC                    | RARC Description <sup>12</sup>                    | 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. |                         |   |                         |
|        |   |                         |   |                         |

<sup>&</sup>lt;sup>11</sup>Washington Publishing Company: http://www.wpc-edi.com/reference/

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<sup>&</sup>lt;sup>12</sup>Washington Publishing Company: http://www.wpc-edi.com/reference/

<sup>&</sup>lt;sup>13</sup>http://www.ncpdp.org/members/members\_download.aspx. NCPDP Reject Codes are in Appendix A